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Home Healthcare and the MEDICARE FRAUD STRIKE FORCE

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Modern federal healthcare fraud investigations use big data to find outliers among providers who are then targeted for enforcement actions. This approach is being used to pursue an outsized number of criminal cases against home healthcare agencies, resulting in decades-long prison sentences and tens of millions in fines. But it is remarkably transparent, giving home healthcare providers ample opportunity to stay out of harm's way. The government has provided the statistical characteristics by which it searches for fraud among home healthcare agencies, along with the benchmarks it uses to determine who is an outlier. And enforcement actions against home healthcare agencies have consistently targeted the same conduct: payments to payment recruiters and physicians in return for referring patients who often do not need the services billed. This article provides practical advice on how home healthcare agencies can gauge and limit their own legal exposure by monitoring their statistics against the government's benchmarks and by instituting basic controls to prevent targeted conduct.

One year ago, an Office of the Inspector General (OIG) report revealed that more than 5% of home healthcare agencies bore statistical hallmarks of fraud (U.S. Department of Health and Human Services, 2016). It showed how federal investigators are using big data to escalate enforcement efforts against home healthcare agencies, bringing criminal cases against their administrators, patient recruiters, and referring physicians. Penalties in recent cases have been severe, with prison sentences frequently exceeding 10 years and fines in the millions.

The OIG report and subsequent enforcement actions also provided useful information on how to avoid this fate. The report listed the statistics the government uses when searching for fraud, and it even provided the government's benchmarks for what makes an "outlier" worthy of government scrutiny and potential prosecution. The government's accompanying criminal prosecutions have followed a predictable pattern, regularly focusing on payments to reportedly unscrupulous patient recruiters and referring physicians in return for drumming up unnecessary claims for services.

In this aggressive enforcement environment, home healthcare agencies—especially ones that do *not* believe they have done anything wrong—are well advised to use this readily available information to limit their exposure. As explained below, home healthcare agencies can and should check their own numbers against the government's benchmarks to see where they stand, and they should take simple steps to ensure that their patient referral sources adhere to their values.

Big Data Meet Home Healthcare Fraud

Modern healthcare fraud enforcement is a data-driven enterprise. Leading the charge is the Medicare Fraud Strike Force, a program established in 2007 to use data analytics and the combined resources of federal, state, and local law government agencies to identify and combat healthcare fraud. Its reach is nationwide, with field offices in Miami, Los Angeles, Detroit, south Texas, Brooklyn, south Louisiana, Tampa, Chicago, and Dallas. And its efforts have led to thousands of criminal cases and billions in penalties.

Home healthcare agencies (HHAs) make ready Strike Force targets because home care fraud tends to fall along predictable, easily detectible lines. Investigators look for statistical outliers among agencies based on the five characteristics of fraud shown in Table 1. The OIG found more than 500 HHAs (5% of the total) qualified as outliers for more than two characteristics indicating fraud. It provided a map showing "hotspots" for these outliers in areas that, probably not coincidentally, were close to Strike Force field offices (U.S. Department of Health and Human Services, 2016).

Recent Enforcement Actions

Since the OIG report, the government has busily followed its playbook, bringing an outsized number of enforcement actions against HHAs. Although the precise facts of each case differ, the alleged misconduct virtually always involves payments to unscrupulous doctors and patient recruiters in return for referrals. Here are some recent examples from Strike Force "Hotspots" around the country.

Florida

Willsand Home Health Agency
JEM Home Health Care
Healthy Choice Home Services

This case involved an alleged $57 million conspiracy among three Miami-based HHAs to submit false claims to Medicare, about $40 million of which were actually paid according to the Department of Justice (DOJ) (August 30, 2016). Allegedly, these agencies drummed up millions in medically unnecessary services by paying kickbacks to doctors and patient recruiters. Willsand and JEM's owner pleaded guilty and received a sentence of

10 years (later reduced to 6). Healthy Choice's owner also pleaded guilty and received a 6-month sentence. A third person, who was either an owner or manager for all three agencies, chose to go to trial, where he fired his lawyers and represented himself. He was convicted and sentenced to 20 years and more than $36 million in restitution. As for the doctors, two cardiologists pleaded guilty and were sentenced to 21 months and 8 months imprisonment, respectively. A third doctor, however, beats the odds. Dr. Michael Bahrami went to trial and was acquitted (Weaver, 2017).

Mercy Home Care
D&D&D Home Health Care
The manager of Mercy Home Care and a billing employee of D&D&D Home Health Care were convicted in late 2016 of paying kickbacks to doctors and patient recruiters in exchange for patient referrals (DOJ, 2017, February 24). The manager and his 10 alleged coconspirators (who had already pleaded guilty or been convicted) also allegedly backdated claims for services and coached beneficiaries to say that they needed at-home services when they were not homebound, and he allegedly destroyed a kickback ledger prior to his arrest. He was sentenced to 10.5 years in prison.

Inar Home Care Service Corp.
MA Home Health
Golden Home Health Care
Nova Home Health Care
Finetech Home Health
Homestead Home Health Care
Metro Dade Home Health
A mother and daughter pleaded guilty to conspiracy in connection with a $20 million healthcare fraud scheme in March 2017 (DOJ, 2017, March 2). They allegedly paid kickbacks to doctors and patient recruiters in exchange for referrals and also concealed their ownership interests in their companies from Medicare by paying nominees to falsely represent themselves as the companies' owners. Allegedly, they hid millions in illicit proceeds in diapers and towels (Neal, 2017). They will be sentenced in May. One of their recruiters and one of their staffers also pleaded guilty and were sentenced to 24 and 37 months in prison, respectively.

