



Administrator Program
Tuesday, November 18, 2025
3:30pm-4:30pm

8a. Fraud, Waste and Abuse Laws

Presented by:
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Fraud, Waste and Abuse Laws Recent Developments & Compliance Tips

Texas Association for Home Care and Hospice (TAHC&H)

Tuesday, November 18, 2025

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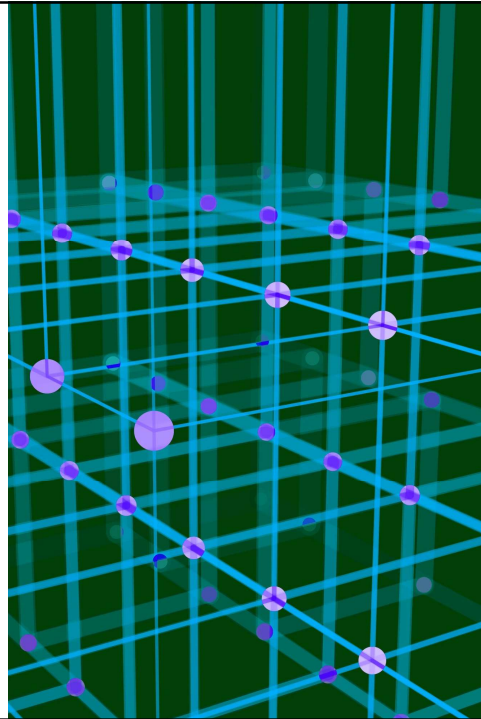
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ATTORNEYS & COUNSELORS AT LAW

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Topics

- Federal Enforcement – Department of Justice
- HHS Office of Inspector General (OIG)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractors (UPICs)
- Administrative Actions
- Applicable Laws
- Compliance Tips



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Federal Enforcement by DOJ - Strike Forces

Strike Forces are actively working to prevent and combat health care fraud, waste, and abuse. These are partnerships between DOJ's Criminal Division, U.S. Attorney's Offices, the FBI, HHS-OIG and the DEA. Strike Force teams currently operate in the following areas:

Louisiana / Mississippi: Baton Rouge / New Orleans / Gulfport
"Gulf Coast Strike Force"

Texas: **Houston / Dallas / San Antonio**
Florida: Miami / Tampa / Orlando
Los Angeles: Los Angeles
Midwest: Chicago / Detroit
New England: Concord / Portland / Burlington / Boston
Northeast Regional: Brooklyn / Newark / Trenton
Prescription: Nashville / Fort Mitchell, KY
Gulf Coast: New Orleans / Baton Rouge / Gulfport

Rapid Response: **National Coverage / Focus on COVID-19 Fraud, corporate healthcare fraud, telemedicine and sober homes**

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Federal Enforcement DOJ - Civil

- DOJ was awarded **\$2.7 billion** in civil False Claims Act related damages during 2023.
- More than **\$1.8 billion** of that is attributable to health care related cases and matters.

Year	2019	2020	2021	2022	2023
Civil Fraud Recoveries	\$3.1B	\$2.2B	\$5.6B	\$2.2B	\$2.7B

- Notably, **\$1.5 billion** of the 2023 recoveries were associated with **whistleblower cases**. Whistleblowers received \$200M from these cases.
- There were **348** new whistleblower cases filed in 2023. There were **94** DOJ initiated civil investigations. Numbers are flat last 3 years.
- During **FY 2021**, DOJ opened **805** new civil health care fraud investigations.

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Current Enforcement DOJ - Criminal

- During FY 2023, DOJ prosecutors filed criminal charges against **143 defendants** in health care fraud cases involving **\$3.83B in alleged health care fraud**.
- It also convicted 186 defendants, with 150 guilty pleas and 36 trial convictions. **DOJ's conviction rate at trial in criminal health care fraud cases was 100%.**
- Average alleged **Loss Per Defendant** Charged in 2023 was **\$26.78M**.
- For every **\$1 invested** in criminal enforcement, DOJ estimates **\$101.78 in return over a ten-year period**, and **\$3.92B in projected savings per year**.
- Enhanced focus on Data Analytics to identify fraud schemes - 2,968 data requests and 223 proactive investigative referrals.



