

Homecare fraud: New compliance concerns

By Deborah A. Randall, JD

Editor's note: Deborah Randall has more than twenty years' experience working with home-centered health care providers, including certified home health agencies, hospices, private duty companies, personal care agencies, and home infusion companies. She is a consultant on all aspects of long-term care as well as telehealth and remote monitoring. She may be reached by telephone in Washington, DC at 202/257-7073 or by e-mail at drandall.solutions@comcast.net.

Homecare fraud concerns have been cyclical in nature. During the early 1990s (following a period of expanded home health care coverage and dollars paid under the Medicare benefit), very large numbers of new home health agencies (HHAs) opened in the states of Florida, Texas, Louisiana, California, and Michigan. The low capitalization needs of HHAs and the cost-based visit reimbursement were perceived as problematic by the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG).

As a result, federal fraud enforcement agencies undertook investigations known as Operation Restore Trust. Multiple home care companies were found to have billed for non-medically necessary care, or for care provided to non-homebound patients. Two very large, well-established home care companies were investigated, and their principal owners were sentenced to prison for criminal activities in their cost reporting. A significant number of HHAs in Florida were reviewed for fraudulent kickback activities, and several persons, including a state senator, received jail terms.

Following a two-stage statutory change, effective by the year 2000, CMS transformed the reimbursement methodology for Medicare-certified HHAs to an episodic, prospective payment-based system (PPS). Two additional changes have since been made in how episodes of care are calculated. Currently, the home health reimbursement group (HHRG) is derived based upon the diagnoses, prior health history, anticipated patient need for skilled therapy and nursing, and deficits in self-care capacity (also known as activities of daily living or ADLs). As Medicare providers, HHAs must file cost reports and must also file under many state Medicaid programs. Although the cost and expense implications of the cost reporting mechanisms appear only remotely related to a given case payment rate, providers must still follow Medicare reimbursement principles and must accurately list ownership, branch office locations, and management control.

In the 2005 Deficit Reduction Act, Congress enacted the optional Medicaid benefit of personally directed, "personal care" in those states that chose to enact the benefit and tailor it in accordance to state-based criteria. At the time, the benefit was considered a positive outcome from a demonstration program on "Cash and Counseling." The new benefit allowed family members and other related persons to be a Medicaid recipient's personal care attendants, as long as safeguards are followed. The result has been an explosive growth in the number of companies registering to offer non-medical, personal-care services such as laundry, cooking, dressing the patient, and light housecleaning. For example, in Maine there are 150 or more

such companies, and payments have risen 58% from 2002 to 2009. Investigations are now also part of the regulatory landscape in Maine and other states with the personal care benefit.

CMS has reported incidences of personal care company fraud, such as the 2008 indictment of a Virginia company that specialized in services to the Russian immigrant population.¹ Since 2000, Congress also added and expanded the opportunities for Medicaid home and community-based waiver programs, which have amplified the number and variety of programs in which persons may receive homecare services compensated by governmental funding.

Now, following these payment expansions and innovations in homecare service, compliance officers need to know the fraud enforcement cycle has come around again. Homecare fraud is on the rise, and the industry is under sharp scrutiny by Congress and the enforcement agencies.

Reports question homecare activities and reimbursement

The Government Accountability Office (GAO) has studied and reported to the Congress on the homecare industry for more than 25 years, almost always with a highly critical tone. In February 2009, GAO issued a report entitled "Medicare: Improvements Needed to Address Improper Payments in Home Health" (GAO-09-185).

In April of 2009, in testimony before Congress about that report, GAO's spokesperson noted home health agencies' "practice of upcoding (overstating the severity of a beneficiary's condition), providing kickbacks, and billing for services not rendered" had "contributed to Medicare's home health spending and utilization" and that "the inadequate administration of the Medicare home health benefit left the program vulnerable."

