



# Hot Point Home Health Legal and Compliance Issues

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A Century Strong - Rocking the Future of Care

Post-Acute Partners in Care Conference





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# ■ ■ Hot Point Home Health Legal and Compliance Issues

- United Program Integrity Contractor (UPIC) and Other Audits
- Arrangements with Medical Directors
- Use of Marketers
- Kickbacks to Discharge Planners



# UPIC and Other Audits

- What is homebound status?
- Why are agencies vulnerable regarding this issue?
- What actions can managers take?



# Homebound Status

- Medicare Benefit Policy Manual – Home Health Services, 30 – Conditions patients must meet to qualify for coverage of home health services
- **Criterion one** – The patient must either:
  - Due to illness or injury, need the need the aid of supportive devices, the use of special transportation, or the assistance of another person
  - Have a condition such that leaving home is medically contraindicated



# Homebound Status

- Medicare Benefit Policy Manual – Home Health Services, 30 – Conditions patients must meet to qualify for coverage of home health services
- **Criterion two** – Both of the following must apply:
  - A normal inability to leave home
  - Leaving home requires “considerable and taxing effort”



# Homebound Status

- Medicare Benefit Policy Manual – Home Health Services, 30 – Conditions patients must meet to qualify for coverage of home health services
- **Situations that do not disqualify beneficiaries:**
- Religious and adult day care programs meeting certain requirements
- Other absences from the home for non-medical reasons that meet certain requirements



# Effects on Home Health Agencies

- Vulnerable due to:
  - Ill-defined standards used to determine homebound status
  - Inability to verify homebound status because of the intermittent nature of Medicare homecare services
- Must address:
  - Does the patient's clinical condition support a conclusion that the patient is homebound?
  - What is the patient actually doing?



# Effects on Home Health Agencies

- Actions to take:
  - Spend less time and energy interpreting the standards
  - Focus on “beefing up” documentation



# Arrangements with Medical Directors

- Why hire referring physicians as Medical Directors?
- How to avoid violations of the law
- Recent enforcement action

# ■ Referring Physicians Who Serve as Medical Directors

- Not required for Medicare certified home health agencies
- Most are hired part-time, but large agencies may have full-time Medical Directors
- Used for a variety of activities, including, but not limited to:
  - Providing support to home care team and functioning as advocates for home health
  - Reviewing home care policies and procedures
  - Assisting with training of staff
  - Consulting

# ■ Referring Physicians Who Serve as Medical Directors

- How can providers avoid violations of the federal anti-kickback statute, Stark laws, and similar state statutes?
- Meet the requirements of the personal services “safe harbor” under the AKS and the contractual exception under the Stark laws
- In addition:
  - Develop standardized agreements used consistently with all referring physicians who receive consulting fees
  - Document services rendered and amount of time spent in these activities

# ■ Referring Physicians Who Serve as Medical Directors

- In addition:
  - Do not have agreements for consulting services with physicians whose services are not used
  - Number of consulting physicians/Medical Directors should be related to provider's size and geographic area served
  - Commercially reasonable services that consulting physicians perform cannot be related to volume and value of referrals made

# ■ Recent enforcement action

- United States ex rel. Herbold v. Doctor's Choice Home Care, Inc.
- Enforcers claim that the defendant owners hired three Medical Directors in order to induce patient referrals, which resulted in the submission of false claims under the Federal False Claims Act
- The Court refused to dismiss the case because:
  - Medical Directors were paid for work they did not perform
  - Defendants' emails to physicians indicated that they considered payments to be for referrals, and showed "knowledge and intent"
  - At least "one purpose of the remuneration" was to induce referrals
  - Physicians' wives were hired and paid based on the volume or value of referrals from their physician spouses, who then began to refer more patients



# Use of Marketers

- False Claims
- Incentive compensation – bona fide employees
- Key court decision

