HOME HEALTH AND HOSPICE MARKETING: SOME COMMON PRACTICES THAT SHOULDN’T BE SO COMMON

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By: Robert W. Markette, Jr.

As the home health and hospice markets become more and more competitive, providers continue to look for new ways to generate referrals, develop new referral relationships and further strengthen old relationships. If one competitor in the marketplace begins to use questionable marketing practices, other providers can feel pressured to follow suit or lose referrals. Unfortunately, this often leads to providers giving into pressure and engaging in questionable or illegal marketing arrangements.

At a time when the federal government has instructed the states to pursue Medicaid fraud more aggressively, it is extremely important for providers to understand how federal fraud and abuse laws restrict certain marketing practices. It is even more important for providers to have the courage to risk losing referrals rather than engage in inappropriate practices simply because everyone else is doing it. Providers need to educate referral sources regarding not only the illegality of certain practices, but the potential penalties for these practices.

Fraud and Abuse – Overview

There are a number of statutes, and accompanying regulations, addressing fraud and abuse in health care. These include, amongst others, the “Anti-Kickback” statute, Stark I & II, the Civil Monetary Penalties statute, and the False Claims Act. A comprehensive explanation of each law is beyond the scope of this article, but a brief overview is helpful.

False Claims Act

The False Claims Act is a Civil War era statute. In recent years, it has become the primary health care fraud enforcement tool of the federal government. This is a result
of two factors, the steep penalties provided for under the Act, and the Acts “qui tam” (pronounced “key tam”) provisions. The qui tam provisions of the statute allow employees and other “whistleblowers” to personally bring suits on behalf of the government and to keep a portion of the award. This provides an incentive for whistleblowers to come forward and file suits on behalf of the government. As a result of the actions of whistleblowers, more cases are pursued than would otherwise be possible.

The Anti-Kickback Statute
When the average person thinks of a kickback, they think of a bribe or similar inducement paid directly to someone, usually a government official, to influence the official’s conduct. This leads them to conclude that the “Anti-Kickback” statute prohibits similar bribes or kickbacks, but this is a mistaken understanding.

The Anti-Kickback statute prohibits a provider from offering, receiving, paying, or soliciting remuneration as an inducement to refer, or a reward for referring, services that are reimbursable under Medicare, Medicaid, or any other federally reimbursable program. At first glance, this statute appears to prohibit exactly what the average person would assume from the title. The statute is actually much broader than that for two reasons, the “one purpose test” and the definition of remuneration.

The One Purpose Test
Often a provider will give something to a referral source for more than one reason. For example, a nurse may bring a box of donuts with her to meet with a referring physician, because the meeting is occurring first thing in the morning. The nurse is doing this for a number of reasons. She may want to eat breakfast, but because she does not want to be rude to the physician, she brings a box of donuts with her. She probably also knows that giving the physician and his staff donuts will cause them to think highly of her and her agency, which will lead to more referrals. Under federal law, if even one purpose of the donuts is to induce referrals, it could be considered remuneration.

This is important to know, because it makes the Anti-Kickback statute very broad in its reach. The Anti-Kickback statute does not apply only to arrangements whose primary purpose is to induce referrals. It applies to any offer, payment, solicitation, or receipt of remuneration if even one of the reasons is to induce or reward referrals, no matter how many other reasons there may be for the remuneration. Just because your primary motivation may be legitimate, if the second, third, or one hundredth reason for the remuneration is to induce or reward a referral, it is a violation of this statute.

Remuneration
Of course, this begs the question, what is remuneration. The Anti-Kickback statute does not define remuneration, but the Department of Health and Human Services Office of Inspector General (“OIG”) applies the term remuneration to mean anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The Civil Monetary Penalty Statute
The Civil Monetary Penalty (“CMP”) statute confers authority to OIG to impose civil penalties upon individuals or entities who violate the statute. Because a civil penalty is civil and not criminal, you can be convicted for a criminal violation under the Anti-Kickback statute and still have civil monetary penalties imposed upon you, without violating the Double Jeopardy Clause of the United States Constitution.

Amongst other things, the CMP statute prohibits offering to or transferring remuneration to any Medicare or Medicaid beneficiary that the transferor knows or should know is likely to influence the beneficiary to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under Medicare or Medicaid.

