HOME HEALTH HOSPICE

ACHC U
EDUCATIONAL RESOURCES

Health Care Fraud, Waste & Abuse in 2021

Beth Anne Jackson
Brown & Fortunato, P.C.

Allison D. Shelton
Brown & Fortunato, P.C.

Brown & Fortunato
Celebrating 25 Years Together

ACHC

Topics

- Laws Frequently Utilized in Enforcement Actions
- Health Care Fraud and Abuse Control Program
- Recent Cases, Actions, and Settlements
  - Medical Directorships
  - Relationships with Excluded Individuals
  - Non-compliance with Medicare Coverage Criteria and Standards
- Recent OIG Audits of Home Health and Hospice Providers
- Where We're Headed in 2021

HOME HEALTH HOSPICE

ACHC U

EDUCATIONAL RESOURCES

Fraud, Waste, & Abuse Laws

False Claims Act, Anti-Kickback Statute, and the Stark Law

False Claims Act, 31 U.S.C. § 3729

- *"Any person who . . . knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; . . . or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money . . . to the Government, is liable to the United States Government for a civil penalty . . . plus 3 times the amount of damages."*
    - Civil Monetary Penalties (CMPs) up to ~$22,000 per claim
    - Treble damages

False Claims Act, 42 U.S.C. § 1320(a)-7b(a)

- *"Whoever . . . knowingly and willfully makes or causes to be made any false statement or representation of material fact for use in determining rights to such benefit or payment . . . shall . . . be fined . . . or imprisoned . . . or both."*
  - Fine up to $25,000 per violation
  - Imprisonment up to 10 years per violation

Anti-Kickback Statute (AKS), 42 U.S.C. § 1320a-7b(b)

- *"Whoever knowingly and willfully solicits or receives any remuneration . . . in return for referring an individual . . . or in return for . . . ordering . . . or recommending purchasing . . . or ordering any . . . facility, service, or item for which payment may be made . . . under a Federal health care program . . . shall be fined . . . or imprisoned . . . or both."*
- *"Whoever knowingly and willfully offers or pays any remuneration . . . to induce [a] person to refer an individual . . . or to . . . order . . or recommend . . . purchasing . . . or ordering any . . . services, or item for which payment may be . . . under a Federal health care program . . . shall be fined . . . or imprisoned . . . or both."*
    - Criminal fine of up to $25,000 and imprisonment for up to five years.
    - Exclusion
    - CMP up to $50,000 per violation
    - Liability under FCA

Stark Law, 42 U.S.C. § 1395

- *"[I]f a physician (or an immediate family member of such physician) has a financial relationship with an entity . . . then the physician may not make a referral to the entity for the furnishing of designated health services . . . and the entity may not present or cause to be presented a claim . . . to any individual, third party payor, or other entity for designated health services furnished pursuant to a [prohibited] referral."*
  - Refund of amounts collected
  - CMPs of up to $15,000 for each service
  - Exclusion
  - CMP of up to $100,000 for each circumvention scheme
  - Liability under the FCA

Other Laws Used in Enforcement Actions

- Travel Act — 18 U.S.C. § 1952
- Conspiracy to Defraud — 18 U.S.C. § 286
- Submission of Fraudulent claims — 18 U.S.C. § 287
- Theft or Embezzlement — 18 U.S.C. § 669
- Making False Statements — 18 U.S.C. § 1035
- Using Mail to Defraud — 18 U.S.C. § 134
- Scheme to Defraud Health Care Benefit Program — 18 U.S.C. § 1347
- Money Laundering — 18 U.S.C. § 1956
- Racketeering Activity — 18 U.S.C. § 1961

ACHC U
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Health Care Fraud and Abuse Control Program (HCFAC)

Background, Collections, Enforcement Agencies

HCFAC Background

- Established under HIPAA
- Directed by Attorney General and HHS Office of Inspector General
- Coordinates enforcement activities among all levels of government
- Collaborations
  - Health Care Fraud Prevention and Enforcement Action Team (HEAT)
  - Health Care Fraud Prevention Partnership
  - Data Integration and Analytics

