HOSPICE ENFORCEMENT UPDATE

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Program Overview

- Trends in enforcement: 2014-present
  - Who is initiating enforcement actions?
  - What types of actions have been initiated?
  - What are the substantive issues and bases for enforcement?
  - Future trends and issues.
- Today’s compliance issues may be tomorrow’s enforcement issues.

Trends

- Increase in Number of Hospice Providers and Medicare/Medicaid expenditures on hospice
  - CMS Use of Moratoria for Home Health Agencies
- Recovery of Overpayments in General
  - Part D and other Duplicate Payments
- Aggressive Pursuit of Fraud and False Claims Violations
Trends

- More Whistleblower Suits
  - Reason: ACA relaxed the standards for whistleblowers to prove violations and increased the share of recovery for whistleblowers.
  - Almost all Hospice cases have been whistleblowers.
- State Actions Parallel to Federal
- Some Reorganization of Enforcement Entities

U.S. DHHS OIG Report

- Requested $400 million for OIG, including OIG/DOJ (HEAT) initiatives and Medicare/Medicaid Program Integrity efforts. In FY 2013:
  - 84 percent of OIG efforts were dedicated to Medicare and Medicaid oversight.
  - $5.8 Billion in total investigative and audit recoveries (up 24% since FY 2009)
  - 3,214 individuals and organizations excluded
  - $8 to $1 Return on Investment for Health Care Fraud and Abuse Control program.
  - 1,660 FTE staff in 80 cities (35% investigations; 42% audit)

U.S. DHHS OIG Report - 2013

- 960 criminal actions against individuals or organizations, including fraud.
- 472 civil and administrative actions, including fraud, false claims, self-disclosures, civil money penalties.
  - $18M in CMPs imposed during FY 2013 (up 34% since 2009)
- 39 CIAs (corporate integrity agreements) in FY 2013
  - Compliance obligations negotiated as part of a settlement of a civil or administrative fraud or false claims action. Alternative to EXCLUSION. Typically 5 years monitoring, and penalties for failure to meet terms.
OIG Proposal to Extend CMPL

- Proposed Rule published in Federal Register
  - Implementing ACA and expanding OIG’s authority
- OIG can already impose civil monetary penalties on, make assessments against, and exclude organizations/individuals for fraud, false claims, improperly influencing providers, kickbacks, etc.
- Proposed rule broadens authority and adds new grounds for CMP, assessments, and exclusion, including:

CMPL, cont’d.

- Failure to Grant [the OIG] Timely Access to Records.
  - Produce records or provide compelling reason why production cannot be made, by deadline in OIG’s written request.
  - If OIG believes records will be altered or destroyed, must produce at the time of the request.
  - Up to $15,000 per day for each day, plus possible exclusion.
- Ordering or Prescribing While Excluded.
  - $10,000 per violation, 3x amount of the item/service, + exclusion.
- False Statements, Omissions, or Misrepresentations in Enrollment Applications or Other Documents.
  - Up to $50,000 per statement, 3x amount of claim based on false statement/omission, or misrepresentation, + exclusion.

CMPL, cont’d.

- Failure to Report and Return an Overpayment.
  - Already required to return within 60 days.
  - Penalty of up to $10,000 per day for each overpayment not reported and returned.
- Making or Using a False Record or Statement that is Material to a False or Fraudulent Claim.
  - Up to $50,000 for each false record + exclusion.
CMPL – Additional Provisions

- Aggravating Circumstances, Penalty and Exclusion.
- Clarifies OIG’s Express Authority – from HHS Secy.
- Medicare Advantage and Part D Organizations.
- Mitigation for Self-Disclosure
- Dollar Thresholds for Mitigation and Aggravation:
  - Under $5,000 = mitigation and over $15,000 = aggravation
  - Separately billable – employer liable for penalties & assessments based on number and value of services.
  - Bundled – employer liable for penalties based on number of days employed, plus assessments based on costs to employer.

DOJ Efforts under FCA

- DOJ adopts policy initiative (based on existing practice) re-asserting commitment to pursue FCA cases.
- Will pursue both civilly and criminally against health care fraud, through:
  - Increased communication between DOJ Civil and Criminal fraud divisions;
  - Specialized Criminal Fraud section;
    - Streamlined investigation process.
    - 100 attorneys.
    - Members will immediately review qui tam (whistleblower) FCA actions to determine whether to open a parallel criminal case
- Use of FCA.

