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**THE ENIGMA OF HOME HEALTH CARE: INITIATIVES TO COMBAT ENDEMIC FRAUD AND
IMPROVE QUALITY OF CARE**

Alec B. Deborin*

I. Introduction

On December 4, 2018, Alexander Ros Lazo, owner and operator of T.L.C. Health Services, pleaded guilty for paying kickbacks and bribes in exchange for home health care prescriptions and referrals of Medicare beneficiaries to T.L.C., his home health agency (“HHA”).¹ Perhaps even more problematic to patient health and safety, T.L.C. had been billing Medicare for occupational and therapy services rendered by a co-conspirator who was not even licensed to practice therapy.² This \$8.6 million fraud scheme is a mere snapshot of the pervasive and harmful fraudulent practices conducted by some HHAs throughout the country which drains limited government resources, including Medicare, and threatens patient safety in favor of increasing patient volume and revenue. Ultimately, our aging, homebound parents and grandparents suffer the effects of the fraudulent practices committed by various HHAs.

For hundreds of years, home health care has been the dominant form of medical care provided to individuals. It was not until the early 20th century and advances in modern medicine that hospitals overtook home health care services as the primary venue for the provision of medical services. Due to an aging population and an increasingly patient-focused health care system, home health care has once again become an increasingly relevant and crucial sector within America’s health care system. Claiming a 3% share of overall health care expenditures in

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¹ DEPARTMENT OF JUSTICE, *Florida Home Health Services Company Owner and Co-Conspirator Plead Guilty for Roles in \$8.6 Million Health Care Fraud Scheme* (Dec. 4, 2018), at <https://www.justice.gov/opa/pr/florida-home-health-services-company-owner-and-co-conspirator-plead-guilty-roles-86-million>.

² *Id.*

2017, or \$97 billion, this sector has rapidly grown in recent years, acting both as a cheaper alternative and supplement to more traditional hospitals, especially for chronic care individuals.³ Of this spending, 77% is comprised of Medicaid and Medicare expenditures, making government expenditure a significant amount of total home health spending.⁴ The trend toward home health care has only risen in recent years: home health care has seen an approximately 20% increase in home and community-based providers since 1995.⁵ This number will only continue to grow; the Bureau of Labor Statistics projected that demand for home health aides will increase by 48% between 2012 and 2022.⁶

It is clear that America's health care system, including home health care, is a complicated and inefficient system that needlessly raises costs. Although health care expenditure slowed in recent years, it is projected to rise at an average rate of 5.5 percent per year between 2018 and 2027, reaching nearly \$6.0 trillion by 2027.⁷ As health care costs continue to increase beyond the rate of inflation, fewer Americans will be able to afford high-quality care. An increased focus on home health care may actually be part of the solution in lowering overall costs and improving the quality of care in the American health care system: it could provide better, individualized care while simultaneously delivering a more economically viable alternative to hospitals.⁸ Indeed, home health care provides valuable services for the

³ CMS.GOV., *National Health Expenditure Highlights*, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf> (last visited Dec. 11, 2018); see generally Rabah Kamal & Cynthia Cox, *How Has U.S. Spending on Healthcare Changed Over Time?*, PETERSON-KAISER: HEALTH SYS. TRACKER (Dec. 10, 2018), at <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start> (charts showing despite the slowing rate of health expenditures in recent years, rates are rising again in line with long-term trends).

⁴ *Id.*

⁵ Steven Landers et al., *The Future of Home Health Care: A Strategic Framework for Optimizing Value*, 28(4) HOME HEALTH CARE MGMT. & PRAC. 262, 265 (2016).

⁶ Brooke Charles, *Home Care Fraud on the Rise*, SECURITYINTELLIGENCE (Feb. 11, 2015), at <https://securityintelligence.com/home-care-fraud-on-the-rise/>.

⁷ CMS.GOV, *supra* note 3.

⁸ Landers, *supra* note 5, at 262.

elderly and individuals with chronic conditions; a patchwork of solutions exists that can further improve quality of care and lower cost.

Home health care, however, is a growing, multi-billion dollar industry that may be resistant to change. The relative success of HHAs presents a double-edged sword: while home health may provide relatively cheaper and more efficient services than hospitals, it also presents greater opportunities for providers to commit fraud. The overarching problem of home health care is one of artificially inflated costs, largely the result of fraudulent Medicare practices. Rampant fraud and abuse scourged home health care in the past few decades and may get worse.⁹ As more and more patients utilize home health care services, an increased proportion of Federal program expenditures are directed toward home health. Unless incentives more closely align between home health care and patients, HHAs have little reason to stray from their profitable, fraudulent enterprises.

The other stumbling block home health regulators face lies in the solitary nature of medical services allegedly provided. Unlike other types of health providers, where audits and investigations can be conducted in the provider's facilities, HHAs provide care and services within the privacy of a patient's home. Therefore, bad actors in the home health sector are more difficult to identify. Because it is easier for HHAs to commit fraudulent billing practices and abuse older patients with chronic conditions, HHAs are more prone to higher rates of fraud, which include billing and claims fraud, abuse of elderly and at-risk patients, company compliance and regulatory fraud, background check fraud, and kickbacks for wrongly certifying and recruiting potential customers.¹⁰

⁹ Joan Davitt & Sunha Choi, *Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use*, 35 J. SOC. & SOC. WELFARE 247, 260 (Mar. 2008) (discussing fraudulent practices, such as illegal subcontracting and referral kickbacks).

¹⁰ Charles, *supra* note 6.