HCFAC Enforcement Agencies

HCFAC

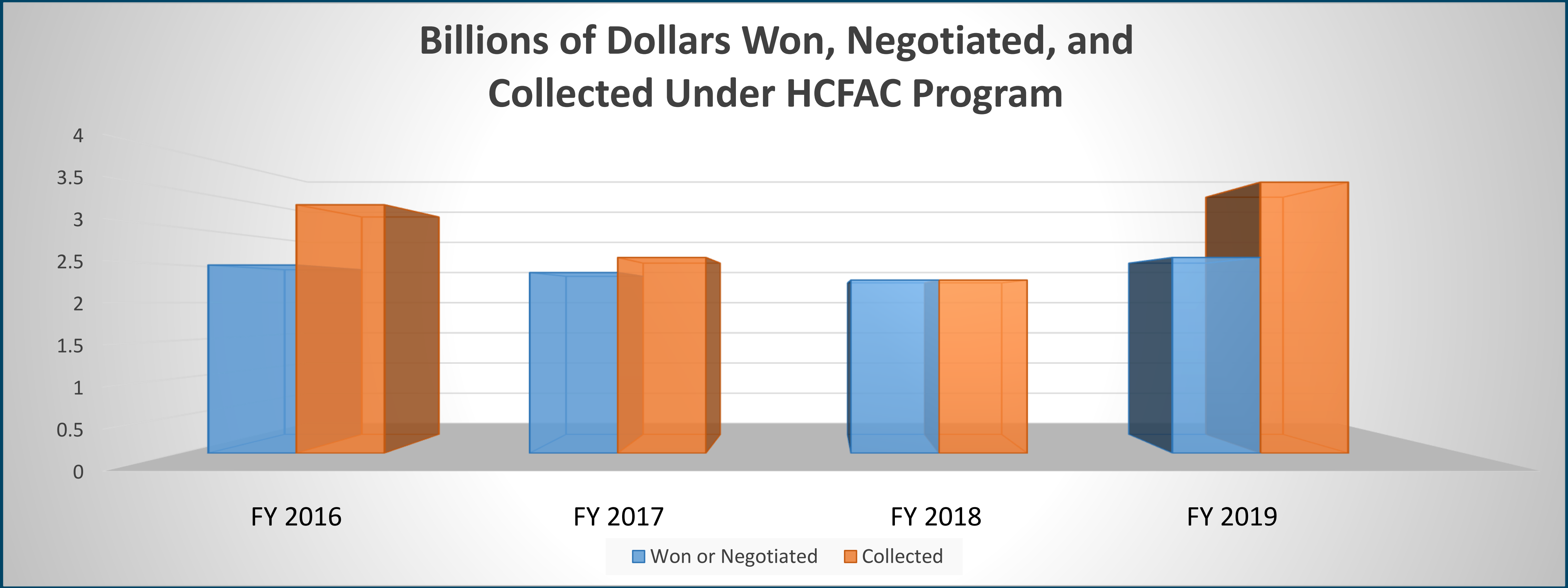
Department of Health and Human Services

- HHS Office of Inspector General (OIG)
  - Office of Audit Services
  - Office of Evaluation and Inspections
  - Office of Investigations
  - Office of Counsel to the Inspector General
- Centers for Medicare and Medicaid Services (CMS)
  - Unified Program Integrity Contractors
- Administration on Community Living
- Office of the General Counsel
- Food and Drug Administration

Department of Justice

- United States Attorneys
- Civil Division
- Criminal Division
- Civil Rights Division
- DOJ Office of Inspector General
- Federal Bureau of Investigations

HCFAC Results



Source: OIG, *Health Care Fraud Abuse Control Program Reports*, FY 2016-2019

OIG Investigative Work

Oct. 1, 2020 – Mar. 31, 2021

- $1.37 Billion in Expected Recoveries
- 221 Criminal Actions
- CMPs Imposed Against 272 Individuals and Entities
- Excluded 1,036 Individuals and Entities

Source: OIG, Semiannual Report to Congress (Oct. 1, 2020 - Mar. 31, 2021)

ACHC U
EDUCATIONAL RESOURCES

Cases Involving Medical Directorships

Recent Settlements, Lessons Learned & Best Practices

Doctor’s Choice Home Care Inc.