Oversight of Enforcers

- July 2014 Report - GAO reviewed claims review processes of:
  - MACs – process any pay claims
  - RACs – postpayment review
  - ZPICs – investigate potential fraud
  - CERT Contractors – reviews claims used to annually estimate Medicare improper payment rate.
- To assess efficiency, effectiveness, and burden on providers.
Oversight of Enforcers

Findings:

• CMS database designed to prevent duplication was not able to prevent all duplication, and contractors were not consistent in entering information.
• CMS did not provide sufficient oversight of the data or provide guidance to contractors on avoiding duplication.
• Contractors’ compliance with communicating provider’s rights was varied.
• Inconsistent coordination between ZPICs and RACs in the same geographic areas.

• Report at GAO-14-474 (July 2014)

ZPICs

• New UPICs = Unified Provider Integrity Contractors
  • Medicare ZPICs + Medicaid MACs
• MACs will remain, but their integrity functions will be folded into UPICs.
• UPICs to pick up some work of PSCs and MICs.
  • MICs to be phased out
• CMS also to consolidate all Medicare and Medicaid data into unified database.

RACs – 2013 Action

• “Paused” in advance of procuring new RAC contracts.
• US House requested HHS to immediately reform RAC program.
• Problems cited include:
  • Persistent operational problems
  • Resources spent in appeals process (time and $$$)
  • 72 percent of hospital appeals overturned.
  • Increase in appeals and backlog of appeals
  • OMHA suspended assignment of ALJ appeal hearing for 2 years due to dramatic increase in number of appeals.
OIG Press Releases – FCA Cases

- Hospice Few False Claims Act Cases Overall, compared to other provider types.
- Vast majority initiated by whistleblowers (all former employees).
- All involve some combination of DOJ, Local US Attorney Offices, and HHS OIG, FBI.
  - More communication, coordination, and integration of efforts...
- Some settled ($ fines) + Corporate Integrity Agreement
- Many cases still pending.

Vitas Hospice (Chemed) - Update

- FCA Suit Alleging Fraudulent and False Claims
  - Admission of patients not terminally ill.
  - Submission of claims for CHC services not medically necessary.
  - Set goals for number of CHC days billed.
  - Aggressive marketing of CHC to patients.
  - Pressured staff to increase CHC claims without regard to patient need.

Vitas - Update

- Set monthly admission/census goals.
- Bonuses paid based on number of admissions and LOS.
- Punished staff for failing to meet admission goals.
- Physicians reportedly felt pressured.
- Discouraged discharges even when patients were no longer hospice eligible.
- CHC billing statistics out of line with averages, per DOJ
Vitas - Update

- Vitas denies allegations and will vigorously defend. Status (2/18/15):
  - Consolidation of Cases (60)
  - Amended Complaint and Responses.
  - Discovery ongoing – Interrogatories, Two requests for document production.
  - Requests for protective orders for confidential information, several depositions, withdrawal of attorneys.
  - Pretrial Conferences, Numerous Motions for Extensions of Time, Additional Appearances.
  - Several Motions to Dismiss – one for failure to state a claim
  - Mediation Deadlines and Relief Requested
  - Motion for Protective Order to Manage Ex Parte Contacts with Former Employees.

AseraCare Hospice - Update

- (Alabama) Whistleblowers/Qui Tam (FCA) – relators were former employees. Allegations:
  - Submitted claims to Medicare for hospice care for patients who were not terminally ill.
    - Many Non-cancer Patients
  - Pressured staff to admit/retain ineligible patients.
  - Rewarded providers that met goals and punished staff that failed to meet census targets and goals (e.g., # admits per week).
  - Staff resistant to discharges and concerned about layoffs with drop in census.

AseraCare- Update

- Signed admit papers without evaluating patients.
- Failed to adequately train staff on Medicare rules.
- Disregarded staff concerns, when expressed.
- Failed to adequately document.
- Disregarded advice and information from outside auditors. No corrective action taken.
  - Non-physicians and physicians “not adequately involved” were making eligibility determinations.
- January 2012 Government intervened.
- Dec. 2014 Case Proceeding to Trial after Judge Ruled on Various Motions.
OIG Actions – HCH Update

- PENNSYLVANIA – Home Care Hospice, Inc. (HCH):
  - Hospice Owner found guilty of conspiracy to defraud Medicare, fraud, money laundering and mail fraud.
  - Submitted claims for services for ineligible patients, and for more expensive services (CHC).
  - Paid kickbacks to doctors and others for referrals (masked as consulting fees).
  - Attempted to mask kickbacks as payments for services (Medical Directors, advisors or hospice physicians).
  - Complicit nurses, Medical Director, and supervisory staff altered clinical records.

