# Memorandum

**To:** File

**From:** Craig Ratner, Esq.

**Date:** 1/16/2018

**Re:** [redacted] Internal Investigation

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At your request, I conducted an internal investigation into Medicaid Fraud allegations made against your client, [redacted] Healthcare, LLC and [redacted] Primary Care, LLC (hereinafter jointly referred to as "[redacted]"), as set forth in two Statewide Investigating Grand Jury Subpoenas, dated [redacted] respectively, and a Search Warrant issued by the Honorable Thomas G. Gavin, Supervising Judge of the Thirty-Eighth Statewide Investigating Grand Jury ("Grand Jury"), and served on [redacted] on 11/09/2016. Specifically, the Search Warrant alleges the following three violations of Pennsylvania law:

1. **62 P.S. § 1407 (Provider Prohibited Acts)**

- Section 1407(a)(1) provides that it is unlawful to knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under the PA Medical Assistance program, or to knowingly present for allowance or payment any claim or cost report for medically unnecessary services or merchandise under the Medical Assistance program, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under the Medical Assistance program, or to knowingly submit false information for the purpose of obtaining authorization for furnishing services or merchandise under the Medical Assistance program.

- Section 1407(a)(2) provides that it is unlawful to solicit or receive or to offer or pay any remuneration, including any kickback, bribe or rebate, directly or indirectly, in cash or in kind from or to any person in connection with the furnishing of services or merchandise for which payment may be in whole or in part under the PA Medical Assistance program or in connection with referring an individual to a person for the furnishing or arranging for the furnishing of any services or merchandise for which payment may be made in whole or in part under the Medical Assistance program. (Although the Commonwealth of Pennsylvania does not have a state false claims act or state anti-kickback statute,

Sections 1407(a)(1) and (2) addresses both violations in state law specifically for the PA Medical Assistance Program.)

2. **Title 18 Pa.C.S.A. § 911 (Corrupt organizations)** – Section 911(b)(1) provides that it is unlawful for any person who has received any income derived, directly or indirectly, from a pattern of racketeering activity in which such person participated as a principal, to use or invest, directly or indirectly, any part of such income, or the proceeds of such income, in the acquisition of any interest in, or the establishment or operation of, any enterprise.

3. **Title 18 Pa.C.S.A. § 3922 (Theft by deception)** – Section 3922 (a)(1) provides that a person is guilty of theft if he intentionally obtains or withholds property of another by deception. A person deceives if he intentionally creates or reinforces a false impression, including false impressions as to law, value, intention or other state of mind; but deception as to a person's intention to perform a promise shall not be inferred from the fact alone that he did not subsequently perform the promise.

**Medicaid HCBS Waiver Program**

The Medicaid HCBS Waiver Program permits the Commonwealth to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. CMS gives the Commonwealth broad discretion to design its waiver program to address the needs of the waiver's target population. These waiver services complement and/or supplement the services that are available to PA Medical Assistance recipients.

The Pennsylvania Department of Human Services ("DHS"), Office of Long-Term Living ("OLTL") administers Medical Assistance programs that provide long-term services to older Pennsylvanians and adults with physical disabilities. In this capacity, OLTL manages the following six HCBS waivers that allow Pennsylvania to spend federal dollars on HCBS for individuals who would otherwise qualify for Medicaid-funded institutional care:

- The Aging Waiver – people who are over the age of 60
- The AIDS Waiver (over 21) – must have symptomatic HIV or AIDS
- The Attendant Care Waiver (18-59) – need minimal services
- The CommCare Waiver (21 and older) – have traumatic brain injury
- The Independence Waiver (18-59) – must have substantial limitations; cannot have intellectual disability or major mental health diagnosis
- The OBRA Waiver (18-59) – have a physical developmental disability (such as cerebral palsy) and substantial functional limitations

OLTL also manages the ACT 150 program, a state-funded program that provides HCBS to Pennsylvanians who are clinically eligible for nursing facility care but do not meet the financial eligibility test for Medicaid.