Fortunately, recent efforts to combat fraud in the American health care system extended to home health care as well. The Affordable Care Act (“ACA”) and the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) show early returns on mitigating Medicare fraud after placing an emphasis on curbing fraud and creating a transitional paradigm shift from service-based care to quality and patient-centered care. The government set up task forces, including a large contingent in Chicago, to audit providers and to ensure compliance with regulations. In recent years, the Department of Justice effectively recouped millions of dollars from providers. While the ACA and MACRA prove moderately effective, a more comprehensive solution is required if the federal government wishes to control costs in a sector plagued with fraud.

In pondering the prevention of fraud in home health care, it is important to keep in mind that home health agencies generally provide an important service and that excessive punishment should be avoided in cases where the provider violated a regulation through a technicality or good-faith mistake. In some cases, providers that did not intend to commit fraud are punished to the same degree as providers who intended to commit fraud. The best approach is to remain vigilant, hold directors and executives accountable for fraudulent activity, and help change the organizational structure of home health organizations to disincentivize fraud and lower costs.

II. Background

History of Home Health Care

The history of home health care is long and complicated in the United States. Beginning in the 19th century, organized home care began with two primary functions: the provision of midwives and to help contain the spread of contagious diseases.¹¹ The role of home health care

¹¹ PENN NURSING, *Home Care*, at <https://www.nursing.upenn.edu/nhhc/home-care/> (last visited Apr. 27, 2019).

services in the American health care system steadily decreased by the 1920s, despite the increasing number of individuals with chronic diseases due to a growing, aging population. Private insurers no longer viewed home health as a viable means for covering chronically ill patients or as a reasonable benefit to include in insurance plans. As hospitals assumed responsibility for acute-care patients and private nursing homes became a viable alternative to hospitals for chronically-ill patients, American society began to view caring for chronically ill patients as a private matter or family responsibility.¹² By the 1960s, home health took a diminished role in American society, being relegated to post-acute hospital care that decreased the burden and operating capacity of hospitals. Perceived as a cheaper health care alternative and one that emptied hospital beds, the Medicare and Medicaid Act of 1965 covered home health but limited its use to post-acute care.¹³ Home health care services began to expand in the 1980s, largely as a result of the Omnibus Reconciliation Act of 1980 (“Omnibus Act”) and several key court rulings. By the 1990s, despite some efforts to limit the burgeoning home health industry, home health care services expanded due to earlier hospital discharges, a decline in the amount of nursing home space available, an aging demographic, and advances in medical technology enabling the provision of higher quality care at home.

Home Health Defined

Home health care consists of medical services provided in a patient’s home and may include an array of services, including skilled medical professional and nursing care, physical therapy, occupational therapy, speech therapy, and hospice care.¹⁴ The Medicare and Medicaid Act established certain eligibility requirements that must be met to receive home health

¹² *Id.*

¹³ *Id.*

¹⁴ ALLIANCE FOR HOME HEALTH QUALITY & INNOVATION, *What is Home Health Care* (2019), at <http://www.ahhqi.org/home-health/what-is>.

coverage. A beneficiary must (1) be confined to his or her home; (2) be under the care of a physician; (3) need intermittent skilled nursing care or certain types of physical, speech, or occupational therapy; and (4) the care given must be medically “reasonable and necessary.”¹⁵ An individual that satisfies those eligibility requirements qualifies for “part-time or intermittent” nursing care or home health aides.¹⁶ Today, intermittent care consists of services provided fewer than 7 days a week, or daily at less than 8 hours each day for up to 21 days, with extensions allowed in extreme cases. The statutory definition of a provider in home health care, known as a home health agency, is a “public agency or private organization, or a subdivision of such an agency or organization, which is primarily engaged in providing skilled nursing services and other therapeutic services.”¹⁷ HHAs must be licensed pursuant to the specific laws of the state in which the HHA is based and must maintain clinical records on all patients.¹⁸ While HHAs must comply with and receive certification based on the specific requirements of its state, most states follow federal statutes like the Medicare Act to determine HHA eligibility.

Expansion of Home Health Care

Two decades after its inclusion in Medicare, home health remained a small health care sector that continued to provide a limited service by providing short-term, post-acute care for patients recovering from hospital care. Seen as a small but important financial burden, it was originally fully covered under Medicare Part A, comprising less than 1% of total Medicare expenditures prior to the 1980s.¹⁹ Medicare spending on home health care began to significantly increase with the Omnibus Act, which abolished the three-day hospitalization requirement

¹⁵ 42 U.S.C. § 1395(2)(A).

¹⁶ 42 U.S.C. § 1395y(a)(1)(A).

¹⁷ 42 U.S.C. § 1395x(o)(2016).

¹⁸ *Id.*

¹⁹ Brian E. Davis, *The Home Health Care Crisis: Medicare’s Fastest Growing Program Legalizes Spiraling Costs*, 6 ELDER L.J. 215, 217 (1998).

previously attached to home care benefits, the 100-visit limit, and the \$100 deductible.²⁰ In other words, the Omnibus Act eliminated the hospitalization requirement for home health care beneficiaries who could theoretically receive home care if they obtained homebound status through physician certification of their eligibility. The beneficiary also did not have to pay a co-pay or deductible for any traditional home health services.²¹ Moreover, the Omnibus Act no longer capped the number of visits per episodic illness for home health care Medicare payments at 100. Together, these reforms changed the original conception of home health from providing post-hospital acute care to chronic care. Patients with chronic, long-term conditions were now eligible to receive home health care benefits in addition to patients with short term and acute-care needs.

The number of home health care beneficiaries expanded in 1988 after a landmark decision in *Duggan v. Bowen*.²² In *Duggan*, plaintiff Medicare recipients sought class certification against the Department of Health and Human Services (“Department of HHS”), challenging the Department of HHS’s “part-time or intermittent care” policy that excluded from its definition part-time care needed for more than four days a week. Under the challenged definition, services provided to a beneficiary after the four-day threshold would not receive Medicare reimbursement. While the Department of HHS would normally be allowed to set guidelines and protocols under its statute-defined scope of discretion as an administrative agency, a court will strike down administrative protocols that are “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law” as prescribed under the Administrative

²⁰ Brooks E. Allen, *The Price of Reform: Cost Sharing Proposals for the Home Health Care Benefit*, 17 YALE J. ON REG 137,149 (2000).