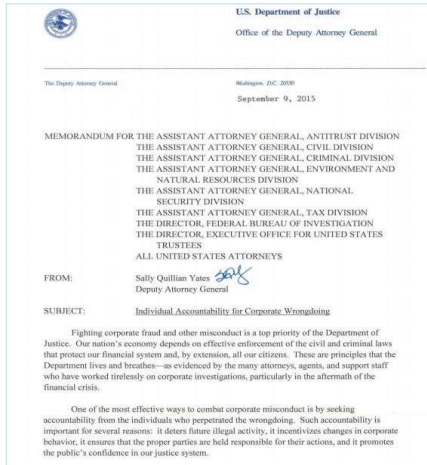
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2025 National Health Care Fraud Takedown (June 30, 2025)

- **Criminal charges** against **325 defendants**, including 96 doctors, nurse practitioners, pharmacists and other licensed professionals, with alleged losses of **\$14.6B**
- Government seized \$245M in cash, luxury vehicles, cryptocurrency and other assets
- **Civil charges** against **20 defendants** for **\$14.2M** in alleged fraud and **settlements** with 106 defendants totaling **\$34.3M**
- Focus was on:
 - Transnational Criminal Organizations
 - Fraudulent Wound Care
 - Prescription Opioid Trafficking
 - Telemedicine and Genetic Testing Fraud
 - Other Schemes involving hospices, home health agencies, and other providers

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Federal Enforcement DOJ Criminal - Focus on Individuals



U.S. Department of Justice
Office of the Deputy Attorney General

The Deputy Attorney General Washington, D.C. 20530
September 9, 2015

MEMORANDUM FOR THE ASSISTANT ATTORNEY GENERAL, ANTITRUST DIVISION
THE ASSISTANT ATTORNEY GENERAL, CIVIL DIVISION
THE ASSISTANT ATTORNEY GENERAL, CRIMINAL DIVISION
THE ASSISTANT ATTORNEY GENERAL, ENVIRONMENT AND
NATURAL RESOURCES DIVISION
THE ASSISTANT ATTORNEY GENERAL, NATIONAL
SECURITY DIVISION
THE ASSISTANT ATTORNEY GENERAL, TAX DIVISION
THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION
THE DIRECTOR, EXECUTIVE OFFICE FOR UNITED STATES
TRUSTEES
ALL UNITED STATES ATTORNEYS

FROM: Sally Quillian Yates *SQY*
Deputy Attorney General

SUBJECT: Individual Accountability for Corporate Wrongdoing

Fighting corporate fraud and other misconduct is a top priority of the Department of Justice. Our nation's economy depends on effective enforcement of the civil and criminal laws that protect our financial system and, by extension, all our citizens. These are principles that the Department lives and breathes—as evidenced by the many attorneys, agents, and support staff who have worked tirelessly on corporate investigations, particularly in the aftermath of the financial crisis.

One of the most effective ways to combat corporate misconduct is by seeking accountability from the individuals who perpetrated the wrongdoing. Such accountability is important for several reasons: it deters future illegal activity; it incentivizes changes in corporate behavior; it ensures that the proper parties are held responsible for their actions; and it promotes the public's confidence in our justice system.

On September 9, 2015, Deputy Attorney General Sally Yates issued a Memorandum entitled:

"Individual Accountability for Corporate Wrongdoing"

This important document instructs DOJ prosecutors to stop resolving corporate cases that release individuals from personal liability, (in the absence of extraordinary circumstances).

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Federal Enforcement DOJ Criminal - Focus on Individuals

- Deputy Attorney General (DAG) Lisa Monaco issued guidance stating:

"The Department's first priority in corporate criminal matters is to hold accountable the individuals who commit and profit from corporate crime.

... Corporations can best deter misconduct if they make clear that all individuals who engage in or contribute to criminal misconduct will be held personally accountable. In assessing a compliance program, prosecutors should consider whether the corporation's compensation agreements, arrangements, and packages (the "compensation systems") incorporate elements such as compensation clawback provisions—that enable penalties to be levied against current or former employees, executives, or directors whose direct supervisory actions or omissions contributed to criminal conduct."

