Texas Prosecutors are Aggressively Targeting Criminal Home Health Fraud

(January 9, 2019): Despite real progress being made with respect to regulatory compliance, home health agencies, their owners, and affiliated health care professionals (such as referring / supervising physicians, therapists and staff) remain under strict government scrutiny. The government's efforts to investigate and prosecute home health fraud cases have been especially evident in Texas. In calendar year 2018, a number of home health agencies, owners and affiliated individuals have been indicted, prosecuted and / or sentenced in connection with their improper conduct. This article examines many of these recent cases and discusses the improper conduct that led to these Texas home health prosecutions.

I. Texas Home Health Prosecutions in Calendar Year 2018:

Several significant home health fraud cases were investigated and prosecuted by the Department of Justice (DOJ) in Texas during 2018. These cases included, but were not limited to the following:

- **Southern District of Texas. December 2018.** In this case, the owner of a home health agency allegedly paid marketers and group home owners for Medicare beneficiary information which he used to bill Medicare and Medicaid for home health services that were either not provided or did not qualify for coverage and payment. The government also alleged that the defendant owner ***"personally falsified home health patient assessment forms to make the beneficiaries appear sicker on paper to receive higher reimbursement rates from Medicare,"*** and that he instructed agency employees to falsify home health certifications and forge physician signatures. A jury found the defendant guilty and he was sentenced to 109 months in prison. The defendant was also ordered to pay ***$3.5 million*** in restitution to the Medicare program.

- **Northern District of Texas. October 2018.** Two owners and the administrator of a home health agency were convicted in this prosecution of various health care fraud violations after a six-day trial. The owners were convicted of conspiracy to commit health care fraud, and one of the owners and the administrator were convicted of two counts of making a false statement in connection with a health care benefit program. ***At trial, evidence was presented that both of the home health agency owners had previously been excluded from participating in federal health benefit programs. The government alleged that the administrator concealed the fact that the home health agency owners were excluded parties. The government further alleged that the administrator signed false documents indicating that a third person was the owner of the agency and that no one associated with the home health agency had been excluded from participating***

in federal health benefits programs such as Medicare and Medicaid. Federal prosecutors were also able to show that the home health agency had billed the Medicare and Medicaid programs more than ***$3.7 million*** to which it was not entitled because the agency was owned by excluded parties. The defendants have not been sentenced as of the date of this publication.

- **Northern District of Texas. October 2018.** In this case, a licensed vocational nurse who was also the part-owner of a home health agency was sentenced to 120 months in prison for her role in the fraudulent submission of home health claims to Medicare for payment. The former part-owner and supervising physician at a physician house call company was also sentenced to 42 months in prison for his role in the fraud. Two additional home health agency employees were also convicted for their roles in the fraud. ***At trial,the government produced evidence that the supervising physician certified the medical necessity of home health services for a number of patients who had never been seen,***and that the physician billed Medicare for over ***$1.6 million***in medically unnecessary home health certifications and physician home visits.

- **Southern District of Texas. October 2018.** A patient recruiter was sentenced to 108 months in prison today for her role in a ***$3.6 million*** home health Medicare fraud scheme in this health care fraud case. ***At trial, the government submitted evidence to prove that the defendant patient recruiter sold personal patient information to a home health agency which it then used to bill the Medicare and Medicaid program for services that were either not medically need or were never even provided***. ***Notably, the patient recruiter paid Medicare beneficiaries, doctors, physical therapy companies and others for the paperwork and Medicare beneficiary information and services needed to facilitate the fraud***. Finally, to hide the fraud, the patient recruiter tried to make it look like she was paid an hourly wage and the marketing services she was providing were legal and proper.

- **Southern District of Texas. June 2018.** The part-owner of a home health agency, who also served as the agency's Director of Nursing, was indicted in this prosecution for conspiracy to commit health care fraud. ***The government has alleged that the defendant, along with an unnamed group of co-conspirators, paid physicians to falsely certify the medical necessity of home health services for Medicare beneficiaries. The defendant and the unnamed group of conspirators are also charged with paying patient recruiters for referring Medicare patients to the home health agency.*** The government has also filed a criminal forfeiture count in the indictment in which it claims that more than ***$16 million*** is subject to forfeiture.