²¹ *Id.* at 176.

²² *Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1988).

Procedure Act.²³ The Court clarified home health care’s “part-time or intermittent” requirement after Medicare beneficiaries claimed that the Department of HHS construed it too narrowly by limiting such services to four days a week.²⁴ The Court held that the Department of HHS’s interpretation of “part-time or intermittent” care provision requiring a person otherwise entitled to receive coverage for home health care on a less than full-time basis to establish that this care was both “part-time” *and* “intermittent” was arbitrary and capricious and that said-beneficiaries were entitled to coverage if they established such services as “part-time” *or* “intermittent.”²⁵

The practical implications of the court’s ruling on the “intermittent care” requirement in *Duggan* cannot be understated. By eliminating the four-day rule, caps on the number of permissible visits allowed by home health care personnel per episodic illness became virtually nonexistent. Strict visit limitations no longer constrained HHAs which could now procure Medicare and Medicaid payments for an unlimited amount of visits as long as all other requirements were met under § 1395 of the Act, including that visits be “medically reasonable and necessary.” The transition of home health care as a post-acute service to chronic-care service accelerated largely as a result of the Omnibus Act and the *Duggan* ruling. The number of individuals in receipt of home health Medicare benefits grew from 1.3 million to 3.2 million within a decade. Expenditures ballooned from \$1.6 billion to \$13 billion between 1983 and 1994.²⁶ Between 1989 and 1997, the number of visits to beneficiaries rose from 27 to 63 per

²³ *Id.* at 1511.

²⁴ *Id.*

²⁵ *Id.* at 1514-15.

²⁶ ALICE G. GOSFIELD, *MEDICARE AND MEDICAID FRAUD AND ABUSE* (2018).

year.²⁷ This expansion of beneficiaries occurred simultaneously with a dramatic increase in the number of home health agencies from 5,700 to over 10,000.²⁸

Types of Home Health Care Fraud

The dramatic increase in the size and scope of home health also brought upon an increased incentive to commit fraud. The fraud and abuse issues in home health care typically entail some combination of false claims, kickbacks, and self-referrals.²⁹ In addition to the various regulatory acts and court decisions in the 1980s and 1990s which increased Medicare coverage for home health care, the very nature of home health care itself precipitated the prevalent fraudulent activity existing today. According to the Office of Inspector General, the main reasons fraud exists in home health includes the fact that beneficiaries only pay co-payments on certain medical equipment but do not otherwise typically pay out-of-pocket, do not receive explanations of benefits for bills submitted for home services, and the limited medical supervision of non-medical personnel, such as Center for Medicare and Medicaid Services (“CMS”) auditors.³⁰ Sometimes, nurses exaggerate or outright falsify information in patient’s charts to make them appear to be home health service eligible.³¹ Other times, home service providers periodically discharge and later re-admit patients to hide any medically unnecessary services from regulators, without any real changes to the patient’s medical conditions.³²

²⁷ Valerie Chech, *The Final Evaluation Report on the National Home Health Prospective Payment Demonstration Agencies Reduce Visits While Preserving Quality*, MATHEMATICA POL’Y RES., INC. (Apr. 30, 2001), citing HEALTH CARE FIN. REV. 1998).

²⁸ *Id.*

²⁹ OFFICE OF INSPECTOR GENERAL, *Special Fraud Alerts*, 60 Fed. Reg. 40847 to 40848 (1995); *see also* Charles, *supra* note 6.

³⁰ *Id.*

³¹ Stephen Chahn Lee, *Feds Crack Down on Health Fraud*, CHICAGO MED. SOC’Y, at <http://www.cmsdocs.org/news/feds-crack-down-on-home-health-fraud> (last visited Apr. 27, 2019).

³² *Id.*

Other illegal activity includes paying and receiving kickbacks in exchange for Medicare or Medicaid referrals which implicate the anti-kickback statute. These payments include referral fees disguised as salaries and job opportunities, direct payments for each patient certified as eligible for home health services, and subcontracting with retirement homes for home health referrals. While some of the referred patients may be legitimately homebound, a requirement for home health Medicare reimbursement, others attain false certification and receive home health services despite their ability to freely travel in and out of their homes. The marketing of needless home health services to beneficiaries is also a significant issue, and often occurs under the guise of illegal kickback and false claim liability.³³

False Claims Act Defined

An entity violates the False Claims Act (“FCA”) if it, “knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.”³⁴ Under the False Claims Act, violators are subject to treble damages and up to \$11,000 for each false claim.³⁵ These fraudulent claims include billing for services never rendered, duplicate claims submitted for the same service, claims for services provided to ineligible patients, and claims for services providers knew to be unreasonable or medically unnecessary under the circumstances.³⁶

³³ *Id.*

³⁴ 31 U.S.C. § 3729 (a)(1)(G).

³⁵ OFFICE OF INSPECTOR GEN., *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*, U.S. DEP’T OF HEALTH & HUM. SERV’ S 3, at https://oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf (last visited Apr. 27, 2019).

³⁶ Charles Piper, *10 Popular Health Care Provider Fraud Schemes*, FRAUD MAG. (Jan./Feb. 2013), <https://www.fraud-magazine.com/article.aspx?id=4294976280>.

