False Claims Act Liability in Post-Acute Care

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False Claims Act Liability in Post-Acute Care

Topics

- Review of FCA Cases – Civil and Criminal
- Recent Developments Relating to FCA Cases
- Compliance Challenges and New Areas of Risk
- Questions and Answers

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Review of FCA Cases – Civil and Criminal

Review of FCA Cases – Civil and Criminal

<u>06/08/2018 – Signature Healthcare (125 SNFs)</u>

- $30 million settlement for allegations –
  - Billing for therapy that were not medically necessary, reasonable, and skilled
    - Unrealistic financial goals
    - Scheduling therapy at highest level without regard to patient need
    - Resulted in Signature providing and billing for unreasonable, unnecessary, and unskilled services for Medicare patients
  - Submission of forged certifications of skilled nursing need to Tennessee Medicaid

Review of FCA Cases – Civil and Criminal

06/25/2018 – Caris Healthcare (Hospice)

- $8.5 million settlement for allegations –
  - Company set aggressive admissions and census targets
  - Patients were admitted and recertified but did not have a terminal prognosis
  - Internal audits, the CMO and nurses caring for the patients, all raised concerns regarding ineligibility
  - Provider continued to submit claims and took no meaningful steps to determine if improper payments had been received

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Review of FCA Cases – Civil and Criminal

07/18/2018 – Southern SNF Mgmt., Dynamic Rehab and 9 SNFs

- $10 million settlement for allegations –
  - Medically unnecessary rehab and inflated RUG levels
  - Corporate policies and practices that encouraged therapy delivery without regard for patient's individual clinical needs
  - False claims resulted from inflated RUG levels
- Consultants were Southern SNF, Dynamic Rehab
- 9 SNFs were located in GA and FL

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Review of FCA Cases – Civil and Criminal

08/23/2018 – Reliant Rehab

- $6.1 million for allegations that it offered improper inducements
  - Kickbacks to SNFs and MDs to promote its therapy business
  - ARNPs to work at client SNFs without charge or for a nominal, below market fee, to induce or reward SNFs for contracts
  - MDs above market compensation to supervise and collaborate with Reliant ARNPs

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Review of FCA Cases – Civil and Criminal

01/28/2019 – Clear Choice and Orlando SNF

- $1.5 million settlement paid by
  - SNF, NHA, management company, owners, orthopedic surgeon
- Allegations included -
  - Payments to the physician under “sham medical director” agreement
  - Payments designed to induce illegal referrals of patients to the SNF for rehab
  - Settlement covered a similar agreement with a related HHA
  - Agreements violated the Stark law
  - Use of “intricate kickbacks using directorships and other misrepresented positions”

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Review of FCA Cases – Civil and Criminal

02/05/2019 – TN Health Management (THM)

- $9.7 million settlement paid for FCA allegations -
  - Submission of false claims to TennCare (Tennessee Medicaid) by its 27 SNFs
  - TennCare requires that a placement evaluation be conducted and certified by an MD for admission to a SNF
  - THM submitted admission evaluations with photocopied or pre-signed MD certifications
  - Allegations encompassed 8 years (2010 – 2017)

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Review of FCA Cases – Civil and Criminal

05/24/2019 – Doctor's Choice (Sarasota, FL)

- Government intervened in qui tam case
- Allegations of:
  - Kickback payments to 3 physicians under sham medical director agreements
  - Some HHA employees were paid in a manner that accounted for the volume of referrals by their physician spouses (Stark law violation)

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Review of FCA Cases – Civil and Criminal

06/11/2019 – Chicago PT Center and 4 SNFs

- $9.7 million settlement paid for allegations -
  - Providing unnecessary services to increase Medicare payments
  - Upcoding patients by furnishing skilled therapy to patients who did not need it or could not benefit from it
  - Part of an effort to bill the highest possible amount to Medicare
  - Owner of PT Center agreed to be excluded for 5 years from all federal programs

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Review of FCA Cases – Civil and Criminal

06/28/2019 – Encompass Health IRF

- $48 million settlement to resolve allegations of a “nationwide scheme”
- Allegations included:
  - Providing inaccurate info to Medicare to maintain IRF status and to earn high rate of reimbursement
  - Admission that were not medically necessary
  - Some patients were too sick or disabled to participate in or benefit from intensive inpatient therapy

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Review of FCA Cases – Civil and Criminal

07/19/2019 – Myriad Genetics

- $9.1 million settlement to resolve FCA *qui tam* case alleging a scheme to fraudulently bill Medicare for certain hereditary cancer tests
- Whistleblower was a medical director for Palmetto GBA (a MAC)
- Serves as a reminder that whistleblowers are not always corporate insiders

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Review of FCA Cases – Civil and Criminal

09/25/2019 – $8.5M Settlement Against Mobile X-ray Company

- Qui tam lawsuit filed by two whistleblowers (Chief Information Officer and Regional Sales Manager for company)
- Allegations covered by the settlement include:
  - Billing Medicare and Medicaid for mobile x-rays under an illegal “swapping arrangement”
  - Providing mobile x-rays to SNF residents below costs or FMV in return for referring Medicare and Medicaid services
  - Falsely certifying compliance with federal anti-kickback laws