- **Southern District of Texas. June 2018.** The owner of a Harris County home health agency was indicted by a Federal Grand Jury for Conspiracy to Defraud the United States, paying and Receiving Health Care Kickbacks, and substantive violations of the Federal Anti-Kickback Statute. Specifically, ***the government has alleged that the defendant owner and a number of co-conspirators paid kickbacks to several patient recruiters in exchange for referring Medicare beneficiaries to the owner's home health agency. The government also alleges that the defendant owner and his co-conspirators paid kickbacks to a number of physicians in exchange for their certification of Medicare-required paperwork, and that they paid Medicare patients for their Medicare information in order to bill the Medicare program for home health services***. The case is set for trial in 2019, and the government also has included a criminal forfeiture count in the indictment, seeking the forfeiture of at least ***$1.2 million***

- **Eastern District of Texas. June 2018.** In this case, the owner of a Missouri City, Texas home health agency, was indicted for conspiracy to violate the Federal Anti-Kickback Statute and f or violations of the Aiding and Abetting statutory requirements. ***The defendant and a co-conspirator patient recruiter are alleged to have paid cash amounts ranging from approximately $1,600 to $2,900 to Medicare beneficiaries to sign up for home health services with the defendant's home health agency***. The matter is set for trial later this year.

- **Southern District of Texas. May 2018.** After a three-day trial, a Federal jury found a patient recruiter for a Texas home health agency guilty for her role in a $3.6 million Medicare fraud case. The patient recruiter was found guilty of one count of conspiracy to commit health care, five counts of health care fraud, and one count of conspiracy to pay health care kickbacks. At trial, evidence was introduced that showed that the defendant and her co-conspirators submitted claims to Medicare for home health services that were not medically necessary and, in some case, were not provided. According to the government, the patient recruiter ***"paid beneficiaries, doctors, physical therapy companies, and others for the paperwork, Medicare beneficiary information, and services needed to facilitate the fraud."***

- **Southern District of Texas. January 2018.** In this final case, a Texas mayor (a licensed physician and Medical Director) and three owners of a number of home health and hospice providers services, were indicted for their roles in an alleged ***$150 million*** health care fraud and money laundering scheme. ***The government has alleged that the owners caused kickbacks and bribes to be paid to the***

defendant physician (and other physicians) who served as Medicare Directors for their home health agency in exchange for falsely certifying that Medicare patients qualified for services. The defendant owners are alleged to have fraudulently kept patients on hospice services for years when such care was not medically appropriate. A number of the defendants are also alleged to have made a false statement to the FBI and / or obstructed justice by producing false and fictitious records to a Federal Grand Jury.

II. What Lessons Can be Learned from these Home Health Prosecutions?

At the outset, it is important to note that none of the home health fraud prosecutions discussed above were based on differing professional assessments of the Medicare beneficiaries' clinical condition or on a battle between medical experts over the medical necessity of home health services. Instead, Texas prosecutors focused on illegal payments in the form of kickbacks and bribes by home health owners and operators in exchange for the referral of Medicare patients, falsification of certifications or statements, and/or for acquisition of beneficiary information. In other words, **the Federal criminal cases being brought against home health owners, operators and affiliated physicians were based on the parties' fraudulent conduct, not on the quality of care provided or the medical necessity of the home health services**. Several fundamental lessons to be learned based on these cases include:

Lesson #1: Sooner or later, improper Medicare claims practices and criminal wrongdoing *WILL* be identified by law enforcement or one of the contractors working for the Centers for Medicare and Medicaid Services (CMS).

Since first passing the Medicare and Medicaid programs in 1965, the government has been compiling utilization, coding, and billing data related to the services billed to Federal and State health benefit programs. CMS shares access to this information with a number of private claims processing and / or program integrity contractors.[1] These entities are required (as part of their contractual obligations to CMS), to conduct data mining analyses of provider and supplier coding, billing and utilization practices. While criminal conduct may escape discovery in the short run, it is essential for home health agencies, their owners, patient recruiters and affiliated physicians to recognize that there is a strong likelihood that the government will ultimately find out about the wrongdoing.

