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Nontraditional Health Care Programs Under The Microscope

By **Paul Cirel** (February 23, 2018, 12:03 PM EST)

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Federally sponsored health care programs have expanded the scope of available services to include "providers" who do not offer direct medical care, but who facilitate or coordinate the provision of health care services by physicians and other more traditional caregivers.

Difficulties in determining how to monitor these newer provider types — whose services are often provided by unlicensed staff and whose billings do not fall into standard procedure code terminology — may have kept them off the government's fraud and abuse radar screen for a while. But not anymore.

The number of nontraditional health care programs and agencies has exploded across the country in recent years as a result of sound government policy aimed at fostering the continued medical maintenance of senior citizens in their homes and their communities, as an alternative to assisted living facilities and nursing homes. The initiative is not only designed to allow a higher quality of life for program participants, it is specifically intended to reduce health care costs — most especially, Medicare and Medicaid dollars — by providing health monitoring, preventative care and the timely provision of primary care in noninstitutional settings.

But the corollary to reduced costs of institutional care is an increase in expenditures for these alternative providers. The inevitable result is heightened scrutiny by state and federal regulators and enforcement agencies, aimed at investigating billing practices and prosecuting fraud and abuse.

Most recently, the Office of Inspector General of the U.S. Department of Health and Human Services and the state Medicaid Fraud Control Units, or MFCUs, have turned their focus to two specific provider categories: home health services and adult day health programs. Also, because of the strict rules regarding eligibility for such services, a fair amount of attention is being paid to those physicians and other gatekeepers who certify recipients to receive such services.

In this closely watched environment, providers and their counsel will do well to anticipate the potential for either audit or investigation, and to consider a self-audit or at least a review of their own protocols and record-keeping practices, with an eye toward the type of conduct that the government has targeted.

In that regard, recent enforcement actions include:

- A Brooklyn-based home health care service and its president in January 2018 agreed to pay over $6.4 million to resolve allegations they violated federal and state False Claims Acts by falsely billing Medicaid for home health aid services they didn't provide.

- The Massachusetts attorney general's office in 2017 criminally charged two separate home health agencies for false billing schemes of $2.7 million each. In each case, the alleged perpetrators submitted false and overstated bills for unauthorized services and for services not provided.

- Also in 2017, the Massachusetts attorney general's office obtained $14 million from a national home health agency to settle allegations it improperly submitted and received overpayments for services not eligible for reimbursement under state regulations.

- A federal jury in December 2017 found a Detroit home health agency owner guilty of a scheme involving $1.6 million in fraudulent Medicare claims for home health services procured through kickbacks and that were medically unnecessary and not provided.

- Two New Jersey adult day care facilities in October 2016 paid $650,000 to settle allegations of Medicaid fraud and a failure to maintain sufficient records to prove that services billed to Medicaid had been performed, including blood glucose monitoring for patients, and monitoring programs in accordance with physician orders.

- In May 2016 a Virginia adult day health care center agreed to pay nearly $386,000 to settle federal and state civil fraud allegations that it had submitted false claims for reimbursements to the Virginia Medicaid Program. The government alleged that the facility knowingly submitted fraudulent claims for transportation services to Medicaid recipients that were not present or transported to the facility on the claimed dates of service.

Home Health Services

A June 2016 report of the OIG states that "[h]ome health has long been recognized as a program area vulnerable to fraud, waste, and abuse." According to the OIG, $18.4 billion was paid to more than 11,000 home health agencies in calendar year 2015. By the OIG's estimate, over $10 billion of those funds constituted improper payments.

A home health benefit is defined by statute as skilled nursing care, home-based assistance and therapeutic services for qualifying home-bound individuals.[1] According to the OIG, billing fraud cases typically involve home health agencies that bill for services that are either not medically necessary or not provided at all.

Also, the OIG has noted that physicians play a key gatekeeper role in the process by certifying the eligibility of beneficiaries and managing their care plans. The OIG's focus therefore extends to doctors who bill for such services.