# ■ ■ Use of Marketers

- False claims
  - Penalties: fines/civil money penalties, jail time, suspension/exclusion from state and federal health care Programs
  - Actions that agencies should take: policy and procedure, training for marketing representatives regarding regulation
- Incentive compensation – bona fide employees
  - Anti-kickback statute and its exceptions - 42 U.S. Code § 1320a–7b
  - OIG Anti-kickback provisions – 56 Fed. Reg. 35952; July 29, 1991
- Key court decision
  - United States v. AIDS Healthcare Foundation, Inc. – 262 F. Supp. 3d 1353 (S.D. Fla. 2017); June 9, 2017



# Kickbacks to Discharge Planners

- Keys to compliance
- Staff members should not...
- Recent enforcement action - DOJ



# Kickbacks to Discharge Planners

- Keys to compliance
- Discharge staff must decide – independent of assistance from post-acute providers – that patients may be appropriate for services
- Do the activities of coordinators and liaisons “induce referrals?”
- Staff members should not:
  - Regularly attend discharge planning meetings for all patients being discharged until a referrals has been made first
  - Engage in so-called “case finding”



# Kickbacks to Discharge Planners

- Recent enforcement action – DOJ
  - Thirty defendants in San Francisco Bay Area charged with kickback scheme allegedly created by CEO of Amity Home Health Care
  - California RN pled guilty to conspiring with home health agency owners to pay and receive illegal kickbacks in exchange for Medicare beneficiary referrals



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# Enforcement Trends



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# CMS Survey Data – Condition

## Citation Frequency Report

National	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Tag #				
<b>Totals represent the # of providers and surveys that meet the selection criteria specified above.</b>		Active Providers=11724		Total Number of Surveys=339
<a href="#">G0570</a>	Care planning, coordination, quality of care	130	1.0%	38.3%
<a href="#">G0940</a>	Organization and administration of services	104	0.8%	30.7%
<a href="#">G0640</a>	Quality assessment/performance improvement	99	0.8%	29.2%
<a href="#">E0001</a>	Establishment of the Emergency Program (EP)	98	0.8%	28.9%
<a href="#">G0700</a>	Skilled professional services	77	0.6%	22.7%
<a href="#">G0406</a>	Patient rights	56	0.4%	16.5%
<a href="#">G0680</a>	Infection prevention and control	50	0.4%	14.7%
<a href="#">G0510</a>	Comprehensive Assessment of Patients	44	0.4%	13.0%
<a href="#">G0750</a>	Home health aide services	41	0.3%	12.1%
<a href="#">G1008</a>	Clinical records	31	0.2%	9.1%
<a href="#">G0848</a>	Compliance with Federal, State, Local Law	21	0.2%	6.2%

# ■ CMS Survey

- Care planning, coordination and quality of care.
  - Care coordination is when the HHA and another provider are both providing care to a patient for which they are independently responsible.
  - Conditions of participation require the agency to retain “overall responsibility for all services provided, whether provided directly by the HHA or through arrangements (i.e., under contract).” – G978
- QAPI.
  - Providers do not have sufficient documentation of progress and/or governing body fulfilling its role.



# CMS Survey

- Emergency Preparedness
  - <https://oig.hhs.gov/oas/reports/region1/12000508.pdf>

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**SIX OF EIGHT HOME HEALTH AGENCY  
PROVIDERS HAD INFECTION CONTROL  
POLICIES AND PROCEDURES THAT  
COMPLIED WITH CMS REQUIREMENTS AND  
FOLLOWED CMS COVID-19 GUIDANCE TO  
SAFEGUARD MEDICARE BENEFICIARIES,  
CAREGIVERS, AND STAFF DURING THE  
COVID-19 PANDEMIC**

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# CMS Survey

- Organization and administration.
  - Drop Sites/Convenience - Sites State Operations Manual
  - “Where permitted by state and local law, an HHA may utilize a drop site for field staff convenience. These drop sites are not considered branches and should not meet the Medicare definition of a branch or operate as such.”
  - 2182.4D - Drop Sites