- As a result, the personal liability of all owners, clinical staff, administrators, marketers and billers has greatly increased. **You cannot expect to avoid personal liability by hiding behind your organization's settlement with DOJ and / or the OIG.**

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HHS-OIG Enforcement

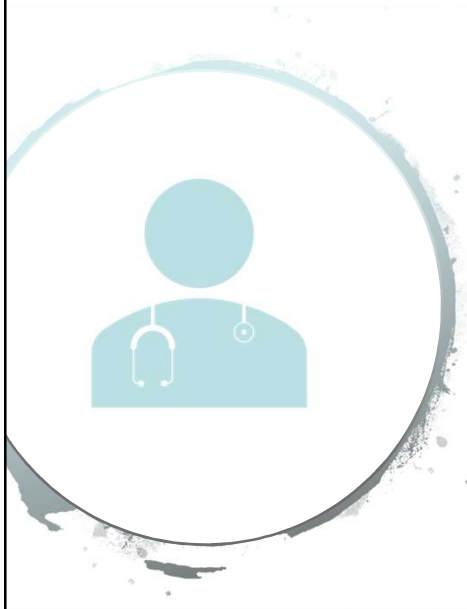
- Provides oversight of Medicare and Medicaid programs through audits, investigations and evaluations of programs and providers, and detects wrongdoers and abusers of HHS programs and beneficiaries.
- Responsible for Advisory Opinions on Federal Anti-Kickback Statute and Beneficiary Inducement Law
- Runs the Health Care Fraud Self-Disclosure Program
- During FY 2023, HHS-OIG:
 - excluded 2,112 individuals and entities from participation in Federal and State health care programs
 - Involved in 707 criminal actions, and 746 civil actions
 - \$3.16B in expected investigative recoveries
- The OIG Work Plan is a digest of audits and evaluations underway or planned during a fiscal year. Key tool to identify potential risk areas. (<https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp>)



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Supplemental Medical Review Contractor (“SMRC”)

- Conducts nationwide medical reviews for CMS
 - Noridian is the contractor
 - Maintains a list of active projects assigned by CMS
 - There are also special projects requested by CMS that do not appear on the SMRC Project List
- Very active in hospice this past year with focus on long length of stay cases
- Audits involve large samples (150+ claims) but are not extrapolated
- Because of large samples, overpayments identified can be significant
- Same appeal process as any other audit



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UPICs

- **Contracted by CMS to Find Fraud.** Tasked with Medicare and Medicaid program integrity activities in 5 regions. Texas is in the Southwestern UPIC overseen by Qlarant Integrity Solutions. They **screen and prioritize leads for investigation, perform data analysis, and conduct audits.**
- **Primary Sources of an Audit.** CMS requires that UPICs store the most recent 36 months worth of data for home health and hospice agency claims. It uses this data, along with the following data sources to identify outliers and potential audit targets.
- **Predictive Modeling / Data Mining.** As Chapter 2, Sec. 2.4.C. of the MPIM details:
"Claims data is the primary source of information to target abuse activities."

Factors Considered Include, but are Not Limited to:

1. Volume of Business
2. Percentage of Medicare / Medicaid patients
3. History of Previous Investigations
4. Error Rates
5. Overpayment history
6. Appeals History

Secondary Sources Include:

1. Complaints
2. Referrals
3. Reports
4. State Licensing Boards



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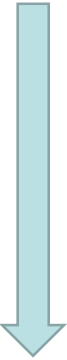
UPICs

- **Cross-Referrals are common:**
 - "UPICs **shall refer** cases of potential fraud to the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Office of Investigations (OI)." **Major Case Coordination project increased referrals 200% as of 2023.**
 - CMS MACs shall analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action shall be initiated. At any time, evidence of fraud shall result in referral to the UPICs for development.
 - MACs are required to:
 - Refer potential fraud, waste, or abuse situations promptly to the responsible UPIC.
 - Forward complaints alleging fraud through the screening staff to the UPIC.
 - Forward to the UPIC detailed documentation of telephone or personal contacts involving fraud issues discussed with providers / suppliers or provider / supplier staff, and retain such information in individual provider / supplier files

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UPICs

- Primary Administrative Actions Recommended by a UPIC:

- 
- #1. Identifying an alleged **overpayment**. *Most Likely*
 - #2. Initiating a **payment suspension** action against a Medicare or Medicaid provider or supplier.
 - #3. Initiating the **revocation** of a provider's or supplier's Medicare billing privileges.
 - #4. **Referring cases to law enforcement** for civil or criminal prosecution. *Least Likely*