The FCA also covers illegal kickbacks for entities with intent to offer of pay remuneration in exchange for referrals.³⁷

Laws must be enforced to be effective. Indeed, investigation and enforcement of health care fraud has grown more sophisticated in recent years, which typically involves close coordination between multiple public and private entities. The Department of HHS oversees the Medicare program and routinely investigates suspicious providers potentially in violation of the FCA. An internal unit of the Department of HHS, CMS works with many different entities, individuals, and law enforcement to prevent and detect fraud. Unified Program Integrity Contractors, for example, are private organizations that contract with the government to investigate Medicare fraud and utilize a data-driven approach to predict and identify fraudulent actors to assist CMS in this way.³⁸ The Health Care Fraud Prevention Partnership is a voluntary partnership between public and private enforcers, including state agencies, law enforcement, and private insurance plans that facilitates information sharing.³⁹ In some cases, nurses, patients, and other individuals notify the government of suspected foul play as part of a *qui tam* lawsuit.

Past and Current Efforts in Remediating Home Health Care Fraud

Past efforts to curb fraud and overall costs in the health care sector largely centered on reforming the Medicare reimbursement model. Traditionally, Medicare providers received reimbursement through a fee-for-service payment model, whereby Medicare paid for the cost of each individual service rendered.⁴⁰ This model incentivized hospitals and physicians to maximize the number of procedures performed instead of focusing on preventative care, and to

³⁷ OFFICE OF INSPECTOR GEN., *supra* note 35; *see also Id.*

³⁸ ANALYTICA, *CMS Unified Program Integrity Contractor (UPIC)*, at <https://www.analytica.net/contracts/cms-upic/> (last visited March Feb. 27, 2019).

³⁹ CMS, *MEDICARE FRAUD & ABUSE: PREVENT, DETECT, REPORT, MED. LEARNING NETWORK 17* (Feb. 2019).

⁴⁰ John T. Preskitt, *Health Care Reimbursement: Clemons to Clinton*, 21(1) BAYLOR U. MED. CTR. PROCEEDINGS 40-44 (2008).

render medically unnecessary services, which increased overall cost.⁴¹ By 1983, with the adoption of the Social Security amendments, acute-care inpatient hospitals adopted a prospective payment system (“PPS”). While still a fee-for-service model, hospitals received reimbursement based on a pre-determined rate set by CMS, regardless of the actual costs of services rendered. Home health care, however, lagged behind and continued to use more traditional payment methods.

Efforts to combat the burgeoning costs of home health care began with studies conducted to test different payment models. Under the National Home Agency Prospective Payment Demonstration of 1990, five states (California, Florida, Illinois, Massachusetts, and Texas) began testing the effectiveness of different models of a PPS for home health care services: Phase I of the demonstration tested a payment system in which reimbursement rates were set on a per-visit basis while Phase II, begun in 1995, tested a system in which rates were set for each “episode of care provided,”⁴² defined as 120 days for the purposes of the study. The results of the Phase I study demonstrated the need to further reduce volume of services in order achieve meaningful cost savings.⁴³ Under Phase II, agencies received a lump sum for the first “episode of health care,” regardless of overall costs or number of visits made. By providing a pre-set reimbursement rate per episode, agencies driven by maximizing profits would reduce costs per episode below the base-payment rate.⁴⁴ In its final evaluation of the effectiveness of both models, CMS found the Phase II model to be more effective in drastically reducing the number of visits made to patients. The average time of care fell from 131 days for cost-reimbursed agencies to 98 days for

⁴¹ *Id.*

⁴² Henry B Goldberg & Robert J Schmitz, *Contemplating Home Health PPS: Current Patterns of Medicare Service Use*, 16 HEALTHCARE FINANC. REV. 109–130 (1994), at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193476/>.

⁴³ Chech, *supra* note 27, at 1.

⁴⁴ *Id.* at 12.

agencies operating under the Phase II prospective payment model.⁴⁵ As for the quality of care under a PPS model, the study found that the decreased number of visits did not significantly impact overall patient health, although patient's health *were* affected in some instances.⁴⁶

Eventually, HHAs adopted a version of this payment model under the Balanced Budget Act of 1997.⁴⁷ As home health costs spiraled out of control, Bill Clinton's administration issued a moratorium on September 15, 1997, that required HHAs to re-enroll for licensure every three years and increased the number of CMS audits performed on them.⁴⁸ Prior to the moratorium, Congress attempted to rein in Medicare costs with the passage of the Balanced Budget Act of 1997. The most significant measure of the Act required the Department of HHS to develop and implement a PPS for home health services.⁴⁹ The new PPS established a method of Medicare disbursement made on a predetermined fixed amount, based on a classification system initially predicated on prior cost reporting data, "that eliminates the effects of variations in relative case mix and wage levels among different home health agencies."⁵⁰ Along with a new method of payment, the Act further required that HHAs receive payment based on the location of the services provided rather than where the services were billed: this gave the beneficiary the right to make written requests to physicians for an itemized statement of Medicare-covered items or services, and redefined "part-time" and "intermittent care."⁵¹ Further, in an effort to decrease overall Medicare costs, the BBA stipulated that Medicare Part A would only cover up to 100 visits "per spell of illness;" Part B would cover any further visits. Overall, the BBA of 1997

⁴⁵ *Id.* at 15.

⁴⁶ *Id.* at 17.

⁴⁷ CMS.GOV, *Home Health PPS* (Mar. 8, 2019), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html>.

⁴⁸ *Id.*

⁴⁹ Balanced Budget Act of 1997. PUB. L. NO. 105-33, 42 U.S.C. § 4602-03 (1997); *see also* Davis, *supra* note 19, at 243-44 (explaining the significance of a prospective payment system and how it reduces costs per visit).

⁵⁰ *Id.* at 226.