## [redacted] Participation in HCBS Waiver Program Managed By OLTL

Although [redacted] is both a licensed Home Care Agency ("HCA") and Home Health Agency, the vast majority of its business is conducted by [redacted] Primary Care, LLC as an HCA licensed by DOH to provide non-skilled Home Care Services – (i) personal care, (ii) assistance with instrumental activities of daily living, (iii) companionship services, (iv) respite care, and (v) specialized care (nonskilled services/activities unique to the consumer's care needs) – to individuals in their homes or other independent living environments pursuant to 28 Pa. Code §§ 611.1 – 611.57.

Since its inception, [redacted] has utilized its HCA licensure and employed DCWs to participate in the HCBS Waiver Program managed by OLTL, specifically the Aging, Attendant Care, Independence, and OBRA Waivers.

### Onsite Investigation

During an 11-day period from February 19 through March 3, 2017, I conducted an onsite internal investigation at [redacted]. The investigation included face-to-face interviews with 23 [redacted] employees in Intake, Case Management, Human Resources, Finance (Verification, Billing, and Payroll), Nursing, and Marketing. I also interviewed [redacted]'s Management and Administrative and Financial Leadership. During these interviews, employees explained the process of authorizing and delivering Personal Assistance Services to eligible consumers through the HCBS Waiver Program.

In addition to face-to-face interviews, I reviewed fifteen (10) complete consumer files, including complete copies of the first five (5) consumer files subpoenaed on 10/17/2016 and provided to the Statewide Investigating Grand Jury on 11/07/2016.

Likewise, I reviewed Time Sheets documenting DCWs' provision of home care services to roughly 50 consumers. (However, since the Grand Jury seized and currently retains most of [redacted]'s consumer files, I was only able to review a copy of the accompanying Service Authorization Form ("SAF") for these consumers.)

Finally, with the assistance of the Billing Department, I conducted a billing audit for 35 consumers (30 consumers chosen randomly using the OIG RAT-STATS random number generator plus the five (5) consumers in the files referenced above). This billing audit involved comparing DCW hours verified by the Verification Department against DCW hours billed through the PA Provider Reimbursement and Operations Management Information System ("PROMISe™") for two randomly selected weeks – one in 2015 and the other in 2016.

### Potential Reasons for Medicaid Fraud Allegations

Based on my investigation, I will evaluate the following potential reason(s) for the Medicaid fraud allegations brought before the Grand Jury against [redacted].

1. **Referral Bonuses** – Based on my interviews with [redacted] management and leadership, the practice of providing referral bonuses existed for certain marketing employees prior to December 2016. Specifically, these marketing employees received bonuses based on the number of eligible consumer SAFs they could generate for [redacted]. I asked for and received evidence of these referral bonuses in the form of QuickBooks™ entries reading "SAF Bonus," "Unskilled SAF Pay," and "Skilled/Unskilled Saf," According to these entries for the four-week period beginning 10/21/2016 and ending 11/18/2016, [redacted] paid referral bonus to marketing employees totaling $1,840. Extrapolating that total over the 33-month timeframe between 03/2014 (the month that the Search Warrant alleges the violations began) and 11/20016 (the month [redacted] ceased the practice of providing referral bonuses to marketing employees), [redacted] paid an estimated $60,720 in referral bonuses to marketing employees.

   As mentioned above, although the Commonwealth does not have a state anti-kickback statute, 62 P.S. §1407(a)(2) provides that it is a "Provider Prohibited Act" to pay any remuneration, including any kickback, from or to any person in connection with referring an individual to a person for the furnishing or arranging for the furnishing of any services or merchandise for which payment may be made in whole or in part under the Medical Assistance program. Based solely on Section 1407(a)(2), the referral bonuses that [redacted] paid to marketing employees could be characterized as a Provider Prohibited Act. Moreover, these same referral bonuses may also implicate the federal Anti-Kickback Statute ("AKS"), which makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program. 42 U.S.C. § 1320a-7b.

   Unlike PA law (62 P.S. § 1407), the AKS specifically excepts from its reach "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services." The AKS safe harbor regulations provide that the term "remuneration," as used in the AKS, does not include any amount paid by an employer to a bona fide employee for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare or a State health care program. Although there is no preemption provision in the AKS, since 62 P.S. §1407 does not specifically define the term "remuneration," it is reasonable to apply the above exclusion from the AKS safe harbor regulations.

