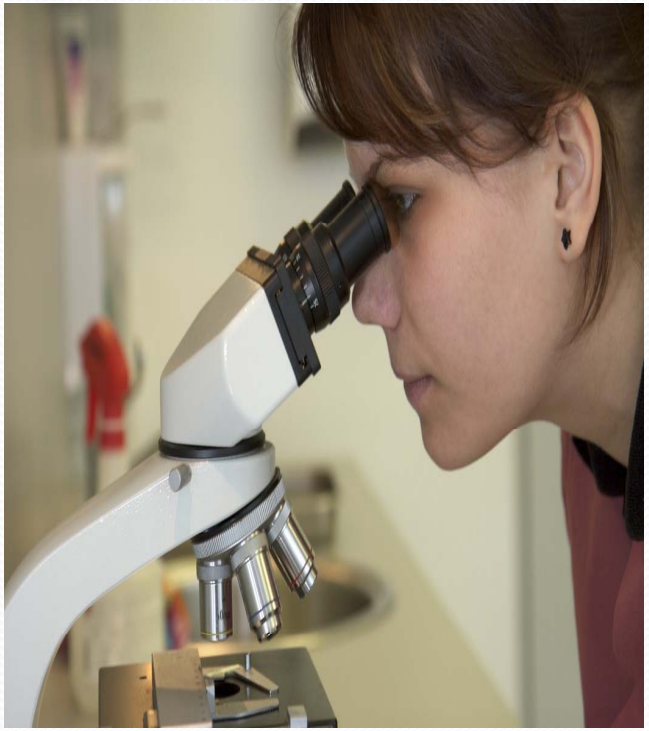
FRAUD AND