# ■ CMS Survey

- Physician's Orders.
  - “[a]ll patient care orders, including verbal orders, must be recorded in the plan of care.” 42 C.F.R. 484.60(a)(3)(emphasis added).
  - If verbal orders are used, the regulation states, “[v]erbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies.” 42 C.F.R. 484.60(b)(3).
  - Verbal orders must be authenticated by the physician “in accordance with applicable state laws and regulations, as well as the HHA's internal policies.” 42 C.F.R. 484.60(b)(4).
- Failing to Follow Physician's Orders.
  - Failing to properly document missed visits.
  - May also result due to another provider being involved.
  - Failing to document patient refusing visits or services.
    - Patient can always refuse care.
    - Must be documented as refusal.



# Recoupment

- Failure to Support Eligibility.
- To qualify for Medicare home health services a beneficiary must be:
  - homebound;
  - in need of intermittent skilled nursing or therapy;
  - under the care of a physician;
  - receiving care pursuant to a plan of care that has been established by a physician and is periodically reviewed by the physician.

# ■ ■ Recoupment

- Failure to Support Eligibility.
- Face to Face
  - Physicians and NPPs can certify patients. Certifying Physician/NPP must order home health.
  - Must have clinical note from Face to Face encounter for audit.
  - Physician/NPP record must support their certification.
- Physician must have had a face-to-face encounter with patient. The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care. If a patient does not receive face to face encounter by day 30, coverage requirements are not met an episode cannot be billed. It must certify patient is homebound and care is medically necessary.



# Recoupment

- Failure to Support Eligibility.
- Homebound status
- Patient must either:
  - Because of illness or injury, need the aid of supportive devices such as crutches, canes, etc.; special transportation; or, assistance of others to leave their residence; or, have a condition such that leaving home is medically contraindicated.
  - There must exist a normal inability to leave the home.
  - Leaving the home must require a considerable and taxing effort.
- Documentation must support all three elements



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# Work Plan

- Home Health Agencies' Emergency Communication Plans: Strengths and Challenges Ensuring Continuity of Care During Disasters.
  - natural disasters highlighted vulnerabilities in HHAs' preparedness for disasters, specifically with regards to communication and continuity of care.
  - determine selected HHAs' compliance with EP CoPs and will report factors these HHAs identify as hindering and/or supporting continuity of care during a disaster.



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# Work Plan

## Limited Compliance With Medicare's Home Health Face to Face Documentation Requirements



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# Work Plan

- Home Health Compliance with Medicare Requirements - Multiple Audits

Department of Health and Human Services  
Office of Inspector General

Office of Audit Services



## Medicare Home Health Agency Provider Compliance Audit:

Department of Health and Human Services  
OFFICE OF  
INSPECTOR GENERAL

MEDICARE HOME HEALTH AGENCY  
PROVIDER COMPLIANCE AUDIT:

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# Work Plan

- OIG Audits
- In calendar year 2023, Medicare paid home health agencies (HHAs) about \$16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about \$1.2 billion.
- Audit reports are part of a nationwide series of home health audits.



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# Work Plan

- Home Health Compliance with Medicare Requirements - Multiple Audits
  - HHA did not comply with Medicare billing requirements for 32 of the 100 claims that we reviewed.
  - HHA received overpayments of \$75,461.
  - HHA incorrectly billed Medicare for services provided to **beneficiaries who were not homebound or did not require skilled services.**
  - Estimate HHA received overpayments of at least \$1.7 million for period.

Department of Health and Human Services

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MEDICARE HOME HEALTH AGENCY  
PROVIDER COMPLIANCE AUDIT:

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# ■ Work Plan

- Home Health Compliance with Medicare Requirements - Multiple Audits
  - HHA did not comply with Medicare billing requirements for
    - 20 to 40% claims that we reviewed.
  - Common elements:
    - beneficiaries who were not homebound.
    - Beneficiaries did not require skilled services.
    - received reimbursement for claims for which the services were not supported by documentation.
    - services that were not delivered in accordance with beneficiary's plan of care
    - claims were assigned with incorrect Health Insurance Prospective Payment System payment codes.