   Notwithstanding the above regulatory argument, I suggest that [redacted] consider conducting the PA Medical Assistance Self-Audit Protocol (likely Option 2), the DHS voluntary protocol which enables providers to voluntarily come forward and disclose overpayments or improper payments of Medicaid funds. As mentioned above, [redacted] paid an estimated $60,720 in referral bonuses to marketing employees. Although these payments are not overpayments or improper payments of Medicaid funds from DHS to [redacted], they could be characterized as improper

payments of Medicaid funds from [redacted] to its marketing employees. By engaging in the Self-Audit Protocol, [redacted] would affirm the fact that the acts underlying the pre-December 2016 payment of referral bonuses to marketing employees are not fraudulent. Moreover, by engaging in the Self-Audit Protocol, DHS will not seek double damages, but will accept repayment without penalty.

2. **Prospective Billing** – Based on my interviews with [redacted] management and leadership, the practice of prospective billing existed for home care services provided by DCWs prior to March 2016. Specifically, [redacted] prospectively billed DHS through PROMISe for the total amount of approved home care services for a consumer in a given calendar month and backfill the billing for a small percentage of these services in the succeeding calendar month. [redacted] apparently engaged in this practice of prospective billing solely to ensure that the company could meet its payroll obligations for both office employees and DCWs. Moreover, as soon as [redacted] was notified that prospective billing may be in violation of state and/or federal law, the company (i) ceased the practice of prospective billing, (ii) engaged the services of a factoring company to finance its accounts receivable, and (iii) initiated the current policy of billing all verified hours within the same business day.

   As mentioned above, although Pennsylvania does not have a state False Claims Act, 62 P.S. §1407(a)(1) makes it unlawful to knowingly or intentionally present for payment any false claim for furnishing services under the PA Medical Assistance program or to knowingly submit false information for the purpose of obtaining greater compensation than that to which a person is legally entitled for furnishing services under the Medical Assistance program.

   Based solely on Section 1407(a)(1), [redacted]'s pre-March 2016 practice of prospective billing could be characterized as a Provider Prohibited Act. Likewise, [redacted]'s pre-March 2016 practice of prospective billing may also implicate the federal False Claims Act ("FCA"), which imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false.

   However, a person does not violate the FCA by submitting a false claim to the government; to violate the FCA a person must have submitted, or caused the submission of, the false claim (or made a false statement or record) with knowledge of the falsity. According to the FCA, "knowledge" of false information is defined as being (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the truth or falsity of the information. Therefore, a person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the FCA.

   If we apply the above referenced FCA "knowledge requirement" to both the FCA and equivalent state law (62 P.S. §1407(a)(1)), [redacted] did not engage in its

pre-March 2016 practice of prospective billing with "actual knowledge" that it was submitting false claims to DHS. More specifically, [redacted] did not have "actual knowledge" that prospectively billing for home care services may constitute a false claim under the FCA and/or a "Provider Prohibited Act" under state Medicaid law. As stated above, [redacted] engaged in the practice of prospective billing for the sole purpose of meeting its payroll obligations and subsequently discontinued the practice as soon as it was notified that prospective billing may be in violation of state and/or federal law. Therefore, [redacted] clearly did not act in "deliberate ignorance" or "reckless disregard" of the possibility that prospectively billing for home care services may constitute a false claim under the FCA and/or a "Provider Prohibited Act" under state Medicaid law.

Like the referral bonus issue, I suggest that [redacted] consider conducting the PA Medical Assistance Self-Audit Protocol (likely Option 2). Although [redacted] does not appear to meet the "knowledge requirement" to implicate the FCA and/or state Medicaid law, it's pre-March 2016 practice of prospective billing could nonetheless be characterized as improper pre-payment of Medicaid funds from DHS to [redacted]. Again, by engaging in the Self-Audit Protocol, [redacted] would affirm the fact that the acts underlying the practice of prospective billing are not fraudulent. Moreover, by engaging in the Self-Audit Protocol, DHS will not seek double damages, but will accept repayment without penalty.