On July 20, 2009 GAO sent a letter to the US Senate stating:

We have identified several weaknesses with the current process for reviewing Medicare claims. Limitations in the number of medical reviews conducted leave the home health benefit—within the Medicare program—vulnerable to improper payments, including payments resulting from fraud and abuse. We reported in February 2009 that in fiscal year 2007, only 0.5 percent of the more than 8.7 million ...HHA.. claims processed were subjected to prepayment review by Medicare's contractors. The contractors focused primarily on claims submitted by HHAs whose billing patterns differed from their peers on measures such as cost per episode. Of those claims that were reviewed, over 40 percent were denied in whole or in part. Furthermore, the contractors rarely performed post-payment medical reviews to recover funds previously paid in error, even when the HHA was identified as billing improperly through prepayment review. Thus, although the limited claims-review process that was performed was valuable in reducing potential improper payments, the extent of errors found would suggest that both prepayment and post-payment medical reviews should be increased to more effectively avoid or recoup overpayments.²

In October 2009, Charlene Frizzara, then Acting Administrator for CMS, informed Congress in a letter³ that "The top three areas of Medicare fraud and abuse are DME, home health agencies and infusion therapy." She pointed out significant findings of fraud in Texas and Southern California appeared related to excessive growth in the numbers of home health agencies in the areas—between 100% and 150%—which she called "a proliferation of unscrupulous home health agencies." She

noted as well a very rapid increase in billings for home health services, also disproportionate to growth rates in other parts of the country. Ms. Frizzara stated that 37 home health provider agreements had been revoked, and that these revoked HHAs had been reimbursed \$6.1 million in the 2007 federal fiscal year. Additionally, she stated there had been abuses of the outlier payment reimbursement mechanism by HHAs in Dade and Broward counties in Florida that "have come to rely upon outlier payments as a predominant part of their overall reimbursement." CMS has suspended many of these HHAs, performed audits about beneficiary entitlement, and interviewed physicians about their role in authorizing care.

As a result of changes in the Patient Protection and Affordable Care Act of 2010 (PPACA),⁴ CMS has issued proposed regulations establishing a new qualification for Medicare home health entitlement—a face-to-face patient visit with the certifying physician within 30 days preceding or 15 days following the initiation of the first certification period of homecare services if the condition has changed.⁵ Additionally, CMS has made new surveys nearly impossible for any HHA by creating a moratorium within the CMS regional offices and limiting payments to state survey agencies. In PPACA, Congress gave CMS opportunities for creating stringent provisions for new enrollments of HHAs in the Medicare program. It also provided penalties for physicians who failed to maintain copies and adequate documentation for the patient certifications of home health care necessary services. Both of these provision are designed to slow the growth of home health and chill activities by physicians who might not stay involved in the home health care of their patients.

CMS had already issued a final regulation preventing a transfer of a home health Medicare provider number in circumstances

where a home health agency is newly created or had changed ownership within the previous 36 months.⁶ CMS has suggested only a minor easing of these barriers to allow a publicly traded home health company to make acquisitions when it and the acquired company have filed cost reports for 5 years; and to allow internal corporate restructurings, including when there is a death of an owner. Otherwise, a full new survey must be requested by the entity seeking to acquire a home health agency in existence or with a prior sale date fewer than 36 months in the past.⁷ These administrative actions have a crippling effect upon even the most compliant of providers who have not exhibited any aberrant billing practices. It appears CMS is of the mind that, with so many HHAs in existence, disrupting the businesses of any and all could yield a net gain in fraud and abuse enforcement.

And, in the Democratic health reform actions during 2010, costs for broadened insurance coverage of the American populace were to be funded, in part, by a very significant cutback in HHA reimbursement for the years 2010 through 2015. House and Senate members agreed to reduce home health payments by nearly \$40 billion in a 10-year time frame. Homecare advocates fear this threatens the access to necessary medical services of elder Americans in the community at the very time the first wave of Baby Boomer demographics will hit.

"Common" homecare fraud is again increasing

The number of homecare investigations and indictments has increased noticeably in the three years 2007-2009. Many of these are what health compliance specialists would regard as "common" fraud: individuals who blatantly and intentionally bill the Medicare or Medicaid programs for services that either were never performed or were provided to individuals whose eligibility or medical condition did

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not qualify them for such reimbursed care. For example, in *United States v. Pearson*,⁸ an indictment was issued on October 20, 2009 of multiple persons in an alleged \$49 million scam for physical therapy services billed but not provided. In *United States v. Long*,⁹ an individual was sentenced on September 23, 2009 for billing personal care services provided to his mother when he, the supposed caregiver, was in prison. In *United States v. Lee*,¹⁰ a Louisiana personal care worker was indicted, along with the conspiring mother of young children who were supposed to receive Medicaid services, but did not.

Several areas of the United States have been hot beds of such fraudulent activity; Southern California, Texas, and Florida are three of these. The activities in these regions have included the broader range of home-delivered services, especially DME, and have, on occasion, involved beneficiary participation on fraudulent schemes, through kickbacks or misuse of Medicare health insurance claim (HIC) numbers. The power wheelchair cases have been in the press for several years, and most are now resulting in lengthy prison sentences and repayment penalties. For example, in *United States v. West*,¹¹ the defendant was sentenced on July 28, 2009 to 37 months in prison for billing over \$6 million in scam fees in the Houston area. A co-defendant is serving 11 years as the organizer.