Remuneration under the CMP
Unlike the Anti-Kickback statute, the CMP statute defines the term remuneration. Under the CMP statute, remuneration “includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value.” OIG has interpreted remuneration to exclude “incentives that are only nominal in value”. Incentives are nominal in value if they are worth no more than ten dollars ($10) per item or fifty dollars ($50) in the aggregate per year.

OIG applies this nominal value analysis to Anti-Kickback cases as well, meaning that if an item or service provided to a referral source is worth less than ten dollars individually or fifty dollars total for the year, giving the item to a referral source will not be considered a violation of the Anti-Kickback statute.
In other words, the nurse who provides the box of donuts to a referring physician is not providing an illegal kickback, if the box of donuts is worth less than ten dollars and if she has not provided fifty dollars worth of donuts to the physician in the previous year.

**Stark (Physician Self-Referral)**
The Stark laws prohibit physicians from referring certain designated health services to providers in which they or a relative have a financial interest. Home health services and hospice services are included amongst the designated health services. Financial interest includes more than just ownership. For example, if you pay a physician for services to your agency or hospice, the physician has a financial interest in your company.

**PENALTIES**
The penalties for violating these statutes can be quite severe. In most instances, a provider found to have violated these statutes will be required to pay back to the federal government an amount much larger than was received in reimbursement for the illegally obtained referral.

Violation of the Anti-Kickback law is a felony punishable by fines of up to $25,000 and up to five years in prison. Violating the Stark Law can lead to denial or reimbursement for the self referred service, being forced to refund money paid for the provision of the self-referred service, imposition of civil money penalties of up to $15,000 for each claim submitted after an inappropriate referral. Knowing violations of the Stark law may be punished by civil penalties of up to $100,000 and exclusion from Medicare, Medicaid, and other federal health care programs.

Violations of the CMP statute may be subjected to penalties of up to $10,000 per item or service and in some cases up to $50,000 per item or service as well as treble damages. Under the False Claims Act, the government can seek civil penalties of $5,500 to $11,000 per false claim. That means for each individual claim submitted to Medicare or Medicaid, the government can seek $5,500 - $11,000 in penalties. These penalties are in addition to the government’s damages. The False Claims Act also allows the government to recover up to three times its damages, again, this is in addition to the penalties.

Not only can the government seek to recover large sums of money from individuals and entities who violate the fraud and abuse laws, the government has other means of penalizing violators. If a provider is convicted of program related crimes, patient abuse, felony health care fraud, and other certain offenses, the government may exclude the provider from participating as a provider in Medicare, Medicaid or other federal health care programs. This means that the excluded individual or entity is no longer eligible to provide services through or to receive reimbursement from any federal health care program. The government can also terminate a violating provider’s provider agreement or set aside money to which the provider is entitled to protect against future abuses.

As you can see, violating the fraud and abuse laws is very dangerous. If you are found to be in violation of these laws, you will, at a minimum, owe the government a great deal of money. Even worse, your days as a Medicare or Medicaid provider may be over forever. There are certain marketing practices that may provide increased referrals, but in the long term, providers who engage in these practices are far more likely to be subjected to penalties that set them back financially, if not ruin them completely.

For most home health and hospice providers, the two fraud and abuse statutes that have the most impact on relationships with referral sources are the Anti-Kickback Statute and the CMP statute. This is because Stark only applies to physicians and physician self-referrals. Thus a home health or hospice provider will only need to worry about Stark if they are receiving referrals from a physician who has a financial interest in the entity.

**EXAMPLES OF MARKETING PRACTICES THAT VIOLATE THE FRAUD AND ABUSE LAWS**

With a little background in place, we shall now review a few arrangements to see how they fare under these laws.

**Sending Your Staff to Help a Referral Source for Free**

This situation can come up in a number of ways. A home health agency might send a nurse to a referring physician’s office to help them complete their paperwork to obtain reimbursement. A hospice may provide staff to a nursing facility to perform duties that would otherwise be performed by nursing facility staff. In these situations, the staff is provided to the referral source for free.
If you provide staff for free or below fair market value to a referral source to perform the duties normally performed by the referral source’s staff, you are providing them with something of value – staff. If even one reason for providing this staff is to induce referrals, you are in violation of the Anti-Kickback statute. In addition to condemning this practice in fraud bulletins, OIG has issued a number of advisory opinions reiterating this position.

