

2010

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Recommended Citation

Brooke Benzio *Fee-for-Disservice: Medicare Fraud in the Home Healthcare Industry*, 19 *Annals Health L.* 229 (2010).
Available at: <http://lawcommons.luc.edu/annals/vol19/iss1/41>

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Fee-for-Disservice: Medicare Fraud in the Home Healthcare Industry

*Brooke Benizio**



If the recession has you looking for a more lucrative line of work, strange as it sounds, you might consider a career in Medicare fraud. Create your own hours, vacation as you please, and still net millions of dollars each year! Individuals in South Florida have already discovered this shortcut to the good life. In fact, in 2008, the Benitez brothers of Miami were indicted for allegedly collecting \$84 million from Medicare—money they spent on a private helicopter and tourist hotels.¹

Although Miami-Dade County is a particularly virulent “hot spot,” Medicare fraud is a serious concern on a national level. Similar hotbeds of fraud have been discovered in Detroit, Los Angeles, and Houston—and industry officials have noticed an alarming trend whereby criminals perfect their schemes in these cities and export them elsewhere. It is difficult to estimate the total amount of Medicare monies lost to fraud nationwide. The Centers for Medicare and Medicaid Services claims the number is around \$11 billion, while industry experts say \$60 billion, but neither estimation is comforting when the program costs over \$500 billion annually.²

Fraud related to Medicare and Medicaid reimbursement has expanded at an alarming rate over the past ten years, and yet, regulatory controls aimed at fixing these problems stagnate. In this article, I will focus on fraud in the area of Medicare reimbursements related to home healthcare (HHC) services. A discussion of this issue is crucial because: (1) the HHC industry is an especially vulnerable magnet for fraud; (2) many experts believe there is a workable solution in adoption of a managed care system; and (3) with

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1. Jay Weaver, *Busting Medicare Fraud*, AARP BULLETIN, Nov. 2009, at 10.
2. *Id.* at 12.

President Obama's reform plans looming, the future of healthcare funding is uncertain.

I. BACKGROUND AND ISSUES

According to the National Institute on Aging (NIA), by 2040, the population of individuals over the age of sixty-five in the United States is expected to reach 1.3 billion.³ Currently, the Medicare program requires upwards of \$500 billion a year to maintain care for half that number of eligible seniors. Notwithstanding state and federal legislation aimed at reducing Medicare fraud, home healthcare remains a particularly difficult area to police because: (1) there are multiple ways to defraud the program; (2) the structure of Medicare reimbursement favors efficiency over legitimacy; and (3) there is little investigation or oversight. Home health care under Medicare is intended for patients who are legitimately homebound and require skilled nursing care. Since 1998, the majority of HHC services have involved the maintenance of chronic conditions instead of the post-hospital care originally intended by Part A. The program pays for part-time skilled care and 80% of the cost of durable medical equipment (DME) when supplied by a certified home healthcare agency. Thus, not only is the program susceptible to obvious fraud (fake patient visits and services), but also supplemental fraud (DME scams, bribes, and kickbacks). Two of the most troublesome areas are insulin injections for diabetics and false payouts for durable medical equipment. In Miami, the average cost for each home healthcare patient with diabetes is about \$11,928 every two months; thirty-two times larger than the national average.⁴ DME is a particularly outrageous fraud vehicle, characterized by Medicare payments for equipment that is unnecessary and never delivered. Even more troubling is the denial of legitimate beneficiary claims because of DME fraudulently billed using the beneficiary's Medicare identification number.

Another problem unique to home healthcare is that of outlier payments; adjusted payments made for beneficiaries who incur unusually large costs. Nationwide, the total amount allocated is approximately \$600 million. Of that, last year Miami-Dade County received \$285 million, and Chicago—with nearly five times the population of Miami—received only \$900,000.⁵

Additionally, patient care initiatives have led to Medicare being publicized as an extremely efficient program. In fact, the program requires

3. U.S. Census Bureau News, *Unprecedented Global Aging Examined in New Census Bureau Report Commissioned by the Nat'l Inst. on Aging*, available at http://www.census.gov/Press-Release/www/releases/archives/aging_population/013988.html (last visited Dec. 24, 2009).

4. Telephone Interview with Gene Tischer, former Executive Dir., Home Care Ass'n of Fla. (Dec. 14, 2009).

5. *Id.*

properly submitted fee-for-service claims to be paid within fourteen days. However, true efficiency requires more than speed, and without any system of legitimizing claims, as long as crooks are able to obtain a valid Medicare number and submit forms properly, they can bill for an unlimited amount of expensive care procedures. Although speedy reimbursement has the benefit of quick payment for legitimate services, it renders the ability to validate claims prior to approval of payment almost completely impossible.

Third, although it may be difficult to believe that a large-scale entitlement program could be vulnerable to such rudimentary fraud schemes and largely unsophisticated scam-artists, a large portion of the problem is attributed to the lack of investigatory measures at the claims-submission level. Claims are largely computer-generated, with little or no human involvement. Thus, the federal system is not asleep on guard duty—rather, they have failed to even show up. Gene Tischer, former executive director of the Home Care Association of Florida (HCAF), uses Fort Knox as an analogy to illustrate the failures of Medicare controls. He imagines a room filled with \$455 billion—the amount Medicare will pay this year—much like the gold bricks housed at Fort Knox.⁶ One would probably expect such a room to have the most advanced security system possible; however, Medicare’s “money room” has left the key under the mat, a spare above the door, and another in the mailbox.