⁵¹ *Id.* at 253.

enjoyed relative success pursuing its goal to rein in home health care costs, as the average number of visits per beneficiary fell 43% between 1997 and 1999.⁵² Under this new payment model, the incentive for HHAs to make medically unnecessary patient visits decreased because reimbursement rates stayed at a predetermined rate based on episodes of care. Still, the new payment method could not completely overcome by the obstacles created by the Omnibus Act and *Duggan* in limiting the frequency of visits or narrowing patient eligibility for home health care.⁵³

Renewed efforts to curtail costs and fraud in home health began with the passage of Medicare Access and CHIP Reauthorization act of 2015 (“MACRA”) and the ACA. Enacted in 2015, MACRA reformed the Medicare payment structure for physician services and implemented a series of policy changes.⁵⁴ By 2019, MACRA will transition from service-based models such as the PPS to primarily two value-based payment models: Advanced Alternative Payment Models (“APMs”) and the Merit-Based Incentive Payment System (“MIPS”).⁵⁵ MIPS establishes a composite score based on four main factors: (1) Quality; (2) Resource Use; (3) Clinical Practice Improvement Activities; and (4) EHR Meaningful Use.⁵⁶ The composite score determines the amount of reimbursement a provider is entitled. Providers with good scores receive a 5% bonus in reimbursement while providers with lower scores are penalized and receive a lower amount of reimbursement. Eligible providers under the advanced APM approach choose to take on risk in the hopes of receiving various payment incentives.

⁵² Chech, *supra* note 27, at 2.

⁵³ Davis, *supra* note 19, at 247.

⁵⁴ Briar Siljander & Jennifer L. Gross, *Assessing the Impact of Medicare Access and CHIP Reauthorization Act: The Repeal of the SGR and Beyond*, 27 HEALTH LAW. 26 (2015).

⁵⁵ *Id.*

⁵⁶ *Id.*

In 2018, CMS introduced Bundled Payments for Care Improvement Advanced (“BPCI Advanced”), a voluntary program that provides participating HHAs the option to be reimbursed through bundled payments.⁵⁷ Bundled payments are a type of advanced APM that incentivize providers to decrease cost and increase quality of care by giving HHAs the opportunity to receive additional payment if they meet certain cost and quality metrics similar to those seen under the MIPS structure. Under the BPCI program, HHAs can receive payment for 32 identified clinical episodes of care.⁵⁸

Because MACRA is still in a transitional phase, most HHAs still operate under the prospective payment model. The merit-based payment system, however, is a step in the right direction to combat certain types of fraudulent billing and improve quality of care. By changing the paradigm from a service-based payment method to one focused on quality and cost control, the merit-based payment system disincentivizes HHAs from billing based on the number of visits made to beneficiaries because this system would no longer be a fee-for-service. Bundled payments, for instance, remove the temptation to decrease quality in order to lower costs. This new payment model has many similarities to the PPS tested under Phase II of the Demonstration project, which set reimbursement rates based on an episodic illness rather than a straight fee-for-service basis. MACRA reimbursement, however, hinges more on quality of care and patient outcome rather than on services rendered under a PPS model. Despite its potential to improve quality and decrease fraud, MACRA is not all-encompassing and will not solve certain types of fraudulent practices, including false “homebound” certification by physicians, and referrals to HHAs for kickbacks. A value-based payment model also presents potential downsides and policy

⁵⁷ Amy Baxter, *CMS Introduces New Bundled Payment Model*, HOME HEALTH CARE NEWS (Jan. 9, 2018), at <https://homehealthcarenews.com/2018/01/cms-introduces-new-bundled-payment-model/>.

⁵⁸ *Id.*

concerns. As home health services have invariably switched from a post-acute service to a longer term, chronic disease care service, HHAs would be forced to demonstrate high-quality care for patients with conditions that may show little improvement from medical care and may even be incurable. As a result, it may be difficult to completely transition HHAs from utilizing prospective payment systems to APM models without structural changes to the HHAs themselves.

In addition to reforming the reimbursement model, the Obama Administration renewed the focus on regulatory enforcement to hold those in leadership positions more accountable over fraudulent activity. In her 2015 Memo titled “Individual Accountability for Corporate Wrongdoing,” Deputy Attorney General Sally Yates outlined six strategies to combat corporate wrongdoing, including fraud in health care:

(1) in order to qualify for any cooperation credit, corporations must provide to the Department all relevant facts relating to the individuals responsible for the misconduct; (2) criminal and civil corporate investigations should focus on individuals from the inception of the investigation; (3) criminal and civil attorneys handling corporate investigations should be in routine communication with one another; (4) absent extraordinary circumstances or approved departmental policy, the Department will not release culpable individuals from civil or criminal liability when resolving a matter with a corporation; (5) Department attorneys should not resolve matters with a corporation without a clear plan to resolve related individual cases, and should memorialize any declinations as to individuals in such cases; and (6) civil attorneys should consistently focus on individuals as well as the company and evaluate whether to bring suit.⁵⁹

⁵⁹ Sally Quillian Yates, *Individual Accountability for Corporate Wrongdoing*, U.S. DEP’T OF JUST.: OFFICE OF DEPUTY ATT’Y GEN. (Sept. 9, 2015), at <https://www.justice.gov/archives/dag/file/769036/download>.