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Review of FCA Cases – Civil and Criminal

02/28/2019 – Vanguard Healthcare and 5 SNFs

- $18M settlement to resolve allegations of billing Medicare and Medicaid for "grossly substandard" nursing home care, including failure to:
  - Administer medications or provide wound care as prescribed
  - Provide standard infection control
  - Meet basic nutrition and hygiene requirements
  - Take steps to help prevent development of pressure ulcers
- CEO and Director of Operations also paid $250,000
- Also alleged to have submitted preadmission forms with forged nurse or MD signatures to Medicaid

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Review of FCA Cases – Civil and Criminal

10/04/2018: Texas - Medicare Fraud Strike Force

- Patient recruiter sentenced to 108 months in prison for her role in $3.6M Medicare HHA fraud scheme
  - She controlled a substantial population of Medicare patients whose personal information she sold to HHAs in exchange for kickbacks
  - She paid patients, MDs, therapy companies, and others for paperwork, beneficiary information, and services to facilitate the fraud
  - To cover up the fraud, she tried to make it look as if she paid hourly as a legitimate marketing representative
  - She and her co-conspirators used a HHA to submit claims to Medicare for services that were not rendered or were not medically necessary

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Review of FCA Cases – Civil and Criminal

10/16/2018: Texas - $11.3 million Medicare HHA fraud scheme

- MDs and nurses sentenced to prison time ranging from 6 months to 120 months
  - From 2007 to 2015, an MD part owner of an HHA, certified Medicare beneficiaries for home care, although he never saw the patients, and the home care was unnecessary and often not provided
  - The nurses falsified assessments and visit notes to make it appear patients qualified and that they received services

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Review of FCA Cases – Civil and Criminal

10/18/2018: Michigan - Medicare Fraud Strike Force case

- 2 HHA owners convicted in multi-million dollar scheme to bill for home health services that were never provided
- Owners also admitted to paying illegal kickbacks for referral of Medicare beneficiaries to their HHAs
- The owners were sentenced to prison time and ordered to pay restitution
- 2 co-conspirators were also convicted and a third was charged but remains a fugitive

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Review of FCA Cases – Civil and Criminal

10/30/2018: Texas HHA Owners Convicted in $3.7M Fraud Case

- 2 HHA owners and 2 employees convicted in $3.7M HHA fraud scheme
  - The 2 owners had been excluded from participating in any federal health care program
  - The HHA administrator signed false documents to conceal the ownership and exclusion
  - The wife of one of the owners signed bank documents and employee paychecks to conceal the involvement of her husband
  - The HHA also billed for services that were not needed

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Review of FCA Cases – Civil and Criminal

12/17/2018: Florida - Medicare Fraud Strike Force case

- Miami resident plead guilty for her role in $4.6 million fraud case
  - From 2010 to 2014, she accepted kickbacks in return for the referral of Medicare beneficiaries to 3 HHAs, many of whom did not need or qualify for home health care
  - She was an MD in Cuba but was never licensed in the US
  - She admitted to performing HHA nursing visits and preparing related medical records, as well as changing claim coding to increase reimbursement

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Review of FCA Cases – Civil and Criminal

Esformes FCA Case in South Florida

- On 04/05/2019:
  - Philip Esformes was convicted in $1.3B Medicare and Medicaid FCA case
  - This was the largest healthcare scheme ever charged by the DOJ
  - False claims were for services not furnished, not medically necessary, or procured through the payment of kickbacks
- On 09/12/2019:
  - Philip Esformes (50 y/o) was sentenced to 20 years in prison and 3 years of supervised release
  - A hearing for restitution and forfeiture has been scheduled for 11/2019

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Review of FCA Cases – Civil and Criminal

10/10/2019 – RN Pleads Guilty to Medicare Kickback Scheme

- RN case manager in non-profit hospital in California pleaded guilty to conspiring with the owners of HHAs to pay and receive illegal kickbacks in exchange for referrals of Medicare beneficiaries

10/07/2019 – Texas MD Convicted in $16M Fraud Scheme

- MD signed false and fraudulent “plans of care” and other documents for HHA services
- Paid beneficiaries to sign up for HHA services that were not medically necessary and/or provided

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Recent Developments Relating to FCA Cases

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- "Granston Memo" – January 2018
  - DOJ guidance on factors to consider in the potential dismissal of "meritless" FCA cases
  - Instructs that when DOJ decides not to intervene in a FCA case, it should also consider whether to dismiss the case
  - FCA case can be dismissed regardless of the objections of the relator
  - 7 bases for dismissal are offered, including "preserving government resources"
- Senate Finance Committee Chairman Grassley responded that at least some of DOJ concerns were vague and questionable

Recent Developments Relating to FCA Cases

"Brand Memo" – January 2018

- Prohibited the use of agency guidelines as basis for proving FCA violations
- Using guidelines as de facto regulations evades the required rulemaking processes
- In the past, DOJ had at times blurred the distinction between regulations and guidance documents
- Guidance documents do not have the binding force or effect of law