- $5.8 Million Settlement
- Announced November 20, 2020
- Sham medical director agreements with physician to providing remuneration for referrals
- Paid employees bonuses for physician spouses’ referrals

Home » Office of Public Affairs » News

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Friday, November 20, 2020

Home Health Agency and Former Owner to Pay $5.8 Million to Settle False Claims Act Allegations

Doctor’s Choice Home Care, Inc. and its former executives, Timothy Beach and Stuart Christensen, have agreed to pay $5.15 million to resolve allegations that the 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, the Department of Justice announced today.

Timothy Beach and Stuart Christensen founded Doctor’s Choice and formerly served as its top executives. Doctor’s Choice is a home health agency based in Sarasota, Florida, with branches throughout the state.

Doctor’s Choice will pay $3,856,000 to settle these allegations and Beach and Christensen will each pay $647,000. Doctor’s Choice will pay an additional $675,000 to resolve separate allegations that employees pressured clinical personnel to increase the number of home visits for Medicare patients to avoid the Medicare Low Utilization Payment Adjustment that would have decreased the reimbursement Doctor’s Choice received from Medicare in the absence of these unnecessary services.

“The Department of Justice will continue to hold companies and individuals accountable for the payment of illegal remuneration in any form,” said Acting Assistant Attorney General Jeffrey Bossert Clark of the Department of Justice’s Civil Division. “Improper inducements have no place in our federal healthcare system, which relies on healthcare providers making decisions based on the healthcare needs of their patients and rather than their personal financial interests.”

“Operating an illegal referral scheme and providing medically unnecessary services places patients at risk and jeopardizes millions of taxpayer dollars,” said Special Agent in Charge of the FBI Tampa Division Michael McPherson. “This settlement highlights the FBI’s commitment to protect the integrity of the federally funded healthcare system.”

Provident Home Health & Hospice

- $1.05M settlement by former owner
- Medical Directorship payments exceeded fair market value
- Period of 2 years
- Induce referrals to Home Health and Hospice
- False claims submitted
  - "Attending physician" was in prison
  - License was suspended
- 5-year period of exclusion

Lessons Learned & Best Practices

- Structure arrangements under available Stark exceptions and AKS safe harbors
  - 42 C.F.R. § 411.357(d) – Stark exception for Personal Service Arrangements
  - 42 C.F.R. § 1001.952(d) – AKS safe harbor for Personal Services and Management Contracts
- Key Considerations for Compliance
  - Written agreement covering services actually provided
  - Arrangement is reasonable and necessary for legitimate business purposes
  - Compensation is consistent with fair market value and does not take into account referrals or business generated between the parties
- Best Practices
  - Documentation of FMV evaluation and need for services
  - Time sheets

ACHC U
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Excluded Individuals

Provider-Self Disclosure Protocol

- 2020 Settlements under OIG Provider-Self Disclosure
  - 63 total settlements
  - 22 arose from the OIG's allegations that the provider employed or contracted with a person the provider knew or should have known was excluded from participation in federal health care programs
  - Approximately $2,271,044 will be paid as a result of such settlements
- Settlements between January and May 2021
  - 4 settlements based on alleged engagement of an excluded person
  - Approximately $515,199 will be repaid

Settlement Agreement (4/12/2021)

- CareCo Medical, Inc. of Waterford, CT
- Employed excluded physical therapist in a management position
- $28,246 to be paid
- HHS-OIG/US DOJ pursued