HCH - Update

- When he found out about a claims audit, directed staff to falsify documentation to submit to the auditors.
- When he found out he exceeded Caps, immediately ordered mass discharges of patients.
  - Admitted to his other hospice business, then transferred back to HCH when cap issue was resolved.
- Diverted $7.77 Million in hospice funds for personal use; false and inflated vendor invoicing, and charitable organization scam.

HCH - Update

- Owner Sentenced: 176 months prison, $16.2 million in restitution to Medicare and $16.2 million in forfeiture judgment.
- Medical Director sentenced to 51 months, $300K fine, and faces mandatory exclusion.
  - Received kickbacks for referrals to hospice.
  - Kickbacks were disguised as Medical Director fees.
2014 Cases – Passages Hospice

• ILLINOIS – Passages Hospice, LLC
  • (US Atty. N. Dist. Ill.)
  • Hospice executive (corporate agent, administrator, and ¼ owner) charged with fraud and obstructing a federal audit.
  • Some patients did not meet terminal criteria.
  • Billed for higher level of care (GIP) than provided or medically necessary; some without Medical Director approval.

Passages, cont’d

• Knew patients didn’t qualify based on outside consultant report AND internal audit.
• Many patients in nursing homes that owner also controlled.
• Long LOS. Used NHPCO statistics for comparison.
  • One patient on for 2,000+ days, another for 1400+ days.
• Gov’t retained a hospice physician to review clinical records of 13 patients, 10 with LOS over 6 months.
  • Physician found 9 not eligible for all or part of admission, and that all GIP days were improper.

Passages, cont’d.

• Witness (former employee) said she was ignored and told to mind her own business when she brought GIP issue to attention of owner.
• Bonuses paid to directors and supervisors based on amount of GIP under their supervision.
• Paid 8 nursing homes $250 for each GIP day per patient.
  • GIP services trended up each year.
• Alteration of patient files requested by TrustSolutions, a CMS fraud audit contractor.
Good Shepherd Hospice, Inc.

- OKLAHOMA – Chain
- Whistleblower Case Brought Under the False Claims Act
- Allegations:
  - Pressured employees to meet census and admission targets, and paid bonuses based on the number of patients admitted.
  - Patients admitted who were not Terminally Ill.
  - Hired Medical Directors because of ties to nursing homes.
- Hospice argued allegations untrue, and focus was on continuing eligibility of small % of patients in 2006-11.
- Settlement: $4 million plus CIA (Feb. 2015)

Serenity Hospice Care, LLC

- GEORGIA – Affiliate also charged.
- Whistleblower case brought under the False Claims Act.
- Billed for services furnished to individuals “not eligible” for hospice.
- Settled for $581,504.

Creekside Hospice II, LLC

- Whistleblowers = 2 former employees.
- Allegations:
  - Submitted claims for individuals not terminally ill.
  - Directed staff to recruit patients regardless of eligibility;
  - Altered documents after election;
  - Altered medical records to appear as if visits made when they were not;
Creekside cont’d.

- Aggressively discouraged patients from revoking;
- Discouraged staff from documenting improvement in clinical records (“chart killers”);
- Billed for inflated services furnished by Medical Director.

Prairie View Hospice, Inc.

- OKLAHOMA – Jury trial of hospice owner. General manager indicted and pled guilty to obstruction of federal audit and gave testimony at trial. (November 2014)
- Allegations:
  - Falsified nurse visit notes and assessments when visits were not made;
  - Exaggerated patients’ medical conditions to appear sicker;
  - Falsified documents and sent them to a Medicare audit subcontractor in response to request for patient records.

Prairie View, Cont’d.

- Owner found guilty on 39 counts Medicare fraud, conspiracy, obstruction of federal audit and making false statements in a health care matter.
- Owner – up to 5 years, $250k per count, restitution, and forfeit all proceeds from criminal acts.
- GM – 5 years + $250k (once).
Horizons Hospice

- PENNSYLVANIA – Medical Director Horizons Hospice.
- Pled guilty of one count health care fraud (Nov. 2014).
- Falsely certifying patients as terminally ill.
- Sentencing set for July 14, 2015. Up to 20 years, + $250K.
- Investigated by FBI, HHS-OIG and Medicaid Fraud Control Unit of Attorney general Office.

Evercare Hospice & Palliative Care

- COLORADO – 2 whistleblower suits (4 former employees) against Evercare Hospice & Palliative Care and parent UnitedHealth Group, Inc. (August 2014). US partially intervened in one suit.
- FCA Allegations include:
  - Admitted and filed claims for patients not terminally ill.
  - Management pressured employee and physicians to admit/retain patients not terminally ill, and challenged or disregarded physician decisions to discharge patients.