Adult Day Health Services

In order to meet federal requirements, adult day health services may only be provided pursuant to a plan of care, and to individuals who would otherwise qualify for nursing home or other full-time facility based care.[2] That plan of care must be developed by a registered nurse employed by the program, and

must include "service coordination." In Massachusetts, the governing regulations define service coordination as "an interdisciplinary collaborative process to assess, plan, implement, coordinate, monitor and evaluate the participant's … medically-related physical, mental behavioral ... needs."

In October 2017, the OIG issued an updated "work plan" — which identifies the OIG's specific areas of interest and enforcement priorities. By the OIG's most recently updated work plan, adult day health care services are now a clearly defined OIG target: "The OIG will review Medicaid payments by states for adult day health care services to determine whether providers complied with federal and state requirements. Providers should ensure that enrollees meet eligibility requirements for the specific program in which they are enrolled and that each enrollee has a plan of care that is updated as care progresses."

Granular Details

Based on the OIG's stated priorities and identified concerns, some common threads emerge. Providers in these areas should consider the following factors whether by way of self-assessment or in responding to an audit or investigation.

An adult day care service provider audit or investigation likely will focus on program attendance, beginning with a comparison of transporting records billing (especially if there is a separate transportation provider) to program attendance logs and billing. Of course, discrepancies don't necessarily equate to fraud. Some participants may regularly or occasionally be transported by a caregiver.

The prudent provider, however, will keep track of alternative transportation either in the transportation log itself or in the patient's plan of care. Investigators will likely examine adult day health center records to determine whether eligibility criteria have been met and that each facility has met the state's staffing requirements. Also, as reflected in the OIG's work plan, adult day health services providers can expect any audit or investigation to focus the participants' plans of care. Are they current? Do they reflect coordination with other service providers?

A visiting nurse program can expect an audit or investigation to include identifying the physician who certified the services as medically necessary, especially if the physician is not the patient's primary care doctor, or if he or she serves as the program's "medical director." Also, because the need for home-based nursing services is often transient, providers can expect any audit or investigation to focus on those patients who have been repeatedly recertified.

When examining whether a home health agency is complying with billing regulations, investigators are likely to concentrate on medical necessity, and the specific nonmedical services (e.g., bathing, dressing and taking necessary medications) which were authorized by a physician as part of a plan of care. Timekeeping records will be especially scrutinized to determine whether each recipient received the requisite amount of care.

Big Data

Data analysis is playing an ever-more important role in home health fraud cases. The OIG in its June 2016 report laid out what the government is assessing when it examines a provider's billing data.

The most common type of home health fraud, according to the OIG, involves billing for services that are

not medically necessary and/or not provided. In that regard the OIG has identified five characteristics commonly found in the cases pursued:

- Beneficiaries that had no recent visits with supervising physicians
- Episodes that were not preceded by a hospital or nursing home stay
- Episodes with a primary diagnosis of diabetes or hypertension
- Beneficiaries with claims from multiple home health agencies
- Beneficiaries with multiple home health readmissions in a short period of time

On the adult day health side, Medicaid Fraud Control Units are comparing program billed service days with billings by other service providers to determine whether the recipient was absent from the program for all or part of the program day.

Armed with this type of claims data, investigators are targeting, auditing or investigating home health agencies, certifying physicians and adult day health programs that are statistical outliers related to these hallmark characteristics in comparison to peers.

Of course, these various analyses are not proof of actual fraud, but they are routinely used to identify potential targets for investigations and audits. As with any other aspect of health care, an ounce of prevention is worth a pound of cure. Thus, for providers, knowing in advance the signs and symptoms of a potential audit or investigation should inform their conduct and their record-keeping going forward.

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[1] 42 U.S.C. § 1395f(a)(2)(C) and 42 U.S.C. § 1395n(a)(2)(A)

[2] 42 U.S.C. § 1396n(c)