

## Beware of Latent Fraud and Abuse Problems in Assisted Living

By Mark Stadler

**T**he detection and prosecution of fraud and abuse is a high-ranking priority in the Medicare and Medicaid programs. Seemingly every day another story appears in the press chronicling the imposition of significant fines and penalties against an unsuspecting provider which ends up financially crippled or out of business. The rate of criminal fraud prosecutions in healthcare has more than tripled over the past five years. For the most recently completed fiscal year, the government's civil and criminal healthcare fraud prosecutions have netted in excess of one billion dollars in judgments, settlements and fines. In an effort to confront this onslaught, providers are rushing to adopt and implement regulatory compliance programs to prevent fraudulent conduct, or to at least minimize penalties where fraud is discovered.

How does this industry-wide focus on fraud affect assisted living facilities? Given the fact that these facilities do not routinely participate in the Medicare and Medicaid programs, one might assume that assisted living facilities are isolated from the fraud fray. This is clearly not the case. The fraud investigators view assisted living facilities as a breeding ground for fraudulent conduct.

It is true that assisted living facilities (as primarily private pay entities) are somewhat immune from the more obvious and common healthcare fraud prosecutions, i.e., filing claims for services not rendered, inflating or upcoding claims, filing false cost reports, failure to adequately document claims and the like. This area has clearly generated the most activity from a fraud and abuse



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At another level, however, the activities of assisted living facilities are fraught with danger from a fraud and abuse prospective. The primary concern here is conduct which can be viewed as violating the various anti-referral rules applicable to all facilities or individuals having any relationship with the Medicare and Medicaid programs. These rules generally prohibit the payment or receipt of any benefit in return for the referral of a Medicare or Medicaid patient. The courts have interpreted these rules broadly. Any payment or benefit provided to a referral source and intended to induce referrals is suspect. Both the payor and the recipient of these benefits are subject to significant civil and criminal penalties (including imprisonment).

The anti-referral rules pose great risks especially for those new to the healthcare industry or unfamiliar with the intricacies of the Medicare and Medicaid programs. Many business practices that would not even raise an eyebrow of suspicion in other industries can give rise to severe consequences in the healthcare market.

Assisted living facilities are at particular risk here because they are viewed as controlling or having a certain amount

standpoint. Since assisted living facilities do not routinely file Medicare and Medicaid claims and/or cost reports, they have little exposure here.

of authority over a resident population comprised of substantial consumers of services covered by Medicare, i.e., the services of physicians and other practitioners, home health companies, hospitals, durable medical equipment companies, etc. Any payment or benefit received by an assisted living facility in return for giving these service providers access to this resident population has the potential to create significant fraud issues.

Some, not totally hypothetical, examples of problem areas are as follows:

- A homecare company provides certain services free of charge or at a reduced rate to residents in an assisted living facility. These services encompass items that the assisted living facility might traditionally provide to its residents (i.e., housekeeping, aid type services). The expectation of the homecare company is that the facility's residents will choose the homecare company as their provider of Medicare reimbursable homecare services, if and when the need arises for such services. The federal fraud-busters have taken the position that the homecare company's provision of these free or reduced charge services constitutes the provision of the benefit in return for the referral of Medicare business.
- A group of therapists rents space at an assisted living facility. The rent paid for this space is in excess of fair-market value, i.e. more than the therapists might be expected to pay if the space was not located in an assisted living facility. From a fraud standpoint, the excess rent paid to the assisted living facility is an inducement to the facility

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to channel patients to the therapists for their Medicare reimbursable therapy needs.

- A physician provides free assessment services at an assisted living facility in return for recognition as a facility endorsed preferred provider of certain services. The free services provided by the physician will be viewed as a benefit provided in return for referrals of or access to Medicare patients.
- An assisted living facility or its owners acquire an interest in a DME company which serves the needs of residents at the facility. Any profit distribution from the DME company to the facility or its owners might be found to constitute the payment of a benefit to encourage the facility to refer its residents to the DME company.
- The assisted living facility receives free or discounted services from a nearby hospital in return for being recognized as the hospital of choice whenever a resident requires emergency care or other hospital services. The services provided by the hospital could be viewed as encouraging referrals.

Although the prosecution of anti-referral cases has not been high on the list of priorities for fraud prosecutors, all of these arrangements do pose significant risks. You can avoid these risks by implementing certain procedures and safeguards:

Approach with caution all relationships with entities or individuals who provide services for which payment can be made under the Medicare or Medicaid program.

If at all possible, structure these relationships so that they fit within the various exceptions or “safe harbors” which are built into the anti-referral rules. This generally entails the development of written agreements ensuring that fair market compensation will be paid for all services provided. Under most circumstances, percentage based compensation should be avoided. In the second example above, the Medicare program would take an extremely dim view of a lease arrangement under which the therapists paid rent which was based upon the number of patients the therapists treated at their office at the facility or the amount of revenue generated

from the facility’s residents.

If the relationship cannot be made to conform with one of these exceptions or safe harbors, consider securing a ruling regarding the propriety of the relationship.

If neither of these alternatives are possible, you must recognize that the relationship will put you at risk under the anti-referral rules. Before proceeding to implement the relationship you should consult with counsel to fully understand the risks involved and carefully weigh these risks against the anticipated benefits of the relationship.

By understanding where you can get in trouble from a fraud and abuse standpoint and taking a few steps to avoid problem areas, you might save yourself from a significant and totally unsuspected fraud prosecution having the potential to do grave damage to your facility.

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✉ For more information, please contact [mstadler@cohenlaw.com](mailto:mstadler@cohenlaw.com)

## NLRB Deals a Blow to Physician Unionization Efforts

On May 24, 1999, the Regional Director for Region Four of the National Labor Relations Board (“NLRB”) rejected a petition from the United Food and Commercial Workers Local 56 seeking to represent approximately 650 physicians associated with AmeriHealth HMO, Inc./AmeriHealth, Inc. in collecting bargaining with AmeriHealth, a wholly-owned subsidiary of Independence Blue Cross of Philadelphia.

John E. Lyncheski and W. Scott Hardy have been closely watching this case, as well as other developments in this emerging legal battleground. While this decision is a setback for physicians’ organizing efforts, the Regional Director based her decision on the specific relationship these physicians had

with AmeriHealth, so the door is still open — and the threat remains — for other physicians in HMO-type relationships to seek union representation. The NLRB ruled that the doctors in this case were not “employees” of AmeriHealth, but rather were independent contractors even though AmeriHealth required its physicians to adhere to its detailed Standards of Service, its Site Standards for their office facilities, equipment, accessibility, safety practices and record-keeping, and its Patient Care Management guidelines, which controlled a wide variety of the physicians’ decisions about what services they may provide to patients pursuant to their existing contracts with AmeriHealth. Future decisions will turn on the facts of each case, and will depend on whether

physicians are so integrated with and controlled by an HMO-type insurer as to be considered “employees” who are privy to the protections of the National Labor Relations Act (NLRA).

John Lyncheski recently addressed the subject of physician union organizing at the American College of Healthcare Executives’ 42nd Congress on Healthcare Management in Chicago, Illinois and will be speaking on the topic again at the American Society for Healthcare Human Resources Administration of the American Hospital Association’s Annual Conference in New Orleans, Louisiana in July.

✉ For more information, please contact [jlyncheski@cohenlaw.com](mailto:jlyncheski@cohenlaw.com) or [shardy@cohenlaw.com](mailto:shardy@cohenlaw.com)