

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

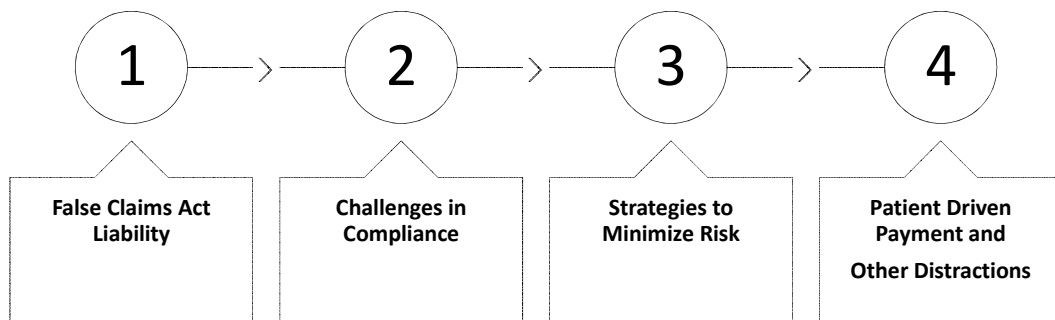
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Post Acute Care – Long Term Care



False Claims Act Liability

False Claims Act Liability - Home Health Care

- 05/17/2018: Illegal kickbacks
 - Michigan HHA owner pleads guilty in criminal case involving \$8 million in fraudulent Medicare claims procured through payment of illegal kickbacks
 - Owner (a PT) admitted to the following as part of his guilty plea:
 - Submitting false certifications to enroll and stay enrolled as a Medicare provider
 - Paying illegal kickbacks to recruiters in exchange for Medicare beneficiary referrals
 - Billing Medicare for claims procured through these illegal kickbacks
 - False claims were submitted to Medicare between 2007 to 2017
 - Case brought as part of the Medicare Fraud Strike Force

False Claims Act Liability - Home Health Care

- 05/25/2018: Michigan – Medicare Fraud Strike Force case
 - MD convicted in \$8.9 million health care fraud scheme
 - Case involved submission of Medicare claims for home health care and MD services procured through kickbacks, that were not medically necessary, not actually provided, or in some cases provided by the defendant who was not a licensed physician during the conspiracy
 - The defendant and her co-conspirators falsified medical records and signed false documents
 - Fraudulent claims were presented from 2011 to 2016

False Claims Act Liability - Home Health Care

- 08/23/2018: California MD convicted in kickback conspiracy
 - According to evidence presented at trial, the MD received kickbacks in cash and by checks from an HHA for Medicare referrals
 - Investigation covered the years from 2008 - 2016
 - These kickbacks resulted in \$4.1 million claims to the Medicare program from referrals from the MD
 - This case resulted from the Medicare Fraud Strike Force

False Claims Act Liability - Home Health Care

- 10/04/2018: Texas - Medicare Fraud Strike Force
 - Patient recruiter sentenced to 108 months in prison for her role in \$3.6 million Medicare fraud scheme involving HHA services
 - She controlled a substantial population of Medicare patients whose personal information she sold to HHAs in exchange for kickbacks
 - She paid beneficiaries, MDs, therapy companies, and others for paperwork, beneficiary information, and services needed to facilitate the fraud
 - To cover up the fraud, she tried to make it look as though she was being paid an hourly wage 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

False Claims Act Liability - Home Health Care

- 10/16/2018: Texas - \$11.3 million Medicare HHA fraud scheme
 - MDs and nurses sentenced to prison time ranging from 120 months to 6 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

False Claims Act Liability - Home Health Care

- 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

False Claims Act Liability - Home Health Care

- 10/30/2018: Texas
 - 2 HHA owners and 2 employees convicted in \$3.7 million HHA fraud scheme
 - The 2 owners had been previously excluded from participating in any federal health care program
 - The HHA administrator signed false documents to conceal the ownership and exclusion of the owners
 - 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

False Claims Act Liability - Home Health Care

- 11/05/2018:
 - Patient recruiter convicted in \$1.1 million kickback scheme involving fraudulent Medicare claims for home health care
 - From 2009 to 2012, recruiter conspired with the owners of a HHA and solicited and received kickbacks for referring Medicare beneficiaries to the HHA
 - The HHA then billed the fraudulent claims to the Medicare program
 - Another Medicare Fraud Strike Force case