❖ *UPICs must coordinate with CMS/MACs for all actions. They don't have independent authority to suspend, revoke, or demand repayment of an overpayment.*

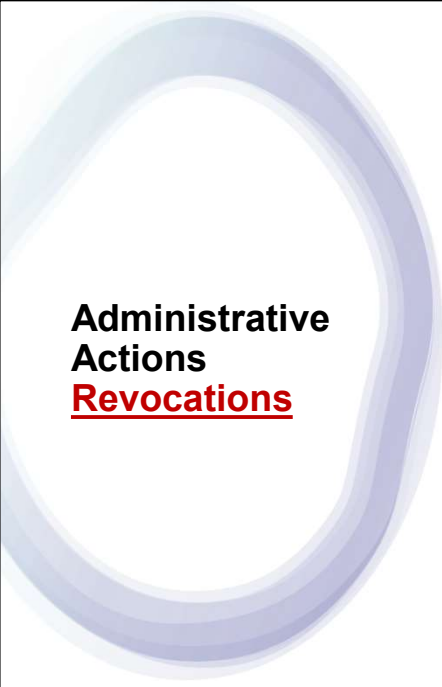
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Administrative Actions Suspensions

- **Suspension Actions.** In 2019, UPICs recommended 462 suspensions (53 of those in Qlarant's SW jurisdiction).
- **Historical Use of "Suspension" Authority by CMS.** CMS is empowered to suspend payments to Medicare providers in three circumstances:
 - A **credible allegation of fraud**.
 - An **overpayment of an undetermined amount** has been identified or payments that have been made (or are scheduled to be made) may be incorrect.
 - The provider **fails to respond to a request for medical records**.
- **A "Credible Allegation of Fraud" Can Flow from Any Source, Including:**
 - *Fraud hotline complaints.*
 - *Claims data mining.*
 - *Provider audits.*
 - *Law enforcement investigations.*

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Administrative Actions Revocations

- **Revocation Actions.** In 2019, UPICs recommended 162 revocations. CMS MACs also recommend revocations. The reasons for revocation have varied but have typically been associated with:
 - Failure to keep enrollment record current (e.g., report a change of location)
 - Failure to report a final adverse legal action
 - Felony conviction in last 10 years
 - Pattern or practice of billing errors
 - Employing excluded individuals / failing to properly screen

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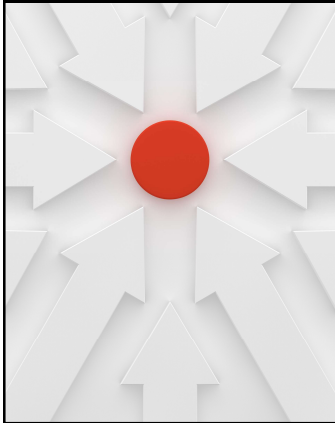
Administrative Actions TPE Audits



- **TPE Audits.** On October 1, 2017, CMS and the MACs implemented the national **Targeted Probe and Educate (TPE)** Program which is applicable to home health agencies and hospices. The original goal was to **incorporate learning and an opportunity to take corrective action** over several periods rather than subject a Medicare provider to immediate sanctions for noncompliance. How are home health and hospice agencies selected for a TPE audit?
 - ❖ **The provider has a history of questionable billing practices.** Any home health and hospice with a history of errors is likely to be subject to a TPE audit at some point.
 - ❖ **The home health or hospice agency has previously been audited and their claim error rates were higher than average.** CMS wants to ensure that providers who have already faced compliance challenges have implemented sufficient new protocols to avoid errors in the future.
 - ❖ **An organization provides services with high national billing error rates OR a history of problematic business practices (both home health and hospice agencies fit in this category).** Even if a home health or hospice agency has never been audited or found noncompliant in any way, it may be targeted for a TPE audit simply because particular services are incorrectly billed at a higher rate nationally.
 - ❖ **The services billed represent a significant financial risk to the Medicare program.** Regardless of whether a specific home health or hospice agency has a high error rate, the services billed to Medicare represent a high financial burden on the Medicare program.