In addition to claims investigation, the enforcement arm of the Medicare program is severely lacking. However, legislators are beginning to take steps toward eradicating fraud. The nation’s first federal Medicare fraud strike force was put together in Miami in 2007. The task force indicted 197 suspects that year—nearly doubling the number from previous years.⁷ Now, similar strike forces are operating in Los Angeles, Detroit, and Houston. Since 2007, these groups have indicted nearly 300 defendants, accounting for an alleged \$680 million in fraudulently obtained Medicare dollars.⁸ Although these prosecutorial “crackdowns” are certainly an improvement, beefing up enforcement measures at the end of the chain will do little to prevent fraud or catch it before the money is paid (to a criminal who will purchase a lot full of Lamborghinis that will not easily return usable dollars to the Medicare piggybank). Further, in January 2010, the federal government is imposing a 10% cap on claim payments while they scrutinize suspicious dealings—a first in Medicare history.⁹

Although enforcement needs are finally beginning to be addressed, future measures need to account for the traditional pitfalls of “white-collar” crime

6. *Id.*

7. Weaver, *supra* note 1, at 12.

8. *Id.*

9. *Id.* at 13.

prevention: (1) fraud of this kind is dynamic; (2) visible fraud determines the level of resources allocated to control and prevention; and (3) often, fraud initiatives focus almost completely on implementing new systems to detect threats, thus creating numerous laws without “teeth.” In the past, legislative measures that closed loopholes within the system seemed to merely displace fraud.

One of the first major steps forward in the state of Florida was 2008’s proposed Senate Bill 1374, which provided stricter scrutiny of the state’s HHC industry. With help from the HCAF, the bill took aim at some of the most nefarious practices; most notably: (1) slowing licensure of new agencies; (2) requiring strict reporting measures for claims related to diabetic care; and (3) attempting to eradicate patient collusion, where beneficiaries receive cash payments to falsify documents or permit misuse of their Medicare identification number. The agency licensing cap is especially important. Based on 2009 estimations, there were 2,361 home health agencies licensed in Florida, with 958 of those (approximately 41%), located in Miami-Dade County. SB-1374 was “amended” by the actual passage of SB-1986, which includes additional provisions requiring more involved quarterly reporting from HHC agencies. This sort of internal “self-audit” measure will do a great deal to improve accountability because agencies that fail to comply will face large fines and potential suspension of their licenses. Moreover, the Senate is currently contemplating the Healthcare Fraud Enforcement Act (HFEA) of 2009, which would give a greater “bite” to federal enforcement measures. Specifically, the HFEA makes it easier to expose illegal kickbacks and provides for recovery under the False Claims Act, strengthening existing federal case law.¹⁰

II. LOOKING FORWARD: RECOMMENDATIONS AND FUTURE CONCERNS

The healthcare fraud issue is multifaceted, and there is no “magic bullet.” However, many industry professionals believe that in order to eradicate Medicare fraud in the home healthcare industry, the system itself needs to be changed. Home healthcare is primarily fee-for-service, which remits payment per service rendered, without scrutiny. However, if the system was more similar to a managed care organization, there would be human analysis at the submission level—thus, claims would not get paid unless the services rendered were legitimized. Simply put, a large majority of fraud could be eradicated simply by requiring intensive verification measures.

Despite the expected success of a managed care approach, the system is subject to a great deal of criticism. Primarily, patients’ rights activists

10. S.B. 1986, 2009 Leg., Reg. Sess. (Fl. 2009); *see also* Fischer v. United States, 529 U.S. 667 (2000) (financial fraud perpetrated against Medicare providers is federally actionable).

believe that managed care is synonymous with a lack of choice and diminished quality of care. Under the typical fee-for-service arrangement, patients are not subject to an extensive “treatment justification” process before receiving services. However, to be fair, Medicare aside—a substantial majority of healthcare coverage in the United States consists of some sort of managed care system, and despite opposition, this trend does not seem to be slowing. Furthermore, with respect to home healthcare, if managed care were to become the default, a large number of agencies would become obsolete; and with heightened licensure and certification requirements like those set out in Florida’s HHC bills, many of the fraudulent and “sham” agencies could be excised from the program.

Additionally, the industry would benefit greatly from rules regulating which doctors may give signature approval for home health services. For instance, if only the primary-care physician has the authority to sign-off on the plan-of-treatment, there is more accountability on the part of the provider, and it is less likely that Medicare will be billed for services that are not medically necessary, or for which the patient does not meet applicable criteria. Further, with regard to patient services, continuity of care is best served by requiring approval of the primary care physician.

Now, with the Obama Administration’s healthcare reform bill on the horizon, effective and legitimate Medicare payments are an even more pressing concern. The plan will procure funding for new programs, in part from \$500 billion in savings accumulated from cuts in Medicare programs over the next ten years—\$50 billion of which will come directly from home healthcare.¹¹ Although many feel that home care saves money and improves quality for the patient; without these budget savings, there will be fewer public healthcare dollars for new programs. Essentially, seniors worry they will lose portions of their Medicare coverage in order to provide for the uninsured.

The reform bill attempts to protect against this by including provisions for eliminating fraud and abuse within Medicare and Medicaid programs. However, as discussed earlier, legislative controls are only one piece of the puzzle. Without improved enforcement bodies to ensure cooperation with the new regulations, laws aimed at eliminating fraud are essentially worthless. Therein lies the appeal of the managed care system; the top-down investigative structure acts as a “gatekeeper.” Returning to the Fort Knox analogy, a managed care system’s claims analysis process is equivalent to installing a high-tech alarm system and placing armed guards at the door. If it were your \$455 billion in the safe, I expect you might insist on such protocols to safeguard your investment—and incidentally, it is our \$455 billion, so we must to take the necessary steps to protect it.

11. Telephone Interview with Gene Tischer, *supra* note 4.