Department of Health and Human Services

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# Cases / Settlements

- **Home Health Company to Pay \$450,000 to Resolve Allegations of False Medicaid Billing**
- The false claims included
  - billing home health services for patients while the patients were outside of their homes attending Adult Day Health Center programs,
  - billing for services that were not approved by a physician,
  - billing for services provided by nurses while those nurses were travelling outside the state,
  - billing for services recorded as being provided by the same nurse at the same time to two different members living in separate households, and
  - billing for services without the proper billing modifier codes to secure a higher rate of reimbursement.

# Cases / Settlements

- **Home health care company settles allegations of improper billing, agrees to pay United States \$175,000**
- The complaint alleged that HHA violated False Claims Act by
  - billing federal healthcare programs for medically unnecessary nursing visits,
  - billing for patients that were not homebound and
  - manipulating patient records and records of nursing visits to justify false and fraudulent claims.
- The complaint alleges that the company's former owners knew of and approved the activities.

# ■ ■ Cases / Settlements

- **Home Health Company Agrees To Pay \$300,000 To Resolve Allegations Of Illegal Kickback Scheme**
- HHA illegally paid its medical director in order to induce him to refer Medicare patients to HHA for services that were billed to the United States.
- The United States alleged that these financial arrangements violated the physician self-referral law, commonly known as the “Stark Law,” and the Anti-Kickback Statute, giving rise to liability under the False Claims Act

# ■ Cases / Settlements

- **Physician pays nearly half million dollars to resolve home health care fraud allegations**
- Investigation appeared to show doctor had certified patients for home health services without any knowledge of the patients' medical condition or homebound status.
- Doctor merely signed forms that Unified representatives provided to him on a regular basis.
- HHA sent improper payments to doctor in violation of the Anti-Kickback Statute.



# Marketing/Referrals



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# Basic Federal Fraud and Abuse Laws

- **Laws:**

- The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b);
- Physician Self-Referral Law (Stark), 42 U.S.C. § 1395nn;
- The Civil Monetary Penalties Statute, 42 U.S.C. § 1320a-7a;  
and,
- The False Claims Act 31 U.S.C. § § 3729, et. seq.



# Risk Areas – Marketing/Referrals

- Marketers and Bonuses
- Marketing materials
- Medical Directors
- Facilities

# ■ ■ OIG's Compliance Program Guidance for Home Health Agencies

- The OIG issued a detailed discussion of compliance risks in the OIG's Compliance Program Guidance for Home Health Agencies. This guidance details practices the home health agencies can implement to minimize their risks. See, "Publication of the OIG Compliance Program Guidance for Home Health Agencies" 63 Fed. Reg. 42,410 (August 7, 1998) (<https://oig.hhs.gov/authorities/docs/cpghome.pdf> )

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**DEPARTMENT OF HEALTH AND  
HUMAN SERVICES**

**Office of Inspector General**

**Publication of the OIG Compliance  
Program Guidance for Home Health  
Agencies**

**AGENCY:** Office of Inspector General  
(OIG), HHS.

**ACTION:** Notice.

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# ■ ■ Safe Harbor – Marketing/Referrals

- OIG has repeatedly stated that independent contractors cannot be paid commissions. If they are employees, bonuses are an option.
- Employee Safe Harbor
  - For AKS purposes, the term remuneration “does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.”

# ■ ■ Safe Harbor – Marketing/Referrals

- Marketing as part of employee goals and basis for annual evaluations.
- Can not be paid based on length of stay.
- Should not be paid based on payor.
- Policies should describe bonus criteria – include compliance with admission criteria.
- Should have a cap on compensation.
- Compensation should be set out in writing.
- Marketers should not be involved in admission decisions.
- Risk - because marketers do not furnish items and services.