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Administrative Actions TPE Audits



- Palmetto's current **hospice focus list** for TPE Audits (not exhaustive):
 - Bene sharing
 - GIP > 7 days
 - New hospice providers
 - LOS greater than 365 days
 - High Risk Hospice in Texas
 - PPEO for CHOWs, 100% changes in shareholders/members, newly certified
- Palmetto's current **home health focus list** for TPE Audits (not exhaustive):
 - Bene sharing
 - Eligibility and Medical Necessity

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Administrative Actions Prepayment Audits

- How Should You Respond if Your Home Health or Hospice Agency is Placed on Prepayment Review?
 - ❖ **DON'T IGNORE THE PROBLEM** – you need to be reviewing all documentation before submission for completeness and compliance. Cure what can be appropriately cured!
 - ❖ Providers should also keep in mind that a poor showing in connection with a prepayment audit, can lead to:
 - ☐ Postpayment audit
 - ☐ Suspension
 - ☐ Revocation
 - ☐ Referral to HHS-OIG for possible CMP action.
 - ☐ Referral to DOJ for possible False Claims Act and / or criminal enforcement.
- There is a Difference Between Receiving an ADR and Being Placed on Prepayment Review. ADRs, or "Additional Development Requests", are:
 - ❖ Initiated by a provider's MAC
 - ❖ Typically relate to a particular probe or edit conducted by the MAC
 - ❖ May be focused on specific services, length of stay, a specific provider or a specific diagnosis
 - ❖ Short duration of requests

Prepayment Review **often affects 100% of a provider's claims** and can last **up to a year or more**.

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Applicable Laws

Many laws govern healthcare fraud, waste and abuse, among them:

Civil Laws

- Physician Self-Referral ("Stark") Statute, 42 U.S.C. §1395nn
- The False Claims Act, 31 U.S.C. § 3729 *et seq.*
- Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Criminal laws

- The Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b)
- Criminal Health Care Fraud Statute, 18 U.S.C. Section 1347



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Civil False Claims Act

- **Provisions of the Civil False Claims Act?** (31 U.S.C. § 3729-3733). The False Claims Act remains the primary civil enforcement tool utilized by the U.S. Department of Justice (DOJ).
- The statute imposes civil monetary penalties and damages on any person who **knowingly** submits, or **causes to be submitted**, a false claim to the government for payment.
 - **"Knowingly"** includes **actual knowledge, reckless disregard and deliberate ignorance.**
- **Statute of limitations under the False Claims Act.** Generally, **6-year statute of limitations** that can be tolled (under certain circumstances) up to a maximum of 10 years from when the government knew, or reasonably should have known, that the violation occurred. 31 U.S.C. § 3731(b).
- **Damages and penalties under the False Claims Act.** A person found to have violated this statute may be liable for both civil penalties and treble damages. As of January 15, 2025, the minimum penalty that may be assessed PER FALSE CLAIM is \$14,308, and the maximum penalty is \$28,619.
- **Can you be held liable?** Owners, Administrators, Clinical Staff, Billers and Office Managers are increasingly at risk of being pursued by the DOJ for violations of the False Claims Act under the "causes to be presented" arm of the statute.

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Civil False Claims Act Example Cases

- **August 2024** – Home Heath Company agreed to pay \$3,850,000 to resolve allegations that it violated the False Claims Act in connection with two lines of its business: first, that it knowingly submitted claims to Medicare for home healthcare services for patients who **did not qualify for the Medicare home healthcare benefit or where services otherwise did not qualify for Medicare reimbursement**; and second, that it knowingly submitted claims to Medicare for patients who **did not qualify for the hospice benefit**. Separately, the United States alleged that, between 2016 and 2021, three hospice facilities admitted patients to hospice care who were ineligible for the Medicare hospice benefit because they were not terminally ill or continued providing services to patients who should have been discharged because they no longer met the requirements for the Medicare hospice benefit.
- **February 2025** – Hospice company agreed to pay \$3M to settle allegations made by a whistleblower that between 2013 and 2020 it submitted, or caused the submission of, **false claims to Medicare for 21 patients who did not meet the eligibility requirements for the Medicare hospice benefit** as defined by statute and regulation, despite the hospice knowing the patients were ineligible for the Medicare hospice benefit.
- **June 2025** – Hospice company and its owner agreed to pay \$9.2M to resolve whistleblower case alleging violations of the FCA and Anti-Kickback Statute. Former employee responsible for marketing hospice's services to health care providers filed a whistleblower complaint alleging that the **hospice paid kickbacks to medical directors to induce them to refer patients**. These alleged kickbacks included monthly stipends and a signing bonus paid to the medical directors. The compensation allegedly increased when the medical director referred more patients and decreased when the medical director failed to make referrals.

