Modern Healthcare

Home care under feds' fraud microscope

By Lisa Schencker

Years ago, William Dombi was riding in a taxi when the cabbie turned to him and asked him what he did for a living. Dombi told him he worked in home healthcare and hospice.

"He goes, 'Oh, isn't there a lot of fraud in those areas?' " Dombi recalled the driver saying.

It wasn't what Dombi, a vice president at the National Association for Home Care and Hospice, hoped to hear. "You don't want to end up with a reputation like that," he said.

That's part of the reason Dombi's organization has supported the U.S. Justice Department's efforts to curb home healthcare fraud in recent years. The home-care industry has been the focus of numerous fraud investigations, settlements and judgments. That's related to the proliferation of home healthcare agencies, the relative ease of committing fraud through them, and increased scrutiny by federal prosecutors, experts say.

The government and the home-care industry have been working to combat fraud by putting a hold on approving new centers in some areas of the country, capping certain types of government payments to agencies and using data analyses to uncover foul play. Some say the move toward value-based payments and away from fee-for-service might make committing such fraud more difficult, while others say it may just change the character of the fraud.

"Home healthcare is under the microscope now," said Mark Silberman, a partner with Duane Morris in Chicago who represents home healthcare agencies. "I have no reason to believe those efforts won't continue."

About half of Justice's current healthcare fraud caseload involves home healthcare allegations, said Peter Carr, a Justice Department spokesman. Dombi estimates he's seeing a new indictment or conviction on an almost weekly basis.

Home-care, durable medical equipment, and mental healthcare are the three biggest areas for healthcare fraud, said Marc Smolonsky, a consultant who works on healthcare fraud issues and formerly served as an HHS associate deputy secretary responsible for healthcare fraud operations. Home care, he said, is an easy target for fraudsters, who can bill Medicare for many types of services under the umbrella of home care. "Once you have access to beneficiaries, you can submit all sorts of bills using their beneficiary numbers," he said.**Drawing the HEAT**
In 2010, 1 in 4 home-care agencies had questionable billings, according to a 2012 study by HHS' Office of Inspector General.

The rapid growth of home-care agencies has contributed to the problem, experts say. In Florida, the number of home-care agencies exploded more than 10 years ago after the state eliminated a requirement that agencies get certificates of need before opening, Dombi said. Suspiciously high costs followed, with Miami home-care firms claiming high rates of Medicare outlier payments for unusually high-cost patients. In 2009, Medicare paid Miami-area home health agencies more than $976 million, and more than half of those payments were for outliers, according to a February report by HHS and Justice.

"The volume of necessary care can't sustain that growth, so people start doing things they shouldn't be doing," Dombi said. The vast majority of new agencies have been for-profit.

To crack down on that and other fraud, Justice and HHS in 2009 formed the Health Care Fraud Prevention and Enforcement Action Team, known as HEAT. The HEAT Medicare Fraud Strike Force, composed of federal, state and local investigators, now operates in nine cities, including Baton Rouge, La., Chicago, Dallas, Detroit, Houston, Los Angeles, Miami, New York and Tampa, Fla.

Those cities, particularly Miami and Detroit, are where many fraud cases now are being identified as investigators probe agencies and billings. The Miami Strike Force charged more than 202 defendants for their roles in fraudulently billing Medicare about $570 million for home-care services from fiscal 2009 to 2013, the Justice Department's Carr said. In Detroit, as of fiscal 2013, 84 people had been charged with allegedly billing Medicare for $150 million in fraudulent home-care claims.

In one of the largest cases of home-care fraud, Justice charged Dr. Jacques Roy of Dallas with running a $374 million fraud scheme. Roy ran Medistat Group Associates, which authorities say certified more than 11,000 patients for home-care services they did not need, allowing the company and a number of home-care agencies to submit claims for Medicare and Medicaid services. Roy allegedly used home-care agencies as recruiters so Medistat could bill the unnecessary home visits and medical services, according to Justice. Roy, who has pleaded not guilty, is awaiting trial, while several other people charged in the case have pleaded guilty.

Allegations of billing for unnecessary services and paying kickbacks are common in home-care fraud cases. Some observers say it can be easy for agencies to cross such lines accidentally, while others say those doing wrong know it.

The confusion sometimes arises because services a medical professional deems appropriate are not always the same as what the government will pay for, said Amanda Barbour, a lawyer with Butler Snow in Jackson, Miss., who has defended home-care companies against fraud allegations.

But Dombi said many fraud cases aren't about subjective determinations of medical necessity but rather whether agencies billed for services that were never even provided or were clearly unnecessary. "These are pretty black and white," Dombi said.**Kickback cases**
Many cases also involve allegations of kickbacks paid to recruiters—another area that can be clear-cut or murky, experts say.

Home healthcare agencies are not allowed to pay recruiters to bring in patients for services paid for by the federal government, Barbour said. Sometimes agencies unintentionally break the law, such as by setting up a bonus program for employees who refer patients, she said. But that's not to say other fraudsters don't know what they're doing when paying kickbacks to doctors, independent recruiters and/or others to bring in more beneficiaries. "It can go from the benign to the not so benign," she said.

Amid such allegations of fraud, Barbour said it's important agencies make sure they hire expert staff. "Home healthcare is a really hot-button issue," she said. "This is something that's really going to be scrutinized, so you should really just expect someone's going to come knock on your door one day."

The industry has to be aggressive in seeking solutions, Dombi said. His association has advocated temporarily halting the establishment of new home-care agencies in certain parts of the country. CMS has stopped approving new agencies for government payment in the Chicago, Detroit, Dallas, Fort Lauderdale, Houston and Miami areas. The association also asked the government to limit the percentage of revenue any one agency can get from Medicare outlier payments. The Patient Protection and Affordable Care Act caps that figure at 10% of total payments.

Dombi said it's important to stop home-care fraud, both for the sake of taxpayers and his industry. "We want to avoid across-the-board rate cuts and regulatory requirements where the good guys end up paying for the offenses of the bad guys," he said.

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