# ■ Safe Harbor – Personal Services/Management

- The agreement is in writing
- It is signed by both parties
- The agreement covers all of the services to be provided, and specifies the services to be provided
- If the services are provided on a periodic, sporadic or part-time basis, the agreement specifies the schedule length, and the exact charge for such intervals.



# Concerns

- Free or non-market value for items or services.
- Free items or services contingent on purchases or on access to referral base.
- Payments disguised as grants or other type of funding.
- Travel, entertainment, gifts.
- Free consultants.
- Waiver of cost-sharing.
- Promising certain levels of care/services/length of care in exchange for referrals.

# ■ Gifts

- The Anti-Kickback Statute specifically prohibits offering anything of value as an inducement to refer or a reward for referring. The one purpose test makes this extremely broad.
- CMP statute applies the same analysis to beneficiaries.
- Home health and hospice providers cannot employ giveaways, discounts, etc. without significant risk.
- One applicable safe harbor: Minimal Value.
  - OIG has stated that it will not pursue matters involving remuneration to referral sources or to beneficiaries that involve “minimal value.” Minimal value is defined as \$15/per item up to a maximum of \$75/per person/per year.



# Gifts

- Marketing Compliance Program must:
  - Require marketing team to obtain approval before providing anything of value to a referral source/beneficiary.
  - Require marketers track expenses and submit receipts.
  - Require marketers track attendance at event.
  - Set a budget for these types of expenses.
  - Compliance keeps copies of all expense reports, receipts, etc.

# Cases / Settlements

- **Home Health Agency and Former Owner to Pay \$5.8 Million to Settle False Claims Act Allegations**
  - allegations that HHA and owner violated Anti-Kickback Statute and Stark Law by entering into sham medical director agreements with physicians as a means of providing remuneration for referrals,
  - violated Stark Law by providing bonuses to employees based on referrals to HHA by employees' physician spouses.
  - allegations of unnecessary services to Medicare patients in order to increase number of skilled service visits provided during a home health episode to avoid Low Utilization Payment Adjustment which would have decreased reimbursement.

# ■ Cases / Settlements

- **Two Women Indicted on Charges Stemming From \$100 Million Home Health Care Fraud and Money Laundering Scheme**
  - Failed to train staff, billed for home health services that were never provided or were not medically necessary and billed for home health services that were not authorized.
  - Developed employment relationships as way to pay kickbacks for patient referrals, regardless of medical necessity requirements.
  - They also entered sham employment relationships with patients' family members to provide home health aide services that were not medically necessary and routinely billed for fictitious visits that they knew did not occur.
  - Targeted particularly vulnerable patients who were low-income, on disability and/or suffering from depression and/or addiction.



# Regulatory Burden



# Request for Information

- Executive Order 14192
- “The ever-expanding morass of **complicated Federal regulation imposes massive costs** on the lives of millions of Americans, creates a substantial restraint on our economic growth and ability to build and innovate, and hampers our global competitiveness.”
- ...for each new regulation issued, at least **10 prior regulations be identified for elimination**. This practice is to ensure that the cost of planned regulations is responsibly managed and controlled through a rigorous regulatory budgeting process.

## Unleashing Prosperity Through Deregulation

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A Presidential Document by the Executive Office of the President on 02/06/2025

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# OIG Compliance Guidance Published



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# CMS Crushing Fraud Chili Cook-Off 2025

- CMS announced its “Crushing Fraud Chili Cook-Off Competition” – an effort aimed at utilizing machine learning models to detect anomalies in Medicare claims data. Finalists will receive access to Medicare Fee-for-Service (FFS) Hospice, Part B, and Durable Medical Equipment (DME) claims. CMS will accept submissions through September 19 and will publicly announce the winner the week of December 15, 2025.