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Civil - Federal Physician Self-Referral Law ("Stark")

- Prohibits a **physician** from making referrals for certain **designated health services** (DHS) to an entity in which the physician, or a member or his/her family, has a **financial relationship**, unless an exception applies.
- Potential penalties for violation:
 - ✓ Up to \$15,000 per claim
 - ✓ Up to \$100,000 for each scheme
 - ✓ Denial of payment for DHS and refund of amounts paid
 - ✓ Treble damages
 - ✓ Exclusion from federal health care programs
- **Key terms:**
 - **Financial relationship** = *compensation, ownership or investment interests*. Most common is medical directors.
 - **DHS** - *Home health services are DHS*, but *Hospice services are not*.
 - Stark applies to a physician financial relationship if that physician will **ever** refer Medicare patients to the HHA.
 - Strict liability, civil statute. You must comply or suffer penalties.

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Stark Law (cont'd)



- 42 CFR 424.22(d) expressly prohibits a physician/non-physician practitioner from certifying/re-certifying or establishing a plan of care if he or she has a financial relationship with an HHA, *unless that relationship complies with a Stark exception*
- Commonly used exceptions: *personal service arrangements*, office space lease, equipment lease, *bona fide employment relationships*, nonmonetary compensation, investment in a rural provider
- Personal Service Arrangements exception very similar to AKS safe harbor and commonly used to protect medical director arrangements.

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Stark Law (cont'd)

- **January 2021** - founders of a hospice and home health agency agreed to pay \$1,847,279.36 following an investigation into improper payments to physicians for referrals. The investigation began in 2016 and revealed the owners offered compensation to physicians who were responsible for a significant majority of their patient referrals. Specifically, they *provided physicians with monthly payments pursuant to medical directorship agreements. Those payments were in excess of fair market value for the services the physicians actually provided.* They also sold interests in the hospice to five different physicians which ultimately netted them substantial quarterly dividends. They also provided physicians other gifts and benefits, such as travel and tickets to sporting events.
- **November 2020** - home health agency provided improper financial inducements to referring physicians through *sham medical director agreements and bonuses to physicians' spouses* who were Doctor's Choice employees based on the physicians' referrals.



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Criminal - Federal Anti-Kickback Statute

- Prohibits *knowingly or willfully* soliciting, receiving, offering, or paying any *remuneration* (including any kickback, bribe, or rebate) in order *to induce or reward business* that is payable under a federal health care program.
- Transactions among parties who refer to each other are subject to the AKS.
- If guilty, can result in incarceration plus fines
- Bipartisan Budget Act of 2018, signed Feb. 9, 2018, increased penalties from \$25,000 to \$100,000 per violation
- BBA increased maximum term of imprisonment from 5 to 10 years
- May be excluded
- **Remuneration = anything of value**



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Anti-kickback Statute (cont'd)

- Under §6402(f)(2) of the Affordable Care Act:
“A person need not have actual knowledge of this section or specific intent to commit a violation of this section.” (emphasis added).
- “One purpose” rule – even if lots of other (valid) reasons for remuneration, *if even one purpose is to improperly induce referrals, there is a violation*
- Need to show intent to violate statute – “knowing and willful” – but not specific intent to violate this law.
- Under the ACA, a claim submitted in violation of the Federal Anti-Kickback Statute now automatically constitutes a false claim for purposes of the False Claims Act.