In one opinion, a lab was providing a phlebotomist to a physician’s office to “collect samples” for the lab. The phlebotomist also performed routine administrative and medical tasks normally performed by the physician’s staff. The OIG stated that to the extent the phlebotomist was providing additional clerical services that benefited the physician, it created a “strong inference” that the phlebotomist was providing those office services as an inducement for referrals.

In another lab case, a lab provided lab equipment and lab assistants to a dialysis facility for free. OIG again noted that providing the staff and equipment to the referral source at no cost to the referral source was a “tangible benefit”, because it eliminated the facility’s need to provide the equipment and staff and thus eliminated its costs to provide these services. OIG also noted that the facility was being paid to provide the services.

Another arrangement that can come up is providing a referring physician with a cellular phone, Blackberry, or similar communications device. This may be done to “improve communications” with the referral source. However OIG has issued opinion letters on several similar arrangements.

For example, OIG has found providing free office equipment or computers to referral sources a similarly suspect practice. Providers have attempted to justify such arrangements as necessary for communication or dedicated to a particular service. OIG has found that because the office equipment can be used for the referral source’s day to day operations and not just for communication with the supplying provider, it has tangible value to the referral source. The value is that they do not have to pay for that particular piece of equipment. Therefore, it may be a prohibited inducement in violation of the Anti-Kickback statute.

This prohibition applies to providing free services and equipment. A provider may provide staffing to a referral source if the arrangement is structured to meet what is known as the personal services safe harbor to the Anti-Kickback law. A safe harbor is an exception to the Anti-Kickback statute. If an arrangement fits into a safe harbor, it is not a violation of the Anti-Kickback statute.

OIG has been very clear on its view of these types of arrangements – they are suspect. Providing free staff or equipment to a referral source is remuneration provided to a referral source. A provider would be hard pressed to convince OIG that this was not a violation of the Anti-Kickback statute.

Providing Care Covered by the Nursing Per Diem
OIG has long been concerned about the potential for fraud and abuse in relationships between nursing homes and hospices. As far back as March of 1998, OIG issued a special fraud alert regarding potential fraud in hospice relationships with nursing homes. A hospice may be providing care to an individual who lives in a skilled nursing facility and be pressured by the nursing facility to provide care that is considered part of the skilled nursing facility’s responsibilities. A hospice may be pressured to pay for services covered by the skilled nursing facility per diem. A hospice may also feel pressured to provide free staffing to the skilled nursing facility.

In each of these cases the nursing facility receives a benefit. If the hospice is providing care to a nursing facility patient that is part of the nursing facility daily rate, the hospice is effectively providing free staff. The nursing facility receives a daily rate from the hospice to provide specific services to the hospice patient. When the nursing facility requires the hospice to provide the care covered by this daily payment, the nursing facility is relieved of the costs of providing the services now provided by the hospice. Essentially, the hospice is providing free staff to the nursing facility.

If the hospice is paying an additional amount for services that are covered by the daily rate payment, the facility is being paid twice to provide a service. This is another benefit to the facility. If even one reason these are being done is to induce referrals, it is a violation of the Anti-Kickback statute.

Providing Continuous Care to Patients in the SNF
Some hospices provide continuous hospice care to patients residing in a skilled nursing facility at the request of the nursing facility. Even if the hospice is hesitant to do so, they feel pressure from the nursing
facility and may respond, because of a fear they will lose referrals if they do not agree to provide this level of care.

There are a number of ways that this might happen. The hospice may provide staffing at a continuous care level to the patient who is approved for regular care and absorb the additional costs. Alternatively, the hospice may provide the care and submit claims for continuous level care to Medicare.

If the hospice is providing continuous care to a patient that does not qualify for continuous care, at a minimum they are providing a free service to the hospice beneficiary and to the nursing facility. The benefit to the nursing facility is that the hospice is “staffing” the resident’s care. The hospice is providing care the nursing facility is supposed to be providing under the nursing facility per diem. This is being done to keep the referrals coming and is, therefore, a violation of the Anti-Kickback statute.

