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Post-acute care providers' fraud risks

By Randi Seigel and Krusheeta R. Patel

Like other healthcare providers, post-acute care (PAC) providers—specifically skilled nursing facilities (SNFs), home health agencies (HHAs), and hospice providers (collectively referred to in this article as "PAC providers")—have long faced significant regulatory burdens to ensure compliance with myriad Medicare and Medicaid conditions of participation and conditions of payment (CoPs). Because physicians and nonphysician practitioners are the gatekeepers for many PAC services, PAC providers often rely on unaffiliated physicians and nonphysician practitioners to certify a patient's eligibility for services. This is in addition to overseeing a plan of care and obtaining necessary documentation in the time frames required by the CoPs—which can be challenging. Additionally, PAC providers rely more heavily on referrals from hospitals, physicians, and other community providers than different types of acute care or specialty providers; this greater reliance on opportunities from referral relationships presents more substantial fraud, waste, and abuse concerns.

To understand the current risk areas—many of which are the same that have existed for decades—it is important to understand the history of scrutiny of these PAC providers, which is where this article begins. We then discuss current risk areas and recent government activity in those areas and, finally, where we anticipate ongoing or increased scrutiny.

History of government scrutiny

The federal government has long viewed PAC providers as high risk for engaging in fraudulent and abusive conduct. Many early U.S. Department of Health & Human Services, Office of Inspector General (OIG) Special Fraud Alerts focused on PAC providers. In 1995, the OIG issued a Special Fraud Alert focused on HHAs engaging in several concerning activities, including billing for services not provided; paying kickbacks to referral sources, including physicians, SNFs, and senior living facilities, for referring patients to the agency; and physicians certifying patients as eligible for homecare who are not eligible.[1]

In 1996 and 1998, OIG issued two separate Special Fraud Alerts focused on SNFs: one related to providers rendering services to SNF residents billing for services not provided[2] and the other related specifically to SNF relationships with hospice providers.[3] The latter relationships are particularly vulnerable to fraud and abuse because SNFs provide a sizeable pool of potential hospice patients. SNF hospice patients often have longer lengths of stay, which may require fewer services, making them more profitable than patients who reside at home.

As hospice utilization and spending has grown, OIG has shifted attention to the vulnerabilities in this program. In

particular, OIG has identified fraud schemes to recruit patients who may not be eligible for hospice and billing for a higher level of care than necessary.

Home health

Home health providers have paid at least $422.6 million since 2012 to settle False Claims Act (FCA) allegations. This represents 51 different cases from 2012 to 2020.[4] In 2021, Medicaid Fraud Control Units brought 39 criminal and 28 civil actions against HHAs, resulting in $176 million and $18.4 million in recoveries, respectively.[5]

From January 2022 until August 2022, based on publicly available data, three home health providers have settled FCA allegations for a total of $7.66 million related to alleged lack of medical necessity, upcoding, and failure to return a known overpayment.

Hospice

Hospice providers have paid at least $254 million since 2012 to settle FCA allegations involving at least 37 hospice providers.

In 2021, the Medicaid Fraud Control Unit brought six criminal cases and one civil fraud case against hospice providers resulting in payment of $85,327,396, and there remained 100 open investigations against hospice providers.[6]

SNFs

SNFs have paid at least $45 million since 2012 to settle FCA allegations involving more than eight SNFs. Most of these settlements arose from alleged violations of the Anti-Kickback Statute (AKS).

At the end of 2021, there were 321 open investigations against nursing facilities for fraud.[7]

Current risk areas

PAC providers' risk areas remain generally related to inadvertent or unintentional documentation errors that can result in a PAC providers' receipt of an overpayment, which, if not promptly returned, can result in FCA liability. The federal FCA makes it illegal to knowingly present, or indirectly cause to be presented, a false or fraudulent claim for payment to the federal government.[8] The FCA does not require intent to defraud or "actual" knowledge.[9] Conduct constituting deliberate ignorance or reckless disregard can also land a PAC out of compliance with the FCA. Failure to promptly repay an overpayment can form the basis of a false claim prosecution under the FCA (Medicare and Medicaid providers have an obligation to report and return overpayments within 60 days of identification).[10]

Other risk areas include nefarious conduct, such as admitting or accepting patients who fail to meet Medicare or other payors' eligibility criteria or billing for services that were not provided.