False Claims Act Liability - Home Health Care

- 11/14/2018: Michigan - Medicare Fraud Strike Force case
 - Owner of 2 clinics sentenced to 160 months in prison for \$8.9 million fraud scheme, with 3 co-defendants also receiving jail time
 - \$6.3 million in restitution also ordered
 - From 2009 to 2012, fraudulent claims were billed for home health care and physician services
 - Services were procured through payment of kickbacks, were not medically necessary, were not actually provided, or were provided by an unlicensed MD

False Claims Act Liability - Home Health Care

- 12/04/2018: Florida - Medicare Fraud Strike Force case
 - 2 Miami residents plead guilty for their roles in \$8.6 million fraud case
 - HHA owner admitted to paying kickbacks and bribes to his co-conspirators in exchange for HHA orders
 - His co-defendant conspired with the HHA owner to furnish PT and OT, even though she was not licensed to do so

False Claims Act Liability - Home Health Care

- 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

False Claims Act Liability - Hospice

- 10/30/2017:
 - Vitas Hospice agrees to pay \$75 million to resolve FCA violations
 - Settlement involved allegations that from 2002 and 2013, Vitas:
 - Submitted false claims to Medicare for services to hospice patients who were not terminally ill
 - Rewarded employees with bonuses for the number of patients receiving hospice services, without regard to whether they were actually terminally ill and whether they would have benefited from continuing curative care
 - Billed for continuous home care services (CHC) that were not necessary, not actually provided, or not performed in accordance with Medicare requirements
 - Set goals for the number of CHC days, and pressured staff to increase CHC days
 - Case arose from three Qui Tam lawsuits
 - Vitas also entered into a 5-year Corporate Integrity Agreement (CIA)

False Claims Act Liability - Hospice

- 12/21/2017:
 - Hospice in Gainesville, FL settled FCA allegations for \$5 million
 - Allegations included the following:
 - Submitting false claims for 63 patients who had lengths of stay greater than three years (some of whom were on service nearly six years)
 - Failure to document a valid basis for the initial start of hospice care and/or subsequent hospice coverage
 - Inadequate support of diagnoses
 - Changing diagnoses when patients did not show decline under their original terminal diagnosis
 - The government agreed to accept \$5 million to resolve the allegations based on the provider's ability to pay

False Claims Act Liability - Hospice

- 02/08/2018: Hospice and Owner/CEO settle FCA case
 - Horizons Hospice in Pittsburgh and its owner/CEO agreed to pay \$1.24 million for billing Medicare and Medicaid for hospice services to patients who were ineligible
 - From 06/2007 – 08/2012, the hospice billed for patients who did not have a 6-month life expectancy
 - Allegation that records were falsified to support the false claims

False Claims Act Liability - Hospice

- 05/18/2018: 3 hospices on the “Treasure Coast” of Florida
 - The defendants paid \$2.5 million to settle FCA liability to Medicare
 - Claims submitted from 2005 to 2011
 - Allegation made that patients were not eligible for some of all of their care
 - This case resulted from Qui Tam lawsuits filed by two physicians previously employed by the defendants
 - Allegations included billing for patients who were not terminally ill and who did not qualify for hospice services

False Claims Act Liability - Hospice

- 06/25/2018: Caris Healthcare (Operates hospices in TN, VA, and SC)
 - Caris agreed to pay an \$8.5 million to settle FCA allegations that:
 - Medicare was billed for ineligible hospice patients
 - Company had aggressive admissions and census targets
 - Provider disregarded concerns of nurses, internal auditors, and Medical Director about patients who were not hospice eligible
 - Hospice retained overpayments for patients who were not terminally ill
 - Case resulted from Qui Tam lawsuit filed by an RN who was previously an employee of the hospice

False Claims Act Liability - Hospice

- 12/13/2018: SouthernCare (Pennsylvania)
 - Agreed to pay an \$5.8 million to settle FCA allegations
 - Case arose from 2 whistleblowers who were former employees, who will share \$1.1 million of the recovery
 - From 2009 to 2014, the hospice allegedly:
 - Admitted patients who were not terminally ill and who lacked appropriate medical documentation of their illness
 - Treated some patients for many years

False Claims Act Liability - Hospice

- 02/28/2017: Novus Health Services (Texas)
 - 16 individuals were indicted in a \$60 million fraud scheme involving false claims to Medicare and Medicaid from 2012 to 2016
 - A CPA owned the hospice, who directed the care along with nurses
 - The US Attorney on the case stated:

“That tens of millions of dollars were stolen through fraud is shocking enough,” said U.S. Attorney Parker. “That these defendants used human life at its most vulnerable stage as the grist for this scheme displays a shocking level of depravity that this community simply cannot tolerate.”