In addition to holding wrongdoers more accountable, the Yates memo also brought about an increased government focus on medical necessity cases. Medical treatments fell under heavy scrutiny with the help of big data analytics and auditors began to ascertain the necessity of such treatments and procedures. Moreover, the government readily held the organization, in addition to the individual provider, liable for these fraudulent practices. Despite these new initiatives, however, the Trump administration may have stalled the momentum on the increased focus on executive and corporate accountability. While the Yates Memo remains intact, money recouped from health care fraud declined in 2018 from recent years.⁶⁰

More recently, CMS issued a final rule on face-to-face requirements for home health services effective July 1, 2016.⁶¹ This new regulation requires physicians to document face-to-face encounters, including telehealth services, with the Medicaid beneficiary for the authorization of home health services within certain timeframe.⁶²

In addition to recent rules and regulations designed to disincentivize fraudulent activity, increased enforcement capabilities were spearheaded by Sally Yates and the DOJ to increase enforcement capabilities amongst various federal agencies. Of these federal agencies, the Health and Human Service Office of Inspector General (“HHS-OIG”) plays the most prominent role in combating fraud and abuse, with a substantial amount of its resources going towards Medicare and Medicaid oversight.⁶³ Since its inception in early 2007, HHS-OIG has improved its capabilities through the use of Medicare Fraud Strike Force teams. These units of HHS-OIG

⁶⁰ Sam Skolnik, *Yates Memo Faces Uncertain Fate Under Trump, Attorney Says*, BLOOMBERG: GOVERNMENT (June 2, 2017), at <https://www.bna.com/yates-memo-faces-n73014453088/>.

⁶¹ FEDERAL REGISTER, *Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health* (2016), at <https://www.federalregister.gov/documents/2016/02/02/2016-01585/medicaid-program-face-to-face-requirements-for-home-health-services-policy-changes-and>.

⁶² *Id.*

⁶³ HHS OFFICE OF INSPECTOR GENERAL, *Why is HHS OIG a Good Investment?*, <https://oig.hhs.gov/> (last visited May 28, 2019).

investigators combine data analytics and collaborate with the FBI and other federal agencies, state, and local law enforcement to identify health care fraud, waste, and abuse.⁶⁴ Moreover, these teams are strategically based in locations that typically include endemic levels of home health care fraud, such as Los Angeles, Chicago, and various cities in Florida.⁶⁵ Credible allegations of fraudulent practices are subsequently referred to CMS, who then have the ability to immediately suspend Medicare payments to the perpetrators identified by strike force teams.⁶⁶ Since their inception, these units have been relatively successful: strike force teams operating in 12 different cities have since charged over 4,000 defendants who have collectively billed Medicare a total of over \$14 billion.⁶⁷

III. Solutions to Decrease Fraud and Improve Care

Methods to combat fraud and abuse within home health care face unique challenges, not the least of which are HIPAA and privacy concerns, political uncertainties, difficulties of proving intentional – therefore fraudulent – conduct, and the difficulties of auditing HHAs in general. Despite past and current efforts to combat fraud by restructuring payment structures, increasing the number of audits and penalties, and other forms of regulation, fraud remains an elusive opponent to tackle through reactive means in home health. No “one-size-fits-all” solution exists to curb fraud and reduce cost in home health care. Any solutions should be within the spirit and confines of the Institute for Healthcare Improvement’s *Triple Aim* initiative to improve the patient experience of care, the health of populations, and reducing the per capita cost

⁶⁴ OIG, *Medicare Fraud Strike Force*, <https://oig.hhs.gov/fraud/strike-force/> (last visited Dec. 8, 2018).

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ Robert Holly, *Home Health Agency Owners Sentenced to Prison: Ordered to Pay \$14.1M for Fraud*, HOME HEALTH CARE NEWS (Oct. 21, 2018), <https://homehealthcarenews.com/2018/10/home-health-agency-owners-sentenced-to-prison-ordered-to-pay-14-1m-for-fraud/>.

of health care.⁶⁸ Home health care may require a patchwork of solutions including, organizational structural reforms of HHAs to integrated health care systems, a commitment by the current administration to maintain vigilance in holding individual executives more accountable for fraudulent practices, continuing the recent trend towards a value-based payment model, and rolling back some of the initial problems created by the *Duggan* Court ruling and Omnibus Act. Other possible solutions will be addressed later in this article, such as mandating co-payments for health care services or even transferring patients with chronic conditions from home health care to nursing homes, but should not be implemented for a number of reasons.

Integrated Health Care Systems

The American health care system is a patchwork of fragmented industries and organizations that needlessly increase administrative costs and decreases competition, cause quality of care to suffer, and potentially hamper overall transparency for government regulators and auditors. The best long-term solution to increase the quality of home health and decrease fraud is to implement an Integrated Delivery System (“IDS”). An IDS involves integrating HHAs with other providers to be a part of a larger industry trend of merging and consolidating providers. An IDS that increases cooperation and improves transitional care amongst hospitals, home health, hospice, and other health care services promise to solve major structural issues in home health that enable fraud. IDSs may be diverse in organizational structure and there is no clear definition on what constitutes an IDS.⁶⁹ By better integrating the chain of health care between hospitals and providing various incentives to home health agencies, the system may help avoid some of the pitfalls that have long been endemic in home health care, including illegal

⁶⁸ INST. FOR HEALTH CARE IMPROVEMENT, *The IHI Triple Aim*, <http://www.ihc.org/Engage/Initiatives/TripleAim/Pages/default.aspx> (last visited Apr. 27, 2018).

⁶⁹ Wenke Hwang et al., *Effects of Integrated Delivery System on Cost and Quality*, 19(5) THE AM. J. OF MANAGED CARE 175 (2013).

kickbacks for patient referrals and false homebound certification. The most common IDS model is the Accountable Care Organization (“ACO”), in which health care providers voluntarily join together to provide coordinated care.⁷⁰ Similar to the BPCI Advanced program for participating HHAs, Medicare ACOs are typically reimbursed through bundled payments where reimbursement rates are determined based on cost and quality metrics.⁷¹ Other test models considered for better integration include the Community-Based care Transitions Program (“CCTP”), the Geriatric Resources for Assessment and Care of Elders, and Independence at Home.⁷²

Created under § 3026 of the ACA, the CCTP tests integration models designed to improve the transition between hospitals and other settings like home health care in order to reduce readmission for high-risk Medicare beneficiaries and to document measurable savings to Medicare.⁷³ Community-based organizations, or CBOs, offer transitional care services to lower costs and improve quality of care. These organizations focus on social determinants to improve health outcomes by providing access to housing, transportation, healthy food, and employment opportunities.⁷⁴ Although relatively new, these organizations have increased awareness within the health care industry on the role social determinants play in overall health. HHAs that have transitioned to a value-based payment model should consider partnering with CBOs as it would improve quality of care and incentivize payment under bundled payments and other value-based

⁷⁰ CMS.GOV, *Accountable Care Organizations* (Mar. 8, 2018), at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/>.