Individual

- MISSISSIPPI – Individual charged & pled guilty
- Submitted fraudulent claims to Medicare for services:
  - Not furnished;
  - Furnished to individuals not terminally ill;
  - Based on forged physician signatures.
- Sentence: 70 mo's prison + 3 years supervised release; plus $7,941,335 in restitution to Medicare; forfeit of 17 vehicles ($600k value and 12 pieces of real property ($700k value) (Dec. 2014)
Individual RN

- TEXAS – individual stole RN identify and worked for 8 DFW area hospices as a nurse.
- By signing documents in the name of the RN whose identify was stolen, she caused the hospices to submit false claims. (Aggregate of $2.3 million)
- Investigated by FBI, HHS-OIG, Texas AG Medicaid Fraud Control Unit.
- Pled guilty.
- Faces up to 15 years prison, $250,000 fine and restitution to government.

GIP Utilization

- OIG reports 2012-13 in response to concerns over GIP Services **Utilization**
  - GIP billed but not provided; provided but not medically necessary
  - Long GIP LOS
  - BUT…also some hospices provided no GIP at all, and
  - Some provided no GIP, CHC OR respite!
  - Analysis broken out between for-profit and not-for-profit.

GIP in Hospice-Operated Units

- Breakdown of GIP Services by **Setting**
  - Hospice-owned/operated, hospital, or SNF.
- Findings:
  - 58% of patients received GIP in hospice-operated unit; 33% in hospital; 8% in SNF
  - ALOS for GIP services in hospice-operated unit (6.1 days), hospitals (4.1 days), and SNFs (4.8 days).
GIP

• OIG and other statements on GIP note that hospice is palliative rather than curative, and that hospice assumes responsibility for care for terminal illness and related conditions.
• Statements link palliative care nature of hospice benefit to conclusions about GIP care:
  • Inference that patients are revoking in order to get hospital GIP care.
  • Inference that GIP not necessary for hospice patients because not curative.
  • Lack of understanding of hospice benefit and reasons for GIP.

OIG Work Plan

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<th>2014</th>
<th>2015</th>
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<tr>
<td>- Review use of GIP care, assess appropriateness of GIP care claims, and the content of election statements for beneficiaries who receive GIP care.</td>
<td>- Appropriateness of GIP level of care.</td>
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<td>- Review medical records to address concerns that this level of care is misused.</td>
<td>- Review election statements of beneficiaries.</td>
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<td>- Medical records review – concern over misuse of GIP care.</td>
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<td>- “Hospice care is palliative rather than curative.”</td>
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PGBA Focus on GIP – YouTube Video

• Summarizes PGBA Workshop Handout
  - [https://www.youtube.com/watch?v=23Y_1Z-DkPg&feature=youtu.be](https://www.youtube.com/watch?v=23Y_1Z-DkPg&feature=youtu.be)

• Looked at:
  • GIP LOS
  • ALOS on hospice
  • ALOS in GIP by setting (Hospice IPU, Hospital, SNF)
  • Potential Causes of long LOS (compared providers’ information)

• IDENTIFIED THREE PROBLEM AREAS:
  • Evaluation
  • Discharge Planning
  • Documentation
PGBA Focus on GIP - Background

• 2015 Hospice Workshop Handout: Prior OIG studies and conclusions on inappropriate hospice care.
• Guidelines:
  • GIP not custodial or residential
  • Pt must return to RHC once stabilized.
  • Pt may remain in facility for safety but hospice only gets RHC rate.
• Statistics:
  • $$$ spent on GIP care
  • GIP Utilization, # of admits, and frequency of GIP stays
  • Number of hospices furnishing GIP in own facilities, versus hospital or SNF
  • LOS in GIP, LOS in GIP by setting (IPU, Hospital, SNF)
  • Incidence of GIP furnished by new and established providers, by size, by region, specific to J11.

PGBA Focus on GIP - Symptoms

• Symptom Changes Leading to GIP Care (from PGBA Slide)
  • Sudden deterioration requiring intensive nursing intervention.
  • Uncontrolled nausea and vomiting.
  • Pathological fractures.
  • Respiratory distress which becomes unmanageable.
  • Transfusions for relief of symptoms.
  • Traction and frequent repositioning requiring more than one staff member.

• Wound care requiring complex and/or frequent dressing changes that can not be managed in the patient’s residence.
• Severe agitated delirium or acute anxiety or depression secondary to the end-stage disease process requiring intensive intervention and not manageable in the home setting.
PGBA Focus on GIP - Documentation

• Document pain & why management is necessary in GIP setting.
• Describe services provided. Each note “stands on its own” to support level of care.
• Context and precipitating event leading to GIP status.
• Describe all failed attempts at pain mgmt/symptom control.
• Specify all symptoms/new symptoms including progress, context or changes that cannot be managed at home, as well as responses to interventions in the GIP setting.