Recent home care cases alleging fraud and kickbacks

Compliance officers need to monitor all of the following areas of homecare concern.

■ Ownership of homecare entities

OIG has recently, in its Annual Report, cited concerns about shell ownership structures in home health agencies and DMEs, stating:

In 2008, OIG examined a small random sample of DME suppliers with

uncollectible Medicare debt and found that these suppliers were associated with other DME suppliers and home health agencies (primarily through shared ownership, management, or family relationships) that had received approximately \$58 million in Medicare payments. The associations are of interest because Federal investigators suspect, and have found in some cases, that individuals associated with the Medicare debt may omit ownership or management information on enrollment applications and inappropriately receive Medicare payments through businesses publicly fronted by associates or family members.¹²

Perhaps in response to pressure from OIG and Congress to the fraud levels within geographic areas where unchecked numbers of HHAs were mushrooming, CMS issued a Directive on December 18, 2009 (which has since been rescinded and replaced by the July 23, 2010 proposed rule) that no HHA which had been in existence less than 36 months, or which had changed ownership in that time frame, would be allowed to transfer a Medicare certified provider number or to bill. Without the transfer of a provider number, most HHA sales transactions are in limbo or are stymied in their effectiveness. CMS stated that to control fraud within home health, the Medicare Administrative Contractors (MACs, formerly fiscal intermediaries) are directed to return to the applicant any Form 855 request for change of ownership (CHOW) for a provider owned less than 36 months.

■ Physician care plan oversight

Recently, a home care company, Aging Care Home Care (ACHC) was the center of a significant fraud investigation. Its owner and operator, Janice Davis, was charged and sentenced to 15 years in prison, because from 1991-2005, she allegedly destroyed, concealed, covered up, and falsified records

and documents (including physician service logs), intending to impede and obstruct a federal Medicare investigation. That investigation revealed that many of ACHC's doctors did not perform the services indicated in the records, which had been billed as care plan oversight services. Rather than the physicians directly billing Medicare, OIG findings were that ACHC tracked these services and billed Medicare for the physicians as a means of inducing the physicians to refer patients to the company for home health and hospice services. The government also alleged federal Stark Law and Anti-kickback Statute violations by ACHC's creation of a sham physician advisory board, paid not for actual duties performed, but for illegal Medicare referrals.

■ Credentialing

Numerous homecare reimbursement and fraud cases have been opened by federal and Medicaid enforcement officers, charging untrained home health aides are serving patients in their homes, or unlicensed professionals are utilized in the delivery of care. The Medicare Conditions of Participation are explicit in the training and credentialing of home health workers, as well as requiring that all state legal requirements have been met. Today, failures in this area are more likely to be treated as a quality-of-care violation of the Civil Monetary Penalties Act, rather than innocent clerical omissions or errors.

■ Kickbacks

Consumers of in-home supportive services (IHSS) in California have been caught in fraud investigations brought by the MediCal investigators. As a direct result, caregivers in in-home services programs must now undergo an orientation about fraud issues and cost concerns in the program, and they must pay for their own background checks and fingerprinting. Fraud cases showed some caregivers

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were splitting wages with patient recipients and some patients were lying to social workers and fabricating evidence of need.

Kickbacks to referrers of new home care business remain a constant problem in many states, particularly in Florida and southern California. These kickbacks may go to physicians, to “brokers” who case-find for HHAs, to discharge planners of hospitals, and assisted living or nursing facilities. In some cases, personal care or private duty companies may offer a referral, based on the condition that the staff of that private company are hired to be the caregivers to the patient when admitted to the HHA for care. Many HHA staff still have not been properly educated about the absolute bar to any of these enumerated activities, although they may be common practices that HHA staff may be acquainted with in other businesses. And, with the exception of the Visiting Nurse Associations of America (VNAA), there is still no national homecare association code of ethics that takes a stand on fraudulent conduct, as AdvaMed has done for the medical device industry and PhRMA for the prescription drug industry.