The situation for the hospice is even worse if the hospice is billing for continuous care for a patient that does not qualify. In this situation, the hospice is now intentionally submitting false claims. This opens the hospice to even greater liability. Each claim submitted is fraudulent.

The provider may be prosecuted criminally for wire fraud or mail fraud as well as sued civilly under the False Claims Act. In addition, the hospice and its owners and management would almost certainly be excluded from ever participating in Medicare again.

Taking Referral Sources out to Dinner and Other Perks

Providers like to acknowledge their relationship with good referral sources and thank them for the patients they send to the provider. These acknowledgements can include dinner at a nice restaurant, tickets to a play or sporting event, or other items to say thanks. It can also include candy, wine, coffee or any number of gifts sent at Christmas time.

For health care providers, acknowledging customers or referral sources with a gift is a violation of the Anti-Kickback statute. The gift is an item that has some value. The provider is giving the item as a reward for the referrals provided or as an inducement for future referrals. Providing anything of value as a reward for referring reimbursable care is strictly prohibited by the Anti-Kickback statute. Providing items of value to patients as an inducement to select the provider for reimbursable services violates the CMP statute. Because this would violate either the Anti-Kickback or CMP statute, you must be careful providing gifts to referral sources or to patients.

Providers can give small gifts, because, as discussed earlier, OIG has stated that if the item is of “nominal value” OIG will not prosecute the violation. OIG has interpreted the phrase nominal value to mean less than $10 per item and $50 in the aggregate annually. The $10 nominal amount limit is less than the value of many common business gifts. This means that Medicare providers will not be able to give them and stay within the nominal amount exception.

For example, a provider would be hard pressed to take a referral source to dinner for less than $10, unless the dinner was at McDonalds. Similarly, providing a referral source or client with tickets to a sporting event, play, or other form of entertainment would almost certainly exceed the nominal amount threshold.

When considering gifts or Christmas treats for referral sources, keep the $10 amount in mind. Similarly, if you have referral sources to whom you give items more than once a year, keep the annual aggregate amount in mind. If you stay below these numbers you will technically be in violation of the statutes, but OIG has clearly stated it will not prosecute these violations. Because it is not clear how far above these numbers OIG will continue to withhold prosecution, when you exceed the nominal value threshold, you cannot assume OIG will continue to ignore the gift.

Paying Bonuses for Referrals

Home health and hospice agencies often employ one or more marketing staff persons. The marketing staff is expected to generate referrals for the agency or hospice. Many providers that employ marketing staff offer bonuses to these employees. This provides an incentive to the employees to generate more referrals.

This may be an acceptable marketing practice, depending upon the relationship between the provider and the marketing personnel. If the personnel are “bona fide employees”, the payment of a bonus linked to the volume or value of referrals generated is acceptable. This is because the Anti-Kickback statute contains a specific exception for payments made to bona fide employees. A bona fide employee means an employee who meets the
IRS definition of an employee. If an individual qualifies as a bona fide employee, any payment to her is not considered remuneration under the Anti-Kickback statute.

Paying referral bonuses to individuals who are not bona fide employees violates the Anti-Kickback statute. For example, a hospice provider might pay a nursing home employee fifty dollars per patient referred to the hospice by the nursing home employee. The hospice is providing something of value to an individual, a payment of fifty dollars. This payment is being offered as an inducement to refer or a reward for referring reimbursable services. Because the bona fide employee exception does not apply to other providers’ employees, each payment is a violation of the Anti-Kickback statute.

Free Services to Beneficiaries

The issue of free services to beneficiaries can arise in a number of settings: a health fair, the patient’s home, a nursing facility, etc. Going back as far as 1995, OIG has commented that offering free services to beneficiaries as an inducement to choose or switch providers is a violation of the Anti-Kickback and CMP statutes. OIG has issued a number of opinions regarding the provision of free items or services to beneficiaries and in almost every instance, the free items or services to beneficiaries were found to be a violation of the fraud and abuse laws.

One recent opinion from OIG addressed the provision of free home safety assessments to Medicare beneficiaries. The free safety assessment is an offer to a client of a free in-home or over the telephone evaluation of the home’s appropriateness for home health care. Usually this service is offered to patients who will be undergoing surgery or have some other need for home health care in the immediate future. The assessment is often preceded by a referral from the patient’s physician or surgeon, but in some cases, the patient simply receives a call from an agency.