False claims

Home health

HHAs continue to face liability for:

- Failure to meet Medicare eligibility criteria, such as the beneficiary not being homebound or not in need of skilled services
- Failure to document services provided
- Billing for services not actually provided

OIG audit continues to audit HHAs and finds that their patients fail to meet or the agency fails to document that the patients meet eligibility criteria.[11] , [12]

In 2021, an audit report published by OIG estimated that an HHA overbilled Medicare by "at least $2.1 million" for, in part, failing to meet medical eligibility criteria.[13] In 2021, PruitHealth Inc., paid $4.2 million to settle FCA claims for failing to document medical eligibility requirements, such as a face-to-face certification, a plan of care, and homebound status, in accordance with requirements.[14]

Hospice

Hospice providers continue to face liability for:

- Failure to obtain a signed certification from the patient's physician or the hospice's medical director of the patient's terminal condition
- Billing for a higher level of care than what is medically necessary
- Failure to obtain documentation of a face-to-face encounter with a hospice patient no more than 30 days prior to the third hospice benefit recertification period

In 2018, a Pennsylvania hospice care provider, SouthernCare Inc., paid over $5 million to resolve FCA allegations for claims involving "hospice care that was medically unnecessary or lacked documentation."[15] In 2020, a Florida hospice agreed to pay $3.2 million to settle allegations that it submitted claims for patients who were not terminally ill and billed for inpatient-level care when the higher level of care was not medically necessary.[16] In 2021, a hospice chain settled an FCA investigation for $5.5 million related to allegations that it provided hospice services to patients who were not terminally ill.[17]

In addition, hospices have faced scrutiny related to "unbundling" services from the hospice per diem rate. In a recent OIG report, following three prior OIG reports on the topic, the OIG identified $6.6 billion paid to nonhospice providers over 10 years for items and services provided to hospice beneficiaries—which potentially should have been included in the hospice benefit.[18] The report noted that 58% of the durable medical equipment, prosthetics, orthotics, and supplies claims were billed to Medicare in error and should have been included in the hospice per diem rate, which resulted in Medicare paying the claims twice.[19]

SNFs

SNFs continue to face liability for:

- The provision of substandard quality of care
- Billing for medically unnecessary treatment, including keeping residents in a SNF longer than needed
- Providing higher levels of rehabilitation therapy than medically necessary

In 2020, a hospice paid $9.5 million to resolve allegations that it violated the FCA by submitting claims for rehabilitation services that were not reasonable, necessary, or skilled, as well as creating false preadmission documentation.[20] In 2021, 11 SNFs in New York were prosecuted under the FCA for, among other allegations, keeping patients at the facilities and billing for their treatment for longer than was clinically indicated.[21] In 2021, a Georgia-based SNF paid $11.2 million to resolve allegations that it violated the FCA by billing Medicare and Medicaid for therapy services that were not reasonable and necessary and for providing grossly substandard care.[22]

A strong compliance program focused on the risk areas can mitigate FCA liability risks

PAC providers should regularly evaluate their intake and operational programs to ensure they have adequate controls in place to assess a patient's eligibility for admission and the level and type of services being provided. Compliance officers should verify monitoring and auditing related to longer-stay patients and residents to assess whether patients or residents continue to qualify for and need services. This requires audits that look not only at the necessary documentation but also the patients' conditions and diagnoses. This oversight will involve a partnership between the compliance and quality departments. If a PAC provider determines eligibility is questionable or documentation is missing, the provider must promptly return any overpayments to avoid FCA liability resulting from knowingly retaining an overpayment. Findings from monitoring and auditing activities should be tracked and trended over time to assess whether any systemic failures could result in greater fines and penalties.

In addition, hospice providers should assess how often nonhospice providers are rendering services to their patients and confirm there are protocols to evaluate whether the service should be billed to and paid for by the hospice or the Medicare program.

For SNFs, it's critical that the quality of care rendered to residents is constantly evaluated. SNFs should consider engaging a third party to perform such quality audits periodically and at least twice a year.

