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Attorney Advertising
Recent Headlines

1. Federal Laws and Key Enforcement Players
2. The Focus of Government Enforcement
3. Recent Regulatory and Legislative Efforts
4. Risk Mitigation
Federal Laws and Key Enforcement Players

Select Federal Laws and Penalties

- Anti-Kickback Statute
- Civil False Claims Act
- Stark Law
- Civil Monetary Penalties
- Other Criminal Provisions
  - Health Care Fraud
  - Mail and Wire Fraud
  - Obstruction
  - False Statements
Key Enforcement Players

U.S. Department of Justice (DOJ)
- United States Attorneys’ Office (USAO)
- Federal Bureau of Investigations (FBI)

U.S. Department of Health and Human Services (HHS)
- Office of Inspector General (OIG)
- Centers for Medicare and Medicaid Services (CMS)

State Attorneys’ General Offices
- Medicaid Fraud Control Units (MFCUs)

Program Integrity Contractors
- Zone Program Integrity Contractors (ZPICs)
- Recovery Audit Contractors (RACs)
- Medicaid Integrity Contractors (MICs)
- Medicare Administrative Contractors (MACs)

The Focus of Government Enforcement
Enforcement Environment
Fraud Enforcement is Profitable for the Government

- **$3.3 billion** in FY 2014 from federal health care fraud settlements and judgments
  - **$15.2 billion** total federal health care dollars recovered Jan. 2009 – Sept. 2014
- Average 3-year ROI (FYs 2012-2014) is **$7.70**
- Also in FY 2014:
  - DOJ opened more than 1700 new criminal (924) and civil (782) health care fraud investigations
  - HHS-OIG investigations led to 867 criminal actions and 529 civil actions against individuals or entities
  - HHS-OIG excluded more than 4000 individuals and entities from federal health care programs

Enforcement Environment
Government Investments in Fraud Enforcement Activities

**Investments in State-of-the-Art Technologies**
- CMS Fraud Prevention System
- Identified or prevented $210 million in improper payments in FY 2013
- 5-to-1 return on investment

**Investments to Increase Collaboration**
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Medicare Fraud Strike Force
- Healthcare Fraud Prevention Partnership (HFPP)
In 2013, about **3.5 million** Medicare beneficiaries received home health services costing around **$18 billion**, from more than **12,000 HHAs**

Medicare spending for home health care has increased by **87%** since 2002

- Home health care spending accounts for **4%** of Medicare fee-for-service spending
- 2001-2013 – number of home health episodes rose from **3.9 to 6.7 million**
- 1997-2013 – therapy visits increased from **10%** to **36%** of visits

According to OIG, since 2010, nearly **$1 billion** in improper Medicare payments and fraud has been identified relating to the home health benefit

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**“Fraudulent home-based services are surging across the country”**

-Special Agent in Charge Derrick L. Jackson, HHS-OIG Atlanta

November 12, 2014

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**Home Health Enforcement**

**HHS-OIG Priorities**

**OIG 2015 Work Plan**

- Compliance with PPS requirements
- Documentation required in support of claims paid by Medicare
- Whether home health claims were paid in accordance with federal laws and regulations
- Employment of individuals with criminal convictions

**Special Fraud Alert (1995) – Susceptible Activities of HHAs**

- Paying a physician for plan of care
- Disguising referral fees as salaries or paying above fair market value
- Providing hospitals with discharge planners, home care coordinators
- Subcontracting with Retirement Communities to induce referrals
Home Health Enforcement

Other Key Risk Areas

- Medical necessity, and eligibility for home health benefit
  - Medically unnecessary skilled services
  - Services provided to patients who are not homebound
  - Lack of a qualifying service

- Documentation sufficiency and compliance with CMS requirements

- Financial relationships with referral sources
  - To steer beneficiaries to a particular HHA
  - To provide or prescribe unnecessary care

- Marketing practices
  - Interactions with referral sources
  - Interactions with beneficiaries

- Home health aide certification and training

Home Health Enforcement

Examples

- Amedisys, Inc. – April 2014 – $150 million settlement to resolve allegations stemming from multiple qui tam actions that it:
  - Billed Medicare for nursing and therapy services that were not medically necessary, for services to patients who were not homebound
  - Misrepresented patients' conditions to increase Medicare payments
  - Management pressured nurses and therapists to provide care based on financial benefits to the HHA rather than the needs of patients
  - Maintained an improper financial relationship with a private oncology practice in Georgia through its employees providing patient care coordination services to the oncology practice at below-market prices
Home Health Enforcement

Examples

- CareAll Management, LLC - November 2014 – $25 million settlement to resolve qui tam allegations that it submitted claims overstating the severity of patients’ conditions and billed for services that were not medically necessary and rendered to patients who were not homebound
- CareAll contended issues in the case stemmed from issues with “paperwork technicalities” and home health visits that were not properly documented
- Second settlement of FCA allegations in two years → enhanced and extended CIA