Elite Home Care
The owner of Elite Home care was arrested in March 2017 and indicted on four counts including two for conspiracy in connection with an alleged $15 million healthcare fraud scheme. He and his coconspirators allegedly caused kickbacks to be paid to beneficiaries and patient recruiters in exchange for referrals, and also submitted false information to Medicare (DOJ, 2017, March 14).

Table 1. National Medians and Outliers Thresholds for HHAs

Characteristic	National Median	Outlier Threshold
No visit to supervising physician within 180 days of home care	22.6%	62.5%
No hospital or nursing home stay prior to home care	49%	n/a (OIG did not find any outliers)
Primary diagnosis of diabetes or hypertension	10.1%	45.1%
Claims from multiple home healthcare agencies	6.3%	25.9%
Multiple home healthcare readmissions in a short time period	5.6%	19.3%

Note. Adapted from U.S. Department of Health and Human Services (2016).

Michigan

Access Care Home Care
Patient Care Home Care
Hands On Healing Home Care
All State Home Care
Two co-owners of a string of Detroit-area companies were convicted at trial of conspiracy for allegedly obtaining patients by paying cash kickbacks to recruiters and physicians (DOJ, 2016, October 28). One of the co-owners was also convicted of obstruction of evidence for stealing incriminating documents before trial. He was sentenced to 30 years in prison and over $40 million in restitution, whereas the other co-owner received an 8-year sentence and $38 million in restitution.

Texas

Fiango Home Healthcare
A husband and wife were convicted on numerous conspiracy counts for submitting over $13 million in false Medicare claims through Fiango, the agency they co-owned (DOJ, 2016, November 11). They were found to have paid kickbacks to physicians and recruiters in exchange for recruiting beneficiaries and also paid kickbacks to beneficiaries themselves. The husband chose to plead guilty 1 week into trial, whereas his wife was convicted by the jury. Both will be sentenced in June.

Aabraham Blessings
Baptist Home Care Providers
Community Wide Home Health
Four Seasons Home Healthcare
Kis Med Concepts

In the largest "provider attendant services" case (i.e., in-home and community-based services paid for by Medicaid) in Texas history, the administrator of five Houston-area HHAs owned by her parents pleaded guilty to a $17 million healthcare fraud conspiracy (DOJ, 2017, March 30). She and her father admitted that they and others obtained patients by paying kickbacks to recruiters and physicians. A recruiter and a nurse also pleaded guilty. Sentencing is scheduled for later this year.

Illinois

Donnarich Home Health Care
Josdan Home Health Care
Pathways Home Health Services

One case that bucks the usual trend involved an alleged $45 million conspiracy, allegedly involving 15 people, once again allegedly to pay kickbacks to recruiters and physicians in exchange for referrals. But this time the case ended differently than most. During a trial for four of the defendants, it became known that prosecutors had failed to provide the defendants with grand jury testimony from a couple of FBI agents listed as government witnesses (Meisner, 2017). As a result, the defendants signed lenient plea deals at the last second. Still, some of the defendants will have to forfeit millions of dollars and will likely face prison time.

Recommendations

The OIG report and case examples above show a federal enforcement effort against HHAs that, though aggressive, is also remarkably transparent. The OIG report again laid out in detail the statistics the government views as hallmarks of fraud as well as the thresholds by which it defines "outliers." And the government has not been shy about the conduct it is targeting: payments for illegitimate patient referrals. HHAs can use this information to strengthen their compliance programs and limit their exposure.

First, agencies should check their own statistics against the OIG report to get a sense of whether they might be among the 500+ agencies who appear to have attracted the government's suspicion for being outliers. For instance, if substantially fewer than 62.5% of an agency's episodes of care were provided without a recent visit to a supervising physician, then that agency is unlikely to be seen as an outlier based on that characteristic. If an agency finds that it may be an outlier, then it has a head start in preparing explanations for its numbers *before* it hears from the government. After all, as the OIG report acknowledged in a footnote, agencies can be statistical outliers for legitimate reasons (such as specializing in a particular class of patients). But being able to tell that story to investigators can take time.

Second, agencies should pay close attention to the people who refer their patients. Again, virtually every enforcement action against an HHA has centered on alleged payments to physicians and patient recruiters in return for bogus referrals. We cannot know whether any of the administrators at these agencies actually *knew* that they were dealing with unscrupulous people, but investigators (and juries) readily adopt the belief that the administrators "had to have known" when misconduct is discovered.

All agencies should therefore ask themselves the following questions:

- How well do we know the doctors and patient recruiters we are working with?
- Have we done sufficient diligence on our referral sources that we could defend our decision to work with them as having been made in good faith?
- What controls do (or could) we have in place to ensure that our patients legitimately need our services?
- What have we done to tell our referring physicians and patient recruiters that we do not want illegitimate business?
- Have they gotten the message?

The one thing HHAs should not do is give in to the urge to dismiss cases like the ones mentioned above as "outliers," so to speak. It may be tempting to think, "I'm not a criminal, and my colleagues aren't criminals, so I've got nothing to worry about." Such confidence, any defense practitioner will tell you, is misplaced. The government is going hard after HHAs, but it is doing so transparently, creating an opportunity for prudent agencies to protect themselves and their administrators. ⌂

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