Anti-kickback risks

PAC providers have several referral channels through hospitals, community-based organizations, and individual physicians. Each of these present heightened risk under the federal AKS. Similarly, OIG has long viewed PAC providers' relationships with one another—as assisted living facilities and group homes are ripe for AKS violations.

The AKS makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by federal healthcare programs.[23] "Remuneration" is defined as anything of value, whether offered or provided directly or indirectly, overtly or covertly, in cash or in kind. Courts have generally held that the AKS is violated if at least one purpose of payment is the improper inducement of referrals or the generation of federal healthcare program business, even if there are other legitimate and lawful purposes for the payment. A violation of AKS constitutes a false claim.

PAC providers have been subject to countless enforcement actions related to violations of the AKS:

- In 2021, seven SNFs under common ownership and management were sued under FCA allegations relating to the SNFs entering "into medical directorship agreements with certain physicians that purported to provide compensation for administrative services, but in reality, were vehicles for the payment of kickbacks to induce the physicians to refer patients to the seven SNFs."[24]

- In 2021, a hospice provider in California was sentenced to 30 months in prison pursuant to a hospice fraud scheme in which a hospice paid illegal kickbacks to patient recruiters in exchange for the referral of hospice beneficiaries.[25]
- In 2021, an HHA paid $17 million to settle allegations that it violated the AKS, alleging that it paid a kickback to a retirement home operator by purchasing two of its HHAs to induce referrals from the retirement home operator.[26]
- In 2022, a patient recruiter pleaded guilty to paying kickbacks to Medicare beneficiaries to recruit them for referral to HHAs. In exchange for referring these beneficiaries, the patient recruiter allegedly solicited and received kickbacks and bribes from the HHAs.[27]

Reviewing financial relationships and marketing activities is critical to mitigating AKS risks

PAC providers should ensure their legal and compliance departments review all relationships with referral sources prior to implementing an arrangement. Specifically, PAC providers should evaluate whether they are furnishing a service to a referral source for free or below fair market value; this includes the provision of staff to perform a service on behalf of a referral source that would otherwise be a cost for the referral source. Anytime a PAC provider furnishes a social worker or other employee or contractor to assist a referral source with discharge planning, coordinating referrals should be carefully analyzed under the AKS. Additionally, PAC providers' contracts with medical directors should be reviewed by the provider's legal department, and there should be ongoing monitoring to confirm that the medical directors are actually providing valuable services for which they are being paid. Lastly, any proposal to offer gifts, travel, tickets, or other items to a referral source should be considered suspect and analyzed to evaluate the risks under the AKS. Compliance departments may want to review large shifts in referral patterns to understand the basis for the shift and determine whether any remuneration flows from the PAC provider to the referral source.

What is on the horizon for PAC compliance?

Looking ahead, we anticipate oversight and investigations of PAC providers to continue in the areas described above.

In addition, concerning SNFs, COVID-19 has brought particular scrutiny to SNF compliance, and there has been a push for more regulatory and enforcement activity affecting SNF providers. We anticipate considerable focus will be on whether residents received quality services during the pandemic and SNF responses to COVID-19.

In addition, the government will be focusing on COVID-19-related fraud, including the use of telehealth. The U.S. Department of Justice has a task force specifically focused on this area. Furthermore, OIG is currently auditing the use of and billing for telehealth services provided during the public health emergency, generally[28] and specifically by HHAs under Centers for Medicare & Medicaid Services (CMS) waivers.[29]

Compliance departments should focus resources on auditing telehealth services to determine if a PAC provider was potentially noncompliant with the CMS waiver requirements. If noncompliance is identified, the PAC provider should ensure that it returns any payments associated with the noncompliant telehealth service.

Takeaways

- Post-acute care (PAC) providers have been and continue to be a target of enforcement actions.

- PAC providers' False Claims Act liability risks generally relate to patients or residents not meeting the Medicare eligibility criteria, providing medically unnecessary services, and billing for services not provided.
- PAC providers' relationships with referral sources are closely scrutinized by government agencies as they pose a risk under the Anti-Kickback Statute (AKS).
- Tailored monitoring and auditing of these risk areas and review of referral arrangements under the AKS can mitigate risks.
- The government is focusing on COVID-19-related fraud—especially the use of telehealth—and compliance officers should engage in targeted auditing of telehealth.

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