Home Health Enforcement

Retention of known overpayments

- Pediatric Services of America Healthcare – August 2015 - $6.88 million settlement to resolve allegations it knowingly failed to report and return overpayments from TRICARE and Medicaid programs in 20 states
- “First of its kind” FCA settlement related to a provider’s failure to investigate credit balances on its books to determine whether they resulted from overpayments made by a federal health care program.
Home Health Enforcement
Patient Recruiters, Kickbacks and Inducements

• August 2013 – owner and director of nursing of a Louisiana HHA sentenced to 15 years and 5 years, respectively and ordered to forfeit $9.2 million, pay $17.1 in restitution
  • Kickbacks to patient recruiters to obtain Medicare beneficiary information
  • Nurses, including nursing director, falsified qualification documents to make it appear beneficiaries qualified for home health services
  • Kickbacks to physicians to sign fraudulent referrals and certifications for home health services that were not medically necessary

• August 2013 – owner of a network of Michigan health care companies and 8 others were sentenced to over 7 years imprisonment, $1.1 million in civil FCA settlements and 40 years in total exclusions
  • Kickbacks for referring patients for home health and other services
  • Illegal payments were made disguised as bonuses, mileage reimbursements, and payments for medical director and consulting services that were never performed

Hospice Enforcement
By the Numbers

• In 2013, more than 1.3 million Medicare beneficiaries received hospice services from over 3,900 hospice providers

• 2013 Medicare expenditures totaled about $15.1 billion
  • More than 400% increase in spending since 2000
  • Nearly $9 billion spent on patients with lengths of stay exceeding 180 days

• 2000-2012 – average length of stay increased from 54 days to 88 days

• 2000-2012 – length of stay at the 90th percentile grew substantially, increasing from 141 days to 246 days

• 68% of Medicare decedents who used hospice had a non-cancer diagnosis, up from 48% in 2000
Hospice Enforcement
HHS-OIG Priorities

OIG 2015 Work Plan

- Hospices in assisted living facilities
- Extent to which hospices service beneficiaries in ALFs
- Length of stay, levels of care received, common terminal illnesses
- Hospice general inpatient care
- Appropriateness of GIP care claims and the content of election statements for hospice beneficiaries who receive GIP
- Concern that this level of hospice care is being misused

Special Fraud Alert (1998) - Suspect Activities Between Hospices and Nursing Facilities

- Offering free goods (or below fair market value) to induce referrals
- Inappropriate room and board payments
- Hospice paying for “additional” services that Medicaid consider to be included in room and board
- Swapping arrangements between hospice and nursing facility

Hospice Enforcement
Other Key Risk Areas

Levels and Locations of Care

Medical Necessity Eligibility and Appropriateness for Benefit

- Admissions
- Long lengths of stay
- Stability and failure to discharge clinically ineligible patients

Documentation

- Adequacy of physician attestations, clinical documentation, financial records, and other documents that support claims for reimbursement
- Timeliness and completeness of physician referrals, plans of care, hospice certifications and face-to-face evaluations

Marketing Practices

- Payments tied to admissions and census goals
- Kickbacks to referral sources
Hospice Enforcement

Examples

- **Levels and Locations of Care**
  - February 2012 – Odyssey Healthcare paid **$25 million** to resolve allegations that it submitted claims for services that were medically unnecessary and billed Medicare for continuous or crisis care services when the patients were not experiencing a crisis
  - June 2015 – Covenant Hospice paid **$10.1 million** to resolve allegations that it submitted claims for general inpatient care that should have been billed as routine care

- **Medical Eligibility and Appropriateness for Hospice Benefit**
  - February 2013 – San Diego Hospice closed and declared bankruptcy following a government audit focused on patient eligibility
  - March 2013 – Hospice of Arizona paid **$12 million** to resolve allegations that it submitted claims for ineligible patients and that it adopted business practices and procedures to delay or discourage discharge of ineligible patients

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Hospice Enforcement

Examples

- **Documentation**
  - May 2014 – The owner of Home Care Hospice was sentenced to **14 years** in prison and ordered to pay **$32.4 million** for a Medicare fraud scheme that included submitting claims for ineligible patients, submitting claims for patients who never received the level of hospice services billed, routinely altering patient records, rewriting documentation to make patient appear sicker than they were, and falsifying documentation for high-cost, intensive hospice care
  - February 2015 – Compassionate Care Hospice paid **$6.5 million** to resolve allegations that hospice nursing services were not adequately provided

- **Marketing**
  - March 2014 – The parent company for Hospice Compassus paid **$3.9 million** to resolve allegations that it submitted claims for ineligible patients and induced employees and staff to admit ineligible patients
  - February 2015 – Good Shepard Hospice paid **$4 million** to resolve allegations related to its business practices and hiring of medical directors
Recent Regulatory and Legislative Efforts

Home Health Regulation/Legislation

- Changes to Face-to-Face Encounter Documentation Requirements
  - Proposed paper and electronic templates