⁷¹ *Id.*

⁷² VICTORIA WEISFELD & TRACY A. LUSTIG., *THE FUTURE OF HOME HEALTH CARE: WORKSHOP SUMMARY*, INST. OF MED. & NAT’L RES. COUNCIL 68-71, (2015).

⁷³ CMS.GOV, *Community-based Care Transitions Program*, (Jan. 18, 2018), at <https://innovation.cms.gov/initiatives/CCTP/>.

⁷⁴ Biana Freda, *Partnering to Improve Population Health: Exploring Effective Community-Based Organization and Health Care Models*, CTR. FOR HEALTH CARE STRATEGIES (Jan. 9, 2017), at <https://www.chcs.org/partnering-improve-population-health-exploring-effective-community-based-organization-health-care-models/>.

payment models.⁷⁵ Not only does an increased focus on quality generally tend to decrease incentives to commit fraud, but the partnering CBO would refer a steady stream of patients to the HHA.

Under the Geriatric Resources for Assessment and Care of Elders (“GRACE”) model, support teams comprised of nurse practitioners and social workers meet with the elderly patient to conduct an initial assessment. This team then meets with a larger GRACE interdisciplinary team consisting of a geriatrician, pharmacist, physical therapist, mental health social worker, and a community-based liaison to develop an individualized care plan alongside with the patient’s primary care physician. By maintaining an electronic medical record and longitudinal tracking system, the GRACE support team coordinates and implements the plan across multiple sites of care. This is an effective model to combat fraud in home health for several reasons. By having a team create an individualized prospective plan of care for the patient, the number of medically unnecessary treatments and hospital readmission rates will decrease.⁷⁶ While a GRACE model is ultimately cost-neutral compared to usual care patients, it does improve quality care while weeding out fraudulent providers through an atmosphere of cross-verification and transparency created through a team setting.⁷⁷

Independence at Home Demonstration (“IHD”) is another model whereby home-based primary care teams, at the direction of physicians and nurse practitioners, provide comprehensive

⁷⁵ Nora Super et. al, *Health Care and Community Based Organizations Have Finally Begun Partnering to Integrate Health and Long-Term Care*, HEALTH AFF., (Feb. 2, 2018), at <https://www.healthaffairs.org/doi/10.1377/hblog20180130.620899/full/>.

⁷⁵ Steven R. Counsell et al, *Geriatric Resources for Assessment and Care of Elders (GRACE): A New Model of Primary Care for Low-Income Seniors*, 54(7) J. AM. GERIATRIC SOC. 1136 (2006).

⁷⁶ *Id.*

⁷⁷ Steven R. Counsell et. al, *Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention*, 57(8) J. AM. GERIATRIC SOC. 1420 (July 29, 2009).

medical care to patients with multiple chronic conditions.⁷⁸ Similar to the MACRA value-based payment structure, IHDs would reward health care providers that provide high quality care while reducing cost. Such an organization would need experience in providing home-based primary care to patients with multiple chronic conditions and service at least 200 eligible beneficiaries.⁷⁹ The primary care teams would include physician assistants, pharmacists, social workers, and other staff to create a care plan for the patient. According to test results garnered by CMS, this is an effective model that provides more comprehensive care to the individual while decreasing cost.

Committing to the Yates Memo

In addition to changing the overall structure of organizations, providing home health services, and improving integration, the government must also ensure the continuation of regulations already in place. The Yates Memo helped hold organizations and individual leaders, including corporate directors and executives, more accountable for fraudulent business activity.⁸⁰ While increasing accountability for HHA leaders does not automatically reduce fraud within their organizations, a strong correlation exists between bad actor executives and organizations that tend to commit fraud. Recent settlements with health care providers include government announcements emphasizing the inclusion of corporate leaders in the resolutions, reminiscent of policy changes promulgated by the Yates Memo.⁸¹ Some recent individual punishments include fines in excess of \$1 million and multi-year exclusions from participating in federal health care programs.⁸² Leaders can no longer “look the other way” without risking severe penalties and

⁷⁸ CMS.GOV. *Independence at Home Demonstration*, at <https://innovation.cms.gov/initiatives/independence-at-home/> (last visited Jan. 3, 2019).

⁷⁹ *Id.*

⁸⁰ Tony Maida & Rebecca C. Martin, *One Year Later: The Yates Memo, False Claims Act, and Director & Executive Liability*, MCDERMOTT WILL & EMERY LLP (Oct. 11, 2016).

⁸¹ *Id.*

⁸² *Id.*

public exposure. With the uncertainty and lack of clear direction under the Trump administration over maintaining these policy changes, a renewed focus on holding individuals, as well as organizations, accountable for fraudulent practices is imperative. Maintaining HHS strike force teams, thorough audits, and focusing on big data go hand in hand with individual accountability and the need for regulatory enforcement.