Providers have argued that this type of assessment is good for a number of reasons, including that it can improve clinical outcomes, because the physician knows before the surgery that the patient can go home for recovery. This eliminates delays that can result when an agency determines the patient’s home is not an appropriate environment for recovery, while admitting the patient who has just returned home.

Nevertheless, OIG has taken the position that these “assessments” are an unlawful inducement. Given OIG’s longstanding position, the conclusion that an in-home safety assessment was a violation was not surprising. The value of the in-person assessments was obviously more than nominal, as the agency was reimbursed more than $10 for providing it.

OIG’s treatment of the telephonic safety assessments provides some new insight into OIG’s position. These telephonic assessments cost the agency less than ten dollars to provide, but OIG still concluded that the telephonic safety assessments had more than nominal value. OIG focused on the “value to the beneficiary”, not just the agency’s costs in providing the assessment.

The value to the beneficiary results from the physician’s referral, the way the service was provided, and the appearance that the assessment could lead to a better surgical outcome. These factors would lead a “reasonable beneficiary” to conclude even the telephonic assessment was a valuable medical service. This means the either form of assessment has value and led the OIG to examine whether it was an inducement.

In addressing whether the assessment would lead the beneficiary to select a particular provider, the OIG noted that the patient’s physician referred the patient to the agency which would lead the patient to conclude the physician would recommend the agency for post-operative services. Furthermore, the assessment provided the agency an opportunity to initiate a relationship with the patient and this opportunity was maximized because the assessment was provided for free. Initiating this relationship was likely to cause the patient to choose the agency for future home care needs, because the agency was familiar to the patient and the patient was likely to choose the agency with which she was already familiar.

OIG concluded by noting the structure and operation of the arrangement appeared calculated to generate postoperative referrals. For this and other reasons, OIG concluded that the agency should know that the free assessment would lead to future referrals.

The fact that a patient is likely to choose the more familiar provider is one that most providers will agree with. Many marketing efforts are designed to create that familiarity. A key reason to perform the safety assessments is to initiate a relationship with the patient, which would lead to future referrals.
Because the notion that a patient is likely to choose the agency with which she is already familiar is not a surprise to any provider, the important point with free services is OIG’s assessment of their value based upon the patient’s perception.

The point here is that even if the actual value of the service is nominal, the services will likely still be considered remuneration. Because the patient will usually perceive home health care to be valuable and as a result of receiving the free home health care, the agency providing the care will be more likely to receive future referrals. Given the recent OIG opinion and its longstanding position on offering free items or services to beneficiaries, a provider should be very hesitant to provide free items or services to a patient.

**Special Case – Health Fairs**

Many providers are concerned that if a telephonic assessment is a violation, then the OIG prohibition on free services eliminates their ability to put on health fairs or attend health fairs and provide free blood pressure checks, etc. There are a few key differences between free in home or other health services and blood pressure checks at a health fair that lead the author to conclude that health fairs are still allowed.

The biggest difference is the actual value of the blood pressure check compared with the in home services. An agency will pay its staff to sit at the fair and provide blood pressure screenings for the entire day. During that day they will give dozens of blood pressure checks. The cost to the agency for each check is less than $10. This fits into the nominal value interpretation put forth by OIG.

Of course, OIG has made it clear that the beneficiary’s perception of value can make a low cost service a “substantial” service. Unlike pre-operative assessments and other in home health services, the circumstances surrounding the provision of the blood pressure check at a health fair are not likely to provide the appearance of value to the individual. There is no referral, no upcoming procedures, no indication that receiving this blood pressure check will affect any health care outcomes, and the vital signs check at a health fair does not create the same relationship as providing in home services.

Furthermore, persons receiving the blood pressure screening do not have the same concrete need for home care in the immediate future. The home services patients were all preparing for surgery and would be in need of home care within a matter of a few days to a few weeks. The health fair visitors may need home care down the road, but the need is neither immediate nor obvious. It could be months or years before a health fair attendee requires home health or hospice services, if they ever need them at all.