Geographic targets

Is the “black box of home care” re-opening? In the early 1980s, the Legal Services for the Aging division of the American Bar Association used this phrase to suggest home care was considered an unknown service, delivered with little oversight in the homes of frail and vulnerable people, where abuse could grow “in the dark.” Today, the Department of Justice and the Department of Health and Human Services see “dark zones” of home care fraud. They have teamed up since 2009 to form targeted fraud investigations using a Health Care Fraud Prevention and Enforcement Action Team (HEAT), directed at major metropolitan areas. These now include Miami/Dade and Broward counties in Florida; Houston; Detroit; Baton

Rouge; Los Angeles/Southern California; and Brooklyn, New York.

The states’ Medicaid fraud units and Inspectors General are also designating homecare as a special focus for fraud investigations. In New York State (NYS), Operation Home Alone targeted the falsification of aide training certificates, which Attorney General Andrew Cuomo called “an egregious violation of trust.”¹³ More than \$34 million in restitution had been obtained by the NYS investigators by mid-2009.

In Louisiana, Medicaid enforcement agencies have pursued corrupt Medicaid recipients or their family members who conspire with others to defraud the system. In *United States v. Brown* (Eastern District of Louisiana, No. 08-0148, verdict September 9, 2009), one of the convicted defendants was the mother of a Medicaid-eligible child; the mother received a kickback when she conspired with a personal care services company and falsely documented services to her child, which were not provided.

Certifications and signatures on care plans

This area has been a chronic problem for HHAs and, when billing precedes the receipt of signed certifications, can result in a violation of the False Claims Act as a reckless disregard of a fundamental of payment entitlement. At a minimum, there can be a substantial reimbursement effect, even for mistaken and self-reported certification timeliness issues. In 2009, Omni Home Care, an HHA in Evansville, Indiana repaid nearly \$2 million in an HHA certification matter.¹⁴

Action plan and lesson for compliance officers

In light of the return cycle of homecare fraud concerns and multiplying investigations by federal and state authorities, compliance officers should:

1. Implement audits for common fraud issues by testing unusual billing surges.

2. Check operations more carefully in geographic areas where common fraud is being reported, especially California, Florida, Texas, Michigan, New York, and Oklahoma.
3. Keep background checks in place and monitor that exclusion lists are checked annually by Human Resources for all current employees and for all newly hired staff.
4. Ensure only appropriate admissions are made and that there is no kickback activity by monitoring any bonus programs for W-2 staff who may be “business building.”
5. Keep the health law counsel of your health system apprised of on-going homecare concerns and pressures in the industry.
6. Be involved and comment on major issues in due diligence for acquisitions.
7. Don’t lose the homecare focus in a hospital system centralized compliance program.
8. Consider specialized training, including for your board of directors.
9. Follow the federal OIG Work Plan, which in 2010 has numerous homecare items.
10. Keep an eye on MedPac, which is advocating extensive and severe homecare restrictions in reimbursement, Medicare participation, and ownership. ■

1 Ilya Zavelesky and Rina Zavelesky, dba Renaissance. Indictment available at <http://richmond.fbi.gov/dojpressrel/pressrel08/fraud022008.htm>
2 Letter from Kay L. Daly, GAO Director of Financial Management and Assurance to Thomas R. Carper, Chairman, and John McCain, Ranking Member, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, US Senate. Letter dated July 20, 2009.
3 Letter of Charlene Frizzara, Acting CMS Administrator, to Congressman Joe Barton, October 7, 2009.
4 Patient Protection and Affordable Care Act (PPACA) Public Law 111-148, Section 6407 enacted in April 2010.
5 75 Federal Register 43236 on July 23, 2010
6 Final PPS payment regulation for CYE 2010, published November 10, 2009.
7 See 75 Federal Register at 43266
8 Southern District of Mississippi, No. 2:09-CR-00043
9 Eastern District of Missouri, No. 4:09-CR-00217-CDP
10 Eastern District of Louisiana, No. 08-148; the defendant was sentenced 11/17/09 to five years in prison, and \$3.9 million in monetary penalties.
11 Southern District of Texas, No. 4:08-cr-00194
12 Top Management and Performance Challenges in the Department of Health and Human Services for Fiscal Year 2009, issued by Inspector General D.R. Levinson, December 2009.
13 State of New York, Office of the Attorney General: Attorney General Cuomo announces Medicaid Fraud Unit sets record with 148 criminal convictions in 2009. Available at http://www.ag.ny.gov/media_center/2010/apr/apr12a_10.html
14 Department of Justice: Indiana Home Health Agency Pays Nearly \$2 Million to Settle False Claims Act Allegations. October 20, 2009. Available at <http://www.justice.gov/opa/pr/2009/October/09-civ-1124.html>