False Claims Act Liability - Hospice

- 02/28/2017: Novus Health Services (Texas) - *Continued*
 - Allegations included:
 - False claims for continuous care hospice services
 - Paying kickbacks to referring MDs and ALFs for ineligible hospice beneficiaries
 - Paying medical directors who provided little or no oversight of hospice care
 - Medical care that was often driven by financial interest, not patient need
 - Falsifying and destroying documents to conceal these activities

False Claims Act Liability – Nursing Home

- 01/12/2016: RehabCare and 4 SNF operators
 - \$133 million recovered for fraudulent SNF claims
 - Settlement resolves allegations that:
 - Claims for inflated therapy reimbursement were submitted to Medicare
 - Claims were based on therapy that was unreasonable, unnecessary, unskilled, or not furnished
 - RehabCare and its SNF customers engaged “in a systematic and broad-ranging scheme to increase profits by delivering...therapy in a manner that was focused on increasing Medicare reimbursement rather than on the clinical needs of patients.”

False Claims Act Liability – Nursing Home

- 01/12/2016: RehabCare’s schemes are alleged to have included:
 - Presumptive placement in the highest therapy category
 - “Ramping” therapy during assessment periods (before 10/01/2011)
 - Continuing therapy after treating therapist recommended discharge
 - Arbitrarily shifting planned therapy minutes between disciplines
 - Increasing treatment minutes at the end of assessment period
 - Minimizing initial evaluation minutes
 - Reporting minutes although patients unable to participate or benefit
 - Rounding or estimating therapy minutes

False Claims Act Liability – Nursing Home

- 05/31/2017: SNF in NJ agrees to settle FCA liability for \$888,000
 - Settlement resolves allegations that Andover Subacute and Rehab Center provided materially substandard or worthless nursing services to some Medicare and Medicaid patients
 - The US and state of NJ contend that from 07/01/2010 to 12/31/2012, the SNF billed NY Medicaid for materially substandard or worthless nursing services provided to certain patients that failed to meet federal standards of care and federal statutory and regulatory requirements
 - The SNF entered into a 5-year Corporate Integrity Agreement

False Claims Act Liability – Nursing Home

- 07/05/2017: Reliant Care Group and Affiliated Entities –
 - Agreed to pay \$8.3 million to resolve FCA liability
 - Alleged to have furnished unnecessary rehab to nursing home residents who:
 - Had a relatively high level of independence; and
 - Who were residing in a SNF primarily because of a psychiatric condition
 - In some instances, rehab management pressured therapists to provide treatment even when the therapists believed the therapy was not medically necessary
 - Reliant furnished unnecessary therapy and sought inflated Medicare reimbursement, as influenced by its own financial considerations
 - Reliant entered into a 5-year Corporate Integrity Agreement

False Claims Act Liability – Nursing Home

- 11/16/2017: 4 San Diego SNFs agree to pay \$6.9 million settlement
 - Settlement resolved kickback and fraud allegations
 - Allegations included:
 - Kickbacks were paid by SNF employees to hospital discharge planners to induce patient referrals
 - Employees used corporate credit cards to pay for gift cards, massages, tickets to sporting events, and a cruise that were given to the hospital discharge planners
 - Case arose from qui tam lawsuit by a former employee of one of the SNFs
 - The 4 SNFs entered into a 5-year Corporate Integrity Agreement

False Claims Act Liability – Nursing Home

- 02/02/2018: Memphis SNF agrees to pay \$500,000
 - Settlement related to Medicare and Medicaid claims
 - From 2012 to 2015, Spring Gate Rehabilitation and Healthcare Center provided substandard and worthless nursing home services to residents
 - Arose from a Qui Tam lawsuit
 - Spring Gate allegedly provided services to residents that were materially substandard and essentially worthless
 - SNF entered into a 5-year Corporate Integrity Agreement