Lessons Learned

"The OIG may impose a penalty; an exclusion; and, where authorized, an assessment against any person who it determines. . . [a]rranges or contracts (by employment or otherwise) with an individual or entity that the person knows, or should know, is excluded from participation in Federal health care programs for the provision of items or services for which payment may be made under such a program." 42 C.F.R. 1003.200

- Provider liability arises when "an excluded person participates in any way in the furnishing of items or services that are payable by a Federal health care program."
  - OIG, "Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs," (Issued Sept. 1999; updated May 2013)

Best Practices

- Regularly conduct background screenings and document searches
  - All new employees and independent contractors
  - Periodic screening of current employees and contractors
  - Databases
    - OIG’s List of Excluded Individuals and Entities (LEIE)
    - GSA’s System for Award Management (SAM)
- Include representations and warranties regarding exclusions in contracts
- Ensure submission of accurate and complete information on CMS 855 forms/PECOS and all other enrollments and applications to federal and state health care programs

HOME HEALTH HOSPICE

ACHC U

EDUCATIONAL RESOURCES

Cases Involving Coverage Criteria, Medicare Standards & More

Extreme Cases: Criminal Charges & Prison Time

Owner of Texas chain of hospice companies sentenced for $150m health care fraud and money laundering scheme (12/2020) - MERIDA HEALTH CARE GROUP

- Jury trial
- Rodney Mesquias told thousands of patients with Alzheimer's and dementia that they had less than 6 months to live
- Enrolled them in hospice
- 240 months in federal prison
- $120M in restitution

"Financial healthcare fraud is abhorrent enough, but to fraudulently diagnose patients with dementia or Alzheimer's is the pinnacle of medical cruelness to both the patient and their family. They falsely gave patients life ending diagnosis and they will pay the price with years behinds bars."

— U.S. Attorney Ryan K. Patrick , S.D. Tex.

Hospice administrator sentenced for role in hospice fraud scheme (2/19/2021)

- Overruled clinical staff who determined beneficiary referrals did not qualify for hospice
- Paid kickbacks to recruiters
- $2.2 M in restitution
- 30 months in prison

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE | Friday, February 19, 2021

Hospice Administrator Sentenced for Role in Hospice Fraud Scheme

The administrator of a Southern California hospice was sentenced Thursday to 30 months in prison for his role in a multimillion dollar hospice fraud scheme.

Acting Assistant Attorney General Nicholas L. McQuaid of the Justice Department's Criminal Division, Assistant Director in Charge Kristi K. Johnson of the FBI's Los Angeles Field Office, and Special Agent in Charge Timothy B. DeFrancesca of the U.S. Department of Health and Human Services Office of Inspector General's (HHS-OIG) Los Angeles Regional Office made the announcement.

Antonio Olivera, 80, of Norwalk, was also ordered to pay $2,193,914 in restitution. Olivera pleaded guilty to one count of conspiracy to commit health care fraud in November 2020. Three co-conspirators have pleaded guilty and are awaiting sentencing.

As part of his guilty plea, Olivera admitted that from 2011 to 2018, while acting as administrator for Mhiramarc Management LLC (Mhiramarc), a hospice located in Downey, California, Olivera and others paid illegal kickbacks to patient recruiters for the referral of hospice beneficiaries to Mhiramarc. Further, when clinical staff at Mhiramarc determined beneficiary referrals did not qualify to receive hospice services, Olivera overruled those determinations and nonetheless caused the beneficiaries to be put on hospice service.

Olivera and co-conspirators caused Mhiramarc to submit approximately $28 million in claims to Medicare, which resulted in the company being paid over $17 million. Olivera was personally responsible for $4,769,982 in false and fraudulent claims to Medicare, resulting in Medicare paying Mhiramarc $2,984,914 for medically unnecessary hospice services for beneficiaries, many of whom had been recruited through illegal kickbacks.

This case was investigated by the FBI's Los Angeles Field Office and HHS-OIG's Los Angeles Regional Office. Trial Attorneys Justin Givens and Claire Yan of the Criminal Division's Fraud Section are prosecuting the case.