Lesson #2: Don't pay kickbacks. . . ever. You will eventually be caught.

The Anti-Kickback Statute became a felony in 1977.[2] Under the Anti-Kickback Statute, it is a criminal violation to offer, pay, solicit or receive anything of value to induce referrals or generate referrals reimbursed by Federal health care programs.[3]The Department of Health and Humans

Services, Office of Inspector General (OIG) first publicized the agency's concerns regarding home health related kickbacks in a ***"1995 Special Fraud Alert."***[4] At that time, the OIG identified the following business practices as improper and potential violations of the Anti-Kickback Statute:

> ***"Payment of a fee to a physician for each plan of care certified by the physician on behalf of the home health agency.***
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> ***Disguising referral fees as salaries by paying referring physicians for services not rendered, or in excess of fair market value for services rendered.***
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> ***Offering free services to beneficiaries, including transportation and meals, if they agree to switch home health providers.***
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> ***Providing hospitals with discharge planners, home care coordinators, or home care liaisons in order to induce referrals.Providing free services, such as 24-hour nursing coverage to retirement homes or adult congregate living facilities in return for home health referrals.***
>
> ***Subcontracting with retirement homes or adult congregate living facilities for the provision of home health services to induce the facility to make referrals to the agency."***

Most of the Texas home health prosecutions pursued by DOJ prosecutors in 2018 involved illegal kickback conduct that the government first identified its 1995 Special Fraud Alert. Despite the fact that more than twenty years have elapsed, a number of home health agency owners, operators, marketing personnel and referring physicians have continued to engage in illegal kickback activities.

Lesson #3: Don't play games. Efforts to deceive the government or obstruct an investigation will only compound your problems.

In the criminal cases outlined in Section II above, a number of the defendants engaged in deceitful conduct. Several examples of the deceitful conduct included:

> ***"A home health agency owner was alleged to have falsified home health patient assessment forms.***
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> ***A home health agency owner was alleged to have instructed home health staff to falsify physician signatures.***
>
> ***A home health agency administrator was alleged to have signed false documents***

> ***indicating that a third-party owned the agency and that no excluded parties were associated with the agency, when in fact, the true owners had been excluded from participation in the Medicare program*.**
>
> ***Defendants were also alleged to have made a false statement to the FBI and / or obstructed justice by producing false and fictitious records to a Federal Grand Jury."***

There are several Federal statutes that are implicated by this type of deceitful conduct.[5] Statutory provisions that may be implicated (depending on the facts), include, but are not limited to:

Fraud and False Statements (18 U.S.C. § 1001). *It is illegal for any person, in connection with any matter before any branch of the federal government or any federal agency, to do any of the following: (1) falsify or conceal a material fact; (2) make any material misrepresentations; or (3) make or use any false document knowing that such document contains a material falsehood.*

False Statements Involving Health Care Programs (18 U.S.C. § 1035). *It is unlawful for any person to, in any matter involving a health care benefit program and in connection with the delivery of or payment for health care services, knowingly: (1) falsify or conceal a material fact; (2) make a material misrepresentation; or (3) use a document knowing that it contains a material misrepresentation.*

Health Care Fraud (18 U.S.C. § 1347). *It is unlawful for any person to knowingly: (1) defraud any health care benefit program; or (2) obtain by false pretenses any money or property owned or under the control of a health care benefit program.*

Obstruction of a Criminal Investigation into Health Care Offenses (18 U.S.C. § 1518). *It is unlawful to prevent, obstruct, or delay the communication of information relating to a federal health care offense to a criminal investigator.*

False Statements Involving Federal Health Care Programs (42 U.S.C. § 1320a–7b(a)). *It is unlawful for any person to: (1) knowingly make a false statement in an application for benefits or payment under a federal health care program; (2) knowingly make a false statement for use in determining rights to benefits or payment under a federal health care program; (3) knowingly conceals or fails to disclose any event affecting one's eligibility for benefits or payment under a federal health care program; (4) knowingly use the benefits or payment of another under a federal health care program for some reason other than their intended purpose; (5) knowingly present a claim for a physician's service under a federal health care program where the person presenting the claim knows the service provider was not a licensed physician; or (6) knowingly assist another in disposing or transferring of assets such that he or she will be eligible for benefits under a federal health care program.*

Violations of these statutes are often uncovered during the course of administrative audits by CMS program integrity contractors. These types of violations may also arise in connection with patient complaints and whistleblower cases.