10/14/2019

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Anti-kickback Statute (cont'd)

- **Safe harbors.** Department of Health and Human Services, Office of Inspector General (OIG) issues "safe harbors" for certain business arrangements and practices that while potentially a violation of law, are permitted as long as certain safeguards are put in place to prevent fraud and abuse.
- Safe harbors are **voluntary**, not mandatory.
- **25 safe harbors currently** - Must meet all terms/criteria of safe harbor for it to apply
- The most likely safe harbors to arise in a home health or hospice compensation or ownership arrangement would likely be:
 - Personal services and management contracts
 - Employee
 - Small entity investment
- Safe harbors are complex and typically require a legal assessment to determine whether a proposed business arrangement qualifies under a specific safe harbor.
- Physician ownership of home health or hospice agencies MAY be protected under the small entity investment safe harbor, but compliance is complex and meeting every element of that safe harbor can be difficult. Consult health care counsel!



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Anti-kickback Statute (cont'd)

Personal Services and Management Contracts Safe Harbor:
(42 C.F.R. § 1001.952(d))



1. **Written, signed agreement.**
2. **Covers and specifies all the services** the agent provides for the term of the agreement.
3. Term of at least **one year**.
4. The **methodology** for determining the compensation paid to the agent over the term of the agreement is **set in advance**, is consistent with **fair market value** in arm's-length transactions and is **not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties** for which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs.
5. Does not involve the counselling or promotion of a business arrangement or other activity that violates any State or Federal law.
6. Aggregate services **do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose** of the services.

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Anti-kickback Statute (cont'd)



Employment Safe Harbor:

- “Remuneration” does not include any amount paid by an employer to an employee, who has a **bona fide employment relationship** with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.
- **Bona fide employee = refers to the IRS test at 26 USC Sec. 3121(d)(2)**
- Often comes up in marketer/kickback cases where fees were commission or success based
- Key factors in prosecuted cases include...was the person really an employee:
 - Form of payment (hourly v. pure commission compensation).
 - Whether alleged employee had an office at employer's location.
 - Whether alleged employee received any training.
 - Whether alleged employee set his or her own hours or worked full-time.
 - Whether employer paid all expenses of alleged employee.

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Anti-kickback Statute (cont'd)

- **Small Entity Investment Safe Harbor:**
 - **Protects investments** in healthcare providers **by those that can make or influence referrals** to the entity.
 - Doesn't just apply to doctors...any health care provider can “influence” referrals to another health care provider.
 - No more than 40% of entity is owned by those in a position to make or influence referrals
 - No more than 40% of entity revenue is the result of referrals by investors in a position to make or influence referrals
 - The Anti-Kickback Statute effectively prohibits most physician investment in home health, but it does not prohibit physician investment in hospice.
 - The Anti-Kickback Statute will apply to investments in hospice agencies by (1) physicians and (2) owners of other providers, for example, owners of home health, therapy, nursing facilities, DME companies, ALFs, etc.
 - Structuring hospice investments to minimize legal risk under the Anti-Kickback Statute is difficult. Consult an attorney experienced with health care fraud and abuse issues!

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Anti-Kickback Statute – Convictions & Charges

Home Health and Hospice Agencies and Related Parties:

- **June 2025** – Two people in San Antonio were charged with conspiracy to defraud the US and pay and receive health care kickbacks in connection with a hospice fraud scheme. As alleged in the information, the individuals paid marketers illegal kickbacks to induce Medicare beneficiary referrals to their company. Based on those referrals, the individuals caused the submission of \$1,692,950 in false and fraudulent claims for hospice services that were procured through illegal kickback and bribes, medically unnecessary, and ineligible for Medicare reimbursement. Medicare paid approximately \$529,287 based on those claims.
- ❖ **June & October 2025** – Seven people in the Houston area have been charged for their alleged roles in a \$110M hospice fraud and kickback scheme. The government alleges they **misled vulnerable elderly adults about what services were being billed** to their Medicare and Medicaid plans. Patients believed they would be receiving palliative or home health services, when in truth, the patients were enrolled in hospice services but were not actually terminally ill. One of the individuals allegedly **paid kickbacks to several group homeowners in exchange for enrolling their beneficiaries in hospice** with the agency and **bribed a physician to certify and re-certify patients as terminally ill when they were not**. It is also alleged that two of the individuals **opened new hospice companies under straw ownership** to continue the fraud and then laundered the proceeds through various accounts. The individuals also allegedly **paid kickbacks to a hospital discharge coordinator in exchange for referrals** from a local psychiatric hospital.
- ❖ **August 2025** - An owner of a home health agency in Houston was convicted and sentenced to 75 months in prison. Evidence at trial showed that the owner, or others working at his direction, **forged signatures of doctors and nurses** by cutting out old signatures and taping them onto newly created doctors' orders, nursing notes and nursing assessments, then submitted the forged documents in response to a Medicare records request. The jury also heard about a registered nurse who had departed in 2017 that the owner **continued using her signature on nursing notes and assessments without her knowledge or consent**. Finally, a witness also testified that the owner **bribed a doctor in exchange for approving home health services**.