Common Allegations Against Hospice Providers

- Incorrect diagnosis of patient as terminally ill
- Failure to document a bona fide face-to-face exam of patient took place
- Shortfalls in physician certification documentation and medical records so that care does not appear to be warranted
- Illegal marketing practices
- Incorrect level of care

Common Allegations Against Home Health Providers

- Beneficiaries not meeting the definition of “confined to the home”
- Beneficiaries not in need of skilled services
- Failure to submit OASIS data in timely manner
- Failure to adequately document services
- OASIS data does not support HIPPS payment code
- Plan of care not followed
- Plan of care not properly certified and recertified (not under care of physician)

Best Practices

- Conduct internal and external audits
  - Implement ongoing, routine process for regular audits and appropriate corrective actions
  - Identify and audit areas of potential non-compliance within organization
    - Issues identified in payor audits
    - Available data comparing organization's performance to peers
  - Review areas deemed high risk by governmental agencies

Best Practices

- Implement effective compliance program
    - Identify potential compliance issues
        - Hotline
        - Exit interviews
    - Log compliance concerns, investigate, and track responsive actions

ACHC U

EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

OIG Medicare Provider Compliance Audits

Late 2020 - Present

OIG Audits In Late 2020 - Present

Provider	Date	Claims at Issue	Associated Amount	Extrapolated Amount	Issues
VNA of Maryland	4/27/21	36/100 19/100	$25,295	$2.1M	Beneficiaries not homebound and did not need skilled services; incorrect payment codes; services not rendered in accordance with plan of care
Brookdale Home Health	2/25/21	46/100	$132,500	$3.3M	Beneficiaries not homebound and did not need skilled services
Tidewell Hospice	2/22/21	18/100	$46,569	$8.3M	Terminal prognosis not supported; level of care not supported; services not eligible for reimbursement
SE Home Health Services	1/13/21	29/100 18/100	$46,404	$1.8M	Beneficiaries not homebound and did not need skilled services; incorrect payment codes
Tender Touch Health Care Servs	12/22/20	27/100 21/100	$42,229	$478,780	Beneficiaries not homebound and did not need skilled services
Hospice Compassus	12/16/20	68/100 35/100	$80,307	$3.4M	Terminal prognosis not supported; services not documented; NOE not timely filed

Best Practices – Responding To OIG Audits

- Hire a lawyer AND an expert
- Dispute claims that you disagree with
  - Explain why
  - Supply additional medical records
  - Medical review contractor will review and often change at least some claims
  - Reduce basis for extrapolation
- Understand your obligations after an audit
  - Obligations under 60-day rule

ACHC U

EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Where We’re Headed In 2021

OIG Work Plan

OIG FY 2021 Work Plan

- Joint Work with State Agencies (expected FY 2021)
  - OIG will partner with state auditors and others to provide effective methods that address improper payments in Medicaid programs such as home health, hospice, DME.
- Home Health Agencies' Challenges and Strategies in Responding to the COVID-19 Pandemic (expected FY 2022)
  - This study is expected to provide insights into the strategies that HHAs have used to address the challenges presented by COVID-19, including how well emergency preparedness plans served HHAs during the pandemic.
- Audit of Home Health Services Provided as Telehealth During the COVID-10 Public Health Emergency (expected FY 2022)
  - OIG to evaluate if services furnished via telehealth were billed in accordance with Medicare rules.

ACHC U
EDUCATIONAL RESOURCES

Questions?

HOME HEALTH HOSPICE

ACHC U
EDUCATIONAL RESOURCES

Thank You!

Beth Anne Jackson, J.D.
Brown & Fortunato, P.C.
905 S. Fillmore, Ste. 400
Amarillo, TX 79101
bjackson@bf-law.com
806-345-6346

Allison D. Shelton, J.D.
Brown & Fortunato, P.C.
905 S. Fillmore, Ste. 400
Amarillo, TX 79101
ashelton@bf-law.com
806-345-6338

BROWN & FORTUNATO
Celebrating 25 Years Together

ACHC