Lesson #4: Medical Director agreements -- it all comes down to the nature of the business relationship.

Both parties need to recognize the importance of conducting due diligence before entering into a contract with a Medical Director. Does the home health agency have an effective Compliance Program in place? Has either the home health agency or the physician being considered for a Medical Director position been the subject of an adverse action by Medicare, Medicaid, or a private payor? To paraphrase the Greek philosopher Aesop, ***"You are judged by the company that you keep."***

When reviewing Medical Director agreements, government prosecutors and investigators are trained to conduct a critical assessment of these business relationships. Are the terms of the Medical Director agreement consistent with Fair Market Value principles? Has the Medical Director properly documented the services he or she provided and properly recorded the amount of time being spent in the performance of his or her Medical Director duties? How many patient referrals are generated by your Medical Directors? In a perfect world, a home health agency would not receive any patient referrals from the agency's Medical Director. To the extent that an agency's Medical Director does, in fact, make a significant number of referrals to the agency for home health services, the government will understandably wonder whether the referrals being made are in exchange, in whole or in part, for the monies being paid to the physician under the Medical Director agreement.

Lesson #5: Do you employ sales or marketing personnel? Regardless of whether you refer to a position as a *Community Outreach Coordinator*, a *Marketing Specialist* or a *Physician Liaison*, the government will still carefully review how these individuals are compensated, and the actual duties that are being performed.

Marketing activities that may constitute ordinary business courtesies if extended to an actual or potential referral source in another industry, are often illegal in the context of Federal health care programs. Home health agencies that employ or contract with individuals to conduct marketing services on behalf of the agency need to ensure that the services being performed do not violate the Federal Anti-Kickback Statute or, if applicable, a state's bribery law or all-payor statute. Compensation agreements that reward a marketing individual based on the number of patient referrals generated are especially problematic.

III. Conclusion:

The likelihood that your home health agency will be subjected to a Medicare or Medicaid

audit or investigation increases every day. As a participating provider in one or more Federal health care programs, providers have an affirmative obligation to ensure that your claims are properly documented, coded, and billed. Additionally, providers must ensure that otherwise payable home health service claims have not been "tainted" by any statutory or regulatory violation of the Stark laws, the Federal Anti-Kickback Statute or the False Claims Act. When examining whether a claim is "payable," a provider needs to remember that even though the medical service at issue may have been medically necessary and qualified for payment, if it is the result of an illegal activity, it will be tainted and will likely not qualify for payment. Unfortunately, many providers have never researched or reviewed the proper rules covering the work they provide. If you have questions? Give us a call. Liles Parker attorneys have extensive experience representing home health providers around the country in connection with Medicare audits and investigations.

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[1] CMS works with claims processing contractors (Medicare Administrative Contractors (MACs)), and program integrity contractors (such as Recovery Audit Contractors (RACs), Supplemental Medical Review Contractors (SMRCs) and Uniform Program Integrity Contractors (UPICs) to identify overpayments and instances of potential fraud which may be referred to law enforcement authorities for investigation and prosecution.

[2] **42 U.S.C. 1320a-7b(b).** The *Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977* (Public Law 95-142), made violations of the Anti-Kickback Statute a felony. It also made those who offered remuneration for referrals and those who received them subject to various penalties.

[3] Under 42 U.S.C. 1320a-7b(f),a "*Federal health care program*" is defined as:

"(1) any plan or program that provides health benefits, whether directly, through insurance, or

otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5); or

(2) any State health care program, as defined in section 1320a-7(h) of this title."

[4] **Federal Register, August 10, 1996 (Volume 60, Number 154).** A copy of this Special Fraud Alert can also be found on OIG's website.

[5] For each of the criminal statutes identified below, there are corresponding regulations which would authorize the imposition of Civil Money Penalties by the Health and Human Services, Office of Inspector General (HHS/OIG), see, 42 U.S.C. 1320a-7a(a).