PGBA Focus on GIP - Documentation

• Justify why actions cannot take place in home.
• Document events leading to GIP and symptoms requiring ongoing GIP status.
• Begin discharge planning on GIP admission and throughout stay.

PGBA Focus on GIP

• Don’t use “patient is dying,” “end of life care,” “general decline,” “pain and symptom control,” or “medication adjustment” as rationale for GIP without substantial additional detailed documentation.
• GIP “not reasonable and necessary” is second most common reason for hospice denials at PGBA.
  • At 19.5%, behind “not hospice appropriate (27.1%)
Relationships with Nursing Facilities

- Carryover from Prior Years' OIG Work Plans.

- Hospice Marketing Practices
  - Coverage requirements, inappropriate enrollment, inappropriate level of services.
  - Aggressive marketing of services to NF residents.

- Financial Relationships with Nursing Facilities
  - Kickbacks to Nursing Facilities:
    - Clinical and clerical staff to assist NF
    - Staff based on facility or patient request, not medical need.
    - DME items and supplies
    - Incentive payments to NF staff (cash-like)

Relationships with Nursing Facilities

- Government Increasing Enforcement Efforts
  - Under the Anti-Kickback Statute and FCA.
  - May authorize criminal and civil penalties
  - May temporarily suspend payments based on “credible evidence of fraud.” (Need OIG approval.)

OIG Report on ALFs - NHPCO

- Part of 2014 OIG Work Plan
- Echoing nursing facility relationships, concerns, themes.
- Looked at claims from 2007-2012.
- Medicare payments for hospice in ALFs have doubled in last 5 years.
- In 2012 Medicare spending for hospice care in ALFs was 14% of total hospice spending.
- ALOS of hospice patient in ALFs is longer than in any other setting.
  - More likely to have LOS of 180+ days
  - 18% had LOS over 1 year; 5% had LOS over 2 years
  - 60% had “ill-defined conditions” (Alzheimer’s, mental disorders)
OIG Report on ALFs

• Looked at visit breakdown by discipline:
  • Average 4.8 hours per week per patient
  • 2.4 hours – aide
  • 1.7 hours - nurses
  • 0.3 hours - SWs
• Few visits were provided on the weekend (4% Saturday and 3% Sunday).
• 97 hospices relied on ALFs for most of their Medicare payments.

[OIG Report: “Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities” (Jan. 14, 2015)]

OIG Report on ALFs

• Recommendations (include in other hospice reforms):
  • Reduce incentives for hospices to target patients with certain diagnoses and likely to have long LOS.
• Target specific hospices for review:
  • High % of payments from care to ALF residents
  • High % of beneficiaries with LOS over 180 days
  • High percentage of beneficiaries with certain diagnoses
  • High % of patients who rarely receive hospice visits.

OIG Report on ALFs

• Develop claims-based measures of quality:
  • Based on average number and type of services the hospice provides;
  • How often physician visits are provided;
  • How often services are provided on weekend.
• Make hospice data publicly available (e.g., through a Hospice Compare feature).
• Provide information to hospices to allow them to compare themselves to peers.
  • Using PEPPER Reports
  • Target % of beneficiaries in specific settings, with certain diagnoses, and receiving higher levels of hospice care.
OIG Work Plan

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<td>• Hospice Services in ALFs – New!</td>
<td>• LOS</td>
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<td>• LOS Issue: ALF residents have the longest LOS in hospice care, and this “bears further monitoring and examination.”</td>
<td>• Level of care received, and “common terminal illnesses.”</td>
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<td>• Levels of care in ALF.</td>
<td>• Data collection will be tied to hospice payment reform and development of hospice quality measures.</td>
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<td>• Most common terminal illnesses.</td>
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Hospice-ALF Relationships

• Under increased scrutiny
• Should have patients from a variety of sources and in a variety of settings.
• Review relationships with ALFs to ensure no evidence of intent to induce referrals.
• Provide the full range, scope and frequency of services to an ALF patient as you would to any other patient.
• Document, document, document.

Other Issues

• Relatedness and Duplicate Billing:
  • Nursing Facilities – Medicaid Supplies
  • Nursing Facilities – Wound Care
  • Therapy Services (PT, OT, SLP)
  • Physician Part B Billing
  • Hospital Outpatient Services (esp. ER).
• Compliance Issues
  • F2F (following home health agencies)
• Live discharges
  • 30-50% = high; 50+% = very high
DISCLAIMER

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