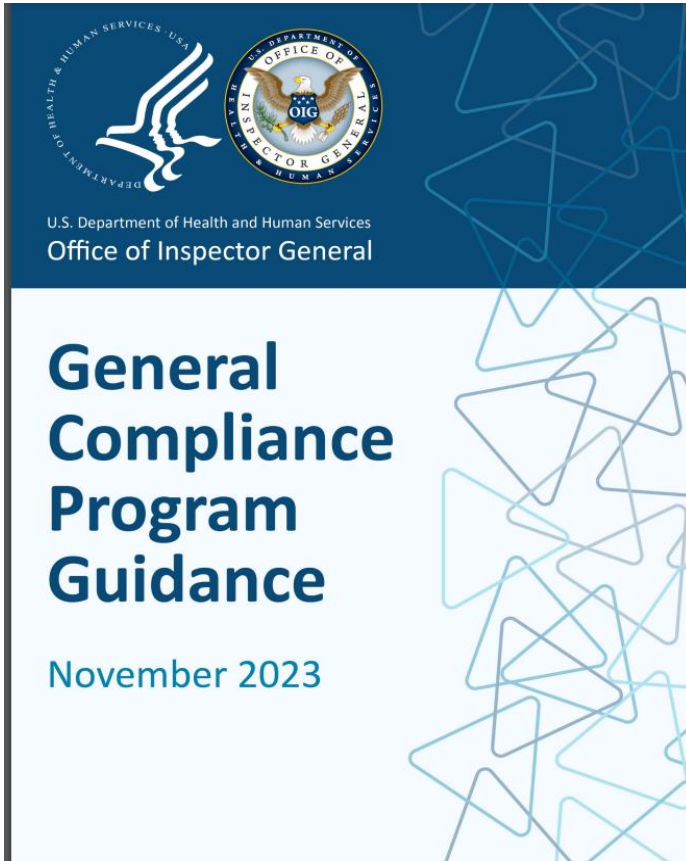
## Crushing Fraud, Waste, & Abuse

CMS is crushing fraud, waste, and abuse to protect Americans.



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.../general  
...e/



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## Old CPGs

## New GCPG & ICPGs

Published in Federal Register

Published on our website

<https://oig.hhs.gov/compliance/compliance-guidance/>

Covered both general compliance considerations and tailored risk areas specific to industry sectors

GCPG – consolidated, generally applicable compliance considerations and legal overview  
ICPGs – focused fraud and abuse risk areas specific to industry sectors and entities involved in health care

Standalone documents

Hub (GCPG) and spoke (ICPGs) approach

Remain good guidance as applicable  
No additional FR supplements will be issued

Greater flexibility to update on our website

- GCPG updated as needed
- ICPGs updated more frequently as new risk areas emerge

Sought comments through FR process

Seek feedback and suggestions for new risk areas on an ongoing basis at [compliance@oig.hhs.gov](mailto:compliance@oig.hhs.gov)

Available as archived material on OIG website

Current information on OIG website



# Survey & Enforcement Procedures

- Hospice survey process
- Surveyors Called to Identify Quality of Care Concerns and Potential Fraud Referrals

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



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## Center for Clinical Standards and Quality

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Ref: QSO-25-06-Hospice

**DATE:** November 13, 2024

**TO:** State Survey Agency Directors

**FROM:** Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

**SUBJECT:** Ensuring Consistency in the Hospice Survey Process to Identify Quality of Care Concerns and Potential Fraud Referrals

### Memorandum Summary

While the primary purpose of CMS' health and safety surveys is to determine compliance with the Medicare Hospice CoPs, there are several elements of the survey process that can uncover concerns that may necessitate a referral to CMS for potential fraud.

It is important that all elements of the survey process, and especially those listed below, be consistently performed to safeguard hospice patients and ensure the integrity of Medicare funding for hospice care.



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## Thank You.



- Questions
- Hall Render's Post-Acute Care Insights, Articles, and News:
- <http://www.hallrender.com/category/long-term-care-home-health-hospice/>

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