As with the estimation of referral bonuses paid to marketing employees, [redacted]'s Billing department could potentially review a portion of billing records prior to March 2016 to determine the amount that it prospectively billed DHS for home care services and then extrapolate that total over the 23-month timeframe between 03/2014 (the month that the Search Warrant alleges the violations began) and 02/20016 (the month [redacted] ceased the practice of prospective). However, it may prove more difficult for [redacted] to estimate the amount it prospectively billed DHS because: (i) the Grand Jury currently retains most of [redacted]'s billing records, and (ii) according to [redacted] leadership, it lost a large portion of its billing records as a result of water damage from a 6/23/2015 flood. (I confirmed that the Philadelphia area did indeed experience a major rain storm on 6/23/2015).

3. **Overbilling/Double-Billing** – With the assistance of the Billing department, I conducted a billing audit for 35 consumers (30 consumers chosen randomly using the OIG RAT-STATS random number generator plus the five (5) consumers in the files referenced above). I compared DCW hours verified by the Verification department against DCW hours billed through PROMISe for two randomly selected weeks – 12/07/2015 through 12/13/2015 and 10/03/2016 through 10/09/2016. Since 30 of 35 current consumers were randomly selected for the audit, approximately half of these 30 consumers did not have any billing for the selected week in 12/2015. Regardless, for 100% of the paid bills for these two randomly selected weeks, the DCW hours verified by the Verification Department and billed though PROMISEe by the Billing department matched the amount paid by DHS for all 35 consumers.

Again, since the Grand Jury currently retains most of [redacted]'s consumer files, I was unable to view copies of the relevant time sheets for the 30 randomly selected consumers, but was able to view the billing data from PROMISe. Though, I was able to view copies of the relevant time sheets for the five (5) consumers in the files referenced above.

4. **Falsification and/or Alteration of Time Sheets** – The Verification department provided me with time sheets documenting DCWs' provision of home care services to roughly 50 consumers. Although the majority of these time sheets appear to be valid, I did notice instances where a consumer's signature may have been copied from a preceding time sheet or identical "Time In," "Time Out," and Total Hours appeared to be copied from day to day.

   Having spent several days observing employees in both the Verification and Billing departments, I believe that it would be extremely difficult, if not impossible, for Verifiers to scrutinize each DCW time sheet to ensure that it is valid. Instead, the Verifiers understandably rely on the good faith of DCWs to submit valid time sheets and consumers to report any problems or concerns with DCWs' provision of home care services.

   Verifiers also work closely with the Case Management department and each other to: (i) identify potential overlap of hours declared by two DCWs for the same consumer, (ii) perform "spot audits" of DCWs to confirm that they are accurately reporting their hours, and (iii) regularly call consumers to make sure that DCWs are providing the services that they are reporting. But, even with daily monitoring of DCWs, the Verification and Case Management departments must still must rely on the good faith of the DCWs and consumers.

**General Recommendations**

In 2016, [redacted] management took some very important steps to address current compliance issues and mitigate its risk against future issues – (i) hiring of a Controller in 06/2016 and the appointment of a new Administrator in 08/2016; (ii) ending certain business practices (referral bonuses and prospective billing); (iii) implementing new policies (billing verified hours on same business day). Below are some additional recommendations:

A. Establish Robust Compliance Program Adhering to Seven Elements of an Effective Compliance Program (critical elements are bolded)

   1. **Implementing written policies and procedures**

   2. **Designating a compliance officer** and compliance committee

   3. **Conducting effective training and education**

4. Developing effective lines of communication
5. Conducting internal monitoring and auditing
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected problems and undertaking corrective action

B. Establish More Robust HIPAA Privacy and Security Policies and Procedures (i.e., eliminate consumer names on video monitors, employees should only be reviewing consumer files if it's part of their job responsibilities, DCWs should only be allowed to access certain areas when onsite)

C. Update All HIPAA forms for consumers and employees

D. Require original consumer and employee signatures on all time sheets.

E. Keep a log of all shredded documents

F. Maintain offsite electronic backup of all consumer files and billing records

G. Maintain open communication with DHS, specifically OLTL and the Bureau of Program Integrity.

H. Update Employee Handbook to include a section on Fraud, Waste, and Abuse (FWA) and HIPAA compliance

I. Update web site to include a Compliance section.