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Recent Developments Relating to FCA Cases

False Claims Act Recoveries in FY 2018

- DOJ recovered $2.8 billion in FCA cases in FY 2018
- $2.5 billion of the recoveries were from the health care industry
- Civil health care fraud recoveries have exceeded $2 billion for 9 consecutive years
- These recoveries do not include amounts of state Medicaid funds DOJ was also able to recover

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Recent Developments Relating to FCA Cases

Quick Facts Relating to Healthcare Offenses FY 2018

- The top five districts for health care fraud offenders were:
  - Southern District of Florida (95)
  - Eastern District of Michigan (18)
  - Southern District of Texas (18)
  - Middle District of Florida (17)
  - Eastern District of Louisiana (17)

SOURCE: United States Sentencing Commission Fraud Team Datafiles, FY 2014 through FY 2018, USSCFTFY14-USSCFTFY18

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Recent Developments Relating to FCA Cases

Quick Facts Relating to Healthcare Offenses FY 2018

- 65.2% of health care fraud offenders were men.
- Ethnic breakdown:
  - 38.7% (white)
  - 28.0% (Hispanic)
  - 21.9%(black)
  - 11.4% (other)
- Average age was 49 years.
- 87.1% were United States citizens.
- 86.8% had little or no prior criminal history

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Recent Developments Relating to FCA Cases

DOJ Pursuit of Criminal Charges in Some SNF FCA Cases

- DOJ is looking to identify criminal charges that can be brought alongside of civil FCA cases
  - Criminal charges may be pursued in cases with allegations of abuse and fraud against elderly patients
  - FCA cases involving grossly substandard (worthless) care or services not rendered may also warrant parallel criminal prosecution

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Recent Developments Relating to FCA Cases

Hospice Cases – Escobar Decision

- 2016 Supreme Court Universal Health decision that "implied false certification" is a viable theory of liability in FCA cases
- Under this theory, demanding materiality and scienter requirements must be satisfied
- Circuit Court decisions have varied in how the materiality standard has been applied

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Recent Developments Relating to FCA Cases

Hospice Cases – Aseracare Case

- Decision in 11th Circuit Court of Appeals 09/09/2019
  - Disagreements between physicians regarding a patient's terminal prognosis do not constitute a false claim absent other evidence to prove the falsity of the assessment
  - Falsity of the assessment must be linked to actual examples of false claims
  - The argument that corporate climate pressured sales and clinical staff to meet aggressive monthly quotas for patient intake that is not linked to specific claims does not support a false claim under the FCA

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Recent Developments Relating to FCA Cases

New DOJ Guidelines for "Cooperation" Credit

- Considered when defendants cooperate during FCA investigation
- Cooperation may be evidenced by:
  - Voluntarily disclosing misconduct unknown to the DOJ
  - Undertaking thorough root cause analysis of the misconduct
  - Disciplining or replacing those responsible
  - Accepting responsibility for misconduct
  - Strengthening compliance efforts to prevent recurrence
  - Credit could reduce damages multiplier and civil penalties

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Compliance Challenges and New Areas of Risk

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Compliance Challenges – SNFs and HHAs

Changeover to New PPS Payment Methodologies

- SNFs changed to PDPM effective 10/01/2019
- HHAs will change to PDGM effective 01/01/2010
- Both new systems focus on value-driven vs. volume-driven payment
- Payments are not based on therapy utilization
- Payments to be based on patient characteristics not service utilization
- Changes in payment methodologies will result in learning curve and potential for an increase the risk of errors

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Compliance Challenges – SNF

Potential Areas of Risk – Under RUG-IV (before 10/01/2019)

- Evaluate practices for Rehab RUGs, especially at Ultra and Very High:
  - Was therapy reasonable, necessary, skilled, and furnished?
  - Was therapy delivered in a manner that was focused on the clinical needs of the patients and not on increasing Medicare reimbursement?
  - Is there any appearance of "thresholding"?
  - Is there documentation to support the active participation of the "clinician" in treatment?
  - Is there any pattern of "presumptive" placement in ultra or very high categories?
  - Do evaluating therapists drive decisions regarding treatment intensity and duration?

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Compliance Challenges – SNF

Potential Areas of Liability – Under PDPM

- SNF Part A claims and therapy (after 10/01/2019)
  - Changes in therapy delivery patterns
  - Significant increase in group and concurrent therapy
  - Changes in therapy intensity for types of conditions before and after PDPM
  - Decline in readmission measures
  - Poor QRP outcome measures
- Significant decline in therapy minutes could draw scrutiny and/or future payment adjustments
- CMS will implement a "robust monitoring program"

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Compliance Challenges – SNF

Other Potential Areas of Risk Under PDPM

- Changes in Section GG coding from historical practices
- Increased coding of mechanically altered diet or cognitive impairment
- Insufficient support for Primary diagnosis and/or ICD-10 coding
- Nursing documentation that lacks evidence of daily skilled care
- Frequency of the optional IPA assessment
- Accuracy of discharges and application of Interrupted Stay Policy

Post Acute Care – Long Term Care
Current Enforcement and Compliance Issues

Questions?