- Proposed Changes to the Home Health Conditions of Participation

- Intermediate Sanctions for HHAs
  - 2013 Home Health PPS finalized regulations authorizing CMS to impose intermediate sanctions on HHAs found to be out of compliance as part of the survey and certification process
Hospice Regulation/Legislation

▪ IMPACT Act
  ▪ Mandated surveys for Medicare-certified providers
  ▪ Medical reviews for hospices with long length of stay patients
▪ Changes to Permitted Principal Diagnoses
  ▪ As of October 1, 2014, “debility” and “adult failure to thrive” are no longer accepted principal diagnoses
▪ Inclusion of All Diagnoses On Claims
▪ Part D – Coordination and Coverage of Certain Classes of Drugs

Newer Enforcement Tools
Increased Focus on Prevention

Temporary Moratoria on Enrollment of Providers
  ▪ No new HHAs in Chicago, Ft. Lauderdale, Miami, Detroit, Dallas, Houston

Suspension of Medicare and Medicaid Payments
  ▪ When there is “reliable information” that an overpayment exists, or pending investigation of a “credible allegation of fraud”
  ▪ For Medicaid, states are required to suspend payments to providers where a credible allegation of fraud has been “verified” by the state

Enhanced Medicare Provider Screening and Enrollment Requirements
  ▪ Greater scrutiny for providers deemed to pose a higher risk of fraud or abuse
  ▪ Newly enrolling HHAs - Fingerprint-based criminal background checks for all individuals with a 5% or greater ownership interest
  ▪ Currently enrolled HHAs and all hospice providers - subject to unscheduled site visits
Newer Enforcement Tools
Expansion of Program Integrity Contractors

Recovery Audit Contractors (RACs)
Creation of new national RAC specific to home health, hospice and DMEPOS

Zone Program Integrity Contractors (ZPICs)
Broad authority to identify cases of suspected Medicare fraud and prevent and recoup improper payments

Risk Mitigation
Compliance Program Activities

Develop and implement an effective corporate compliance program

- Ensuring Effectiveness
  - An effective compliance program is dynamic and evolves
  - One size does not fit all – an effective program is tailored to a provider’s structure and operation
  - Track guidance for government views as to what is necessary
    - HHS-OIG Compliance Program Guidance
    - Federal Sentencing Guidelines
    - Recent CIAs
  - Know your fraud and abuse risk areas – they change

Compliance Program Activities

Auditing and Monitoring

- Audit and Monitor High Risk Areas
  - Develop and adhere to a work plan that sets forth a schedule and scope of internal reviews
  - Consider periodic external reviews by independent third parties
  - Identify and refund overpayments within 60 days
- Evaluate Your Data to Identify Trends and Investigate Outliers
  - Review PEPPER reports
  - Other Home Health metrics: lengths of stay, vague diagnosis codes, therapy utilization patterns, readmission patterns
  - Other hospice metrics: live discharges, lengths of stay > 180 days, primary diagnosis
  - Hospice cap overpayment trends
Compliance Program Activities
Auditing and Monitoring

- Consider Engaging Legal Counsel to Conduct Or Direct Auditing Activities You Want Protected By Privilege
  - Compliance effectiveness review
  - Targeted internal investigations
- Utilize Legal Counsel to Monitor and Manage Financial Relationships
- Ensure Background and Exclusion/Debarment Checks Are Regularly Conducted
  - Not only employees, but also independent contractors and vendors
  - Check both HHS-OIG LEIE database and GSA’s SAM database
  - Also state Medicaid excluded provider lists

Compliance Program Activities
Training and Education

- Designate a specific individual to be responsible for tracking and understanding regulatory changes and disseminating information to appropriate staff
- Importance of documentation training for home health and hospice staff
  - Certification of plans of care
  - Certification of terminal illness
  - Face-to-face visits
- Focused training for marketing staff on interactions with referral sources and beneficiaries
- HHS-OIG HEAT Provider Compliance Training Initiative resources
Other Risk Mitigation Actions

- Track and log compliance questions, complaints and issues raised through the compliance program, steps taken to follow up, how issues were resolved, including corrective and preventative actions.

- Implement systems to ensure timely certifications, F2F visits, therapy reassessment visits.
  - EHRs can have features built-in to flag patients with upcoming requirements.
  - Schedule IDGs sufficiently in advance to help monitor key timing requirements.

- Have means to identify disgruntled employee or contractor.
  - Publicize compliance hotline to contractors, vendors.
  - Conduct and document exit interviews, reviewed by compliance officer.

- Monitor payor and contractor audits for patterns for signs of systemic issues.
  - Multiple audits of same/similar issues, multiple RAC or ZPIC audits.

Government Overtures

- Vary in type and intensity:
  - Contractor audits and additional documentation requests.
  - Administrative subpoenas.
  - OIG subpoenas.
  - Civil Investigative Demands.
  - Grand Jury subpoenas.
  - Search warrant.

- What to expect:
  - Unannounced requests.
  - Clinical documentation demands.
  - Rigorous data analysis.
  - Potential for conflicting interpretation of Medicare guidelines.
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