Rethinking Duggan

Another major consideration is re-assessing the main cause for the expanded scope and size of home health care in the first place. Indeed, home health care did not present much of a problem until its emphasis switched from short-term care to the care of patients with chronic conditions. Legislation could be introduced to override or correct for the holding in *Duggan v. Bowen*, which essentially eliminated the “part-time or intermittent” requirement. By imposing stricter limits on the number of visits organizations can make in a week, home health services would be forced to provide better quality care during the visits they do make. With the transition to a value-based payment model, however, such an imposition would be less necessary if the goal is to disincentivize HHAs from performing medically unnecessary procedures. Re-establishing a stricter limit would also hamper integrated delivery system models, such as the Independence at Home demonstration, that are designed to provide more comprehensive care while lowering costs. Prior to the Omnibus Act and the holding in *Duggan v. Bowen*, visitation limits to four times per week and 100-visits per episode, limited the profit motive for HHAs and made medical services more efficient. Re-establishing these limitations, however, would exclude patients from cost-effective, higher quality benefits home health services may provide for chronically ill patients that require constant visitation by aides and medical personnel.

Other Proposed Solutions that Should Not be Implemented

One potential solution, posed by both political parties and various scholars, is to require beneficiary co-payments. As an area of health care fully covered by Medicare, some believe that creating a small financial burden would simultaneously decrease the overall number of home health participants and make those that already receive home health services more conscious about how their copayments are spent. Though theoretically possible, studies show that this cost-sharing scheme would not deter individuals from home health care and would only increase the financial burden of an increasingly elderly and sick population.⁸³ In any case, benefits derived from this cost-sharing scheme would only constitute marginal benefits that may not be worth the cost of placing financial burdens on patients. Other remedies, including other cost-saving measures, may more effectively curb fraud and abuse without imposing a financial burden on beneficiaries or decreasing the quality of home health care.

Another possible solution is to transfer home service patients, especially those with chronic conditions, to other Medicare and Medicaid services like nursing home facilities and hospitals. In terms of combating fraud, arguments can be made that auditing for fraudulent practices would be easier with a centralized location where an auditor can more readily interrogate patients and staff of the facility. Despite catering to a similar demographic, elderly patients with chronic conditions, nursing homes and home health care currently serve two distinct, albeit similar, purposes. A patient qualifies for nursing care when they are a hospital inpatient for over three days, are certified by the physician that skilled daily care is required, and

⁸³ David Orenstein, *Copays Don't Reduce Cost of Medicare Home Health Care, Study Shows*, BROWN U. (May 8, 2008), <https://news.brown.edu/articles/2017/05/copays>; see generally Qijuan Li, et. al, *Association of Cost Sharing With Use of Home Health Services Among Medicare Advantage Enrollees*, 177(7) JAMA INTERN MED. 1012 (July 2017).

care is delivered by skilled nursing or rehabilitation staff.⁸⁴ In other words, nursing homes are meant to provide 24/7 care, which includes assisted living services beyond the medical care a resident ordinarily receives. The other primary difference between nursing home and home care is the method of payment: Medicare typically covers home services while Medicaid generally reimburses for nursing home care. While reimbursement rates for Medicaid are considerably lower than Medicare, home health care costs less than many nursing homes or other assisted-living facilities.⁸⁵ A patient transfer from HHAs to nursing homes would not be a viable option, given that the ultimate goal is to rein in costs and reduce fraud. Any potential benefit to improve a patient's experience would be negligible compared to the increase in overall costs for medically unnecessary treatment and assisted-living services for patients who only require part time and intermittent care.

While increasing penalties and HHA audits may elicit marginal benefits, they would not solve the systematic root problems of a health care sector originally intended for short-term and acute care at the birth of the Medicare and Medicaid Act. Current penalties are harsh and increasing them will not cause a significant decrease in fraudulent billing. Physicians who falsely certify Medicare beneficiaries for home health care, for instance, are subject to a civil monetary penalty of up to three times the amount of remuneration offered or paid.⁸⁶ In addition to treble damages, each additional false claim is subject to up to \$11,000 in fines under the False Claim Act.⁸⁷ Thus, a few violations can quickly and drastically increase fines. Imposing harsher penalties may also have the unintended consequence of deterring providers from entering the

⁸⁴ EHEALTH MEDICARE, *What's the Difference Between Home Health Care and Nursing Home Care?*, (2018), at <https://www.ehealthmedicare.com/faq/whats-the-difference-between-home-health-care-and-nursing-home-care/>.

⁸⁵ GEORGETOWN HOME CARE, *How Much Does Home Health Care Cost?* (Aug. 14, 2018), <https://www.georgetownhomecare.com/how-much-does-home-health-care-cost/>.

⁸⁶ CMS, *supra* note 39, at 10.

⁸⁷ *Id.* at 7.

home health field in the first place. Similarly, increasing the number audits has limited effects because of the private nature of home health. While hospitals and other medical facilities allow CMS and HHS auditors to visit and interrogate patients, privacy concerns restrict auditors from doing the same with residential homes.

IV. Conclusion

Since its inclusion in Medicare in 1965, home health care transformed from a small sector meant to provide short-term and post-acute care to a rapidly growing health care service that is experiencing near-epidemic levels of fraud. While the switch to quality and patient-based care brought on by the ACA and MACRA will continue to combat fraudulent activity in home health care, these initiatives will not eliminate fraud within a health care sector fundamentally different from its original purpose and state. Home health care remains an important service that is both cheaper and important to eligible beneficiaries.

The best way to curb fraud is with a combination of strict government enforcement and promoting initiatives that align incentives between HHAs and patients. The government must continue to hold individual executives and other high-level employees in Home Health Agencies accountable for fraudulent practices. As part of the transition from volume to value-based care in the health care industry, the federal government should also explore methods that further encourage HHAs to join integrated delivery system models. Ultimately, it is in the home health care industry's own self-interest to integrate within the wider health care community – a step that promises to streamline care, decrease fraud, and improve overall patient health. Integration, as well as vigilant enforcement of existing policies, may make home health care the bedrock for efficient and higher quality care within the American health care system.