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Summary General Overview of Problematic Conduct



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Steps You Can Take TODAY to Strengthen Your Compliance Efforts

- Evaluate Your **Financial Relationships** with Potential Referral Sources.
 - Examine contracts, leases and payment arrangements with physicians and other providers in the community for compliance with Stark exceptions and Anti-Kickback safe harbors.
- Review your **ownership structure** to identify any potential Anti-Kickback or Stark issues. Do you have investors who are sources of referrals or who can influence referrals?
- Review policies, procedures and training for **marketing and community liaison staff**. You will be much better served if your marketing staff are true, bona fide employees, and as such, you must train and supervise them to ensure they are acting appropriately.

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Compliance Tips and Best Practices

Physician Relationships

- Ensure that **every relationship with a physician is documented** and reviewed by a healthcare attorney.
- Document valid business rationale and **fair market value** of services.
- Medical directors should be compensated solely for clinical and admin services. There should be no link to referrals or admissions.
- Physicians should **document time to support payment** for medical director services.
- Review medical director invoices to ensure that services provided, and hours worked are reasonable
- Train medical directors on eligibility criteria, Medicare definitions, and compliance with law
- Monitor relationships with outside referring physicians, their offices, and marketers as part of your compliance program.



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Compliance Tips and Best Practices

Physician Relationships

- Screen your physician referral sources and medical directors **monthly** for exclusion by Federal or State authorities and Medicare enrollment status
- ✓ HHS-OIG LEIE – <https://exclusions.oig.hhs.gov/>
- ✓ Texas HHSC-OIG Exclusions Database - <https://oig.hhsc.state.tx.us/oigportal2/Exclusions>
- ✓ CMS Ordering & Referring Database - <https://data.cms.gov/Medicare-Enrollment/Order-and-Referring/qcn7-gc3g/data>



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Compliance Tips and Best Practices

Marketing Staff

- **Ensure that your employees are truly employees – consider IRS definition**
- **Carefully evaluate compensation plans for marketing employees**
 - ✓ Compensation should not be based on number of admissions or lengths of stay
 - ✓ Even though there is bona fide employment safe harbor/exception, note that many of the cases involving employees still were problematic. Remember “**one purpose**” rule.
 - ✓ Incentive payments, if any, should not be based on individual economic production
- **Compensation for marketing by independent contractors should meet the personal services safe harbor**
 - ✓ Should be at fair market value and not based on volume or value of referrals – fixed fee determined in advance
 - ✓ Contracted services should be valid services and not a “cover” for referrals



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Compliance Tips and Best Practices

Facility Relationships

- Document relationship between HHA or Hospice and any facility
 - ✓ Compliantly structured, written, signed lease of space between agency and any facility
 - ✓ Nursing home/hospice agreement – written, signed, and addressing hospice responsibility for all care, and nursing home responsibility to provide room and board



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Tips and Best Practices Investigations

- **Retain counsel.** Remember, everything you say is evidence.
- **Determine focus of investigation.** Is the focus, criminal, civil or administrative? If the focus is criminal, is the billing company considered a target, subject or witness?
- **Conduct internal investigation.** Get ahead of the government's investigation. Determine the likely extent of any liability. Be careful to ensure that the internal review is privileged.
- **Document retention.** Don't turn a minor investigation into a major investigation by improperly destroying documents.
- **Handling employees.** Avoid antagonizing employees. Guard against possible allegations of obstruction of justice.
- **Take the initiative.** Aggressively work to resolve the case.
- **Work towards a global resolution of claims.** Don't settle the civil claims and leave possible administrative exclusion on the table.

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QUESTIONS

This outline is provided as general information only. It does not constitute legal advice and should not be used as a substitute for seeking legal counsel. Jennifer Papapanagiotou is an attorney with the firm of Liles Parker PLLC.

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