False Claims Act Liability – Nursing Home

- 06/08/2018 - Signature Health Care
 - Operates 115 SNFs, including 7 in Tennessee
 - Agreed to pay \$30 million to resolve FCA liability
 - Rehabilitation therapy was not reasonable, necessary and skilled
 - Forgery of pre-admissions certifications of need for skilled nursing to Medicaid
 - Arose from Qui Tam lawsuits filed by two former therapy employees
 - Allegations regarding therapy services included:
 - Presumptively placing patients in highest therapy levels
 - Providing the minimum minutes necessary to achieve the desired therapy level
 - Pressuring therapists to deliver planned therapy minutes

Challenges in Compliance

Challenges in Compliance: *Why is healthcare in the spotlight?*

- Dollars recovered by DOJ from civil FCA cases in FY 2018
 - \$2.8 billion in total
 - \$2.5 billion of that from the healthcare industry
 - 446 healthcare qui tam lawsuits were filed in FY 2018
- OIG Semiannual Report (6 months ended 09/30/2018)
 - Investigative recoveries of \$2.9 billion
 - Criminal actions against 764 individuals/entities
 - Exclusion of 2,712 individuals/entities
 - Civil actions against 813 individuals/entities

Challenges in Compliance: *Why is healthcare in the spotlight?*

- Comprehensive Error Rate Testing (CERT) in FY 2018
 - Improper Payment Rates
 - Total = 8.12% (\$31.62 billion)
 - HHA = 17.6% (\$3.2 billion)
 - SNF Part A = 7.0% (2.1 billion)
 - Hospital-based hospice = 19.3% (\$275 million)
 - Non-hospital based hospice = 11.0% (\$1.8 billion)

Source: 2018 Medicare Fee-for-Service Supplemental Improper Payment Data
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSupplementalImproperPaymentData.pdf>

Compliance Challenges – Home Health

- **OIG Active Work Plan Items**
 - Review of HHA Claims for Services with 5 to 10 Skilled Visits
 - Home Health Compliance with Medicare Requirements

Compliance Challenges – SNF

- **OIG – Active Work Plan Items**
 - Potential Abuse and Neglect of Medicare Beneficiaries
 - SNF PPS Requirements
 - Involuntary Transfer and Discharge in Nursing Homes
 - CMS Oversight of Nursing Facility Staffing Levels
 - Medicare Payments Made Outside of the Hospice Benefit

Compliance Challenges – Hospice

- OIG –

- *“Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity”* (OEI-02-16-00570, July 2018)
 - Inappropriate billing
 - Billing for an expensive level of care when not needed
 - Fraud schemes
 - Enrolling beneficiaries who are not eligible
 - Billing for services never provided
 - Current payment system creates incentives to minimize services and seek patients with uncomplicated needs

Strategies to Minimize Risk

Strategies to Minimize Risk – PAC Providers

- Ensure robust ongoing risk assessments
- Use available data to assess risk
 - Programs to Evaluate Payment Patterns Electronic Report (PEPPER)
 - Provider specific, non-public data
 - See link below
 - Comparative Billing Report – CBR
 - Available from your MAC or RHHI
 - Provider specific, non-public data

Source: Compliance Projects – Education and Outreach
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Data-Analysis/index.html>

Strategies to Minimize Risk – PAC Providers

- Use published data for your provider type to evaluate risk
 - General Accountability Office (GAO)
 - Office of Inspector General (OIG)
 - MAC and RHHI websites
 - Medicare Payment Advisory Commission (MedPac)
- Provider Compliance Tips*
- Be aware of potential “Targeted Probe and Educate” (TPE) audits

*Source: Compliance Projects – Education and Outreach
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Data-Analysis/index.html>

Strategies to Minimize Risk – PAC Providers

- PEPPER
 - Distribution Schedule – Issued annually
 - Home Health Agencies –in July
 - Hospices – in April
 - SNFs – in April
 - PEPPER Retrieval Rates
 - Home Health Agencies 07/2018 – 36.3% (national)
 - Hospices 04/2018 – 64.8% (national)
 - SNFs 04/2018 – 52.5% (national)

New “Patient-Driven” Payment Models and Other “Distractions”

Patient Driven Payment Models and Other Potential “Distractions”

- Don't lose sight of ongoing compliance initiatives during change
 - Value Based Purchasing
 - Quality Reporting Program
 - Changes to PPS Payment Models
 - SNFs: PDPM
 - HHAs: PDPG
 - Hospices: Service Intensity Add-On
 - Evaluation of Corporate Compliance Plan effectiveness during SNF surveys
 - 42 CFR 483.85 – Compliance and ethics program

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

Questions?