**Multiple Medical Directors or Overpaying a Medical Director**

It is not uncommon for a hospice or a home health agency to have a medical director. The conditions of participation even contemplate having a medical director. Most agencies will contract with a physician to provide medical director services. This makes the medical director “financially interested” in the agency. Because the physician is financially interested, the Physician’s relationship with the agency or hospice must comply with the Professional Services Safe harbor to the Stark law.

If the Physician’s Relationship fits into this safe harbor, the medical director may refer patients to the agency for which he provides medical director services. In order to comply with the safe harbor, the physicians contract must meet specific requirements. One of these is that the medical director be paid “fair market value.”

There are a number ways fair market value can be calculated, but the key concept is the value negotiated between parties at an arms length transaction. This should be carefully calculated, because OIG has commented that one fraud situation of special concern to it is disguising referral fees as salary paid to a physician for services not provided or paying the physician an amount more than fair market value.

Obviously, a physician may feel more comfortable referring business to an agency that he has a relationship with and which he knows from first hand experience is providing quality care. Because of the potential for referrals from medical directors, some agencies go a step further and contract with multiple medical directors. Often this is done so that the agency has a medical director associated with a number of physician practice groups, thus broadening the potential sources of referrals.

However, this is not a situation in which the adage “if one is good two are better” applies. The agency should have a legitimate need for multiple medical
directors. If an agency or hospice does not have a legitimate need for multiple medical directors, the agency or hospice is either paying for services that are not provided or paying for services that are not necessary.

If the medical director is being paid to provide medical director services that are never provided, the arrangement is a violation of the Anti-Kickback statute. If the physician is being paid, but is duplicating the efforts of another medical director, you are, in effect, paying him for services you do not need. If you are paying him for services you do not need, it is hard to make an argument that you are paying fair market value. This would also violate the fraud and abuse laws.

Similarly, if you are paying your medical director more than fair market value, you are violating the fraud and abuse laws. In each of these examples, OIG will suspect that the payments are being made not for services rendered but for referrals provided. This would lead to prosecution by OIG.

OTHER QUESTIONABLE MARKETING OR REFERRAL PRACTICES

Patient Steering
Some providers have found that referral sources are directing patients to particular agencies or hospices. This can happen in many ways. A patient may receive a call from an agency stating that the patient’s physician has chosen this agency for them and they must accept that choice. A home health or hospice patient may go into the hospital, but upon discharge be referred to a different provider without ever being allowed to choose to return to the agency she was at previously. There are many ways unscrupulous providers will steer patients towards themselves or towards a particular provider.

Patient steering is not a fraud and abuse problem. It is, however, a violation of a patient’s right to choose her provider. Indiana law guarantees patients the right to choose their provider. Interfering with this choice or limiting this choice is a violation of the patient’s rights and state law. This is a difficult practice to combat, because in many cases it is difficult to prove. One way to combat patient steering is education.

Patient Education
The patient needs to be aware that her choice of providers is not controlled by her physician, hospital, or other providers, but by her. If you have a patient admitted to a facility that will be readmitted to home care later, be sure to let her know that she has the right to return to your agency, regardless of what she may be told by another provider. You could even provide her or her family with your agency’s contact information so that she could inform you when she is ready for services to resume.

Provider Education
If you identify certain providers who are engaging in patient steering, you can also try to educate them. You can explain to them that the patient has a choice and that choice is guaranteed by Indiana law. Furthermore, the Conditions of Participation require providers to abide by state law, violating state law can lead to findings in a survey.

For some providers, such as hospitals, violating patient choice is also an issue for discharge planning. Upon discharge, providers should be informing patients they have a choice of providers, not simply steering them towards a favored provider.

If education does not work, you can file a complaint with the State Department of Health regarding the violation of the patient’s right to choose. Providers have been cited for steering patients in the past.

CONCLUSION

There are many ways to market your agency or hospice without violating federal law. There are many more ways to market your agency that violate federal law.

In the short term, some of these illegal arrangements may seem like a good idea, because of the potential for quickly generating new referrals. That attitude is “pennywise, but pound foolish”. While in the short term you may benefit, when you are caught, the penalties for the violations, including potentially being excluded from participating in federal health care programs, will put you out of business, if not in jail. When presented with these types of opportunities, decline them and explain to the offeror that they are clearly illegal. They may find someone else to participate, but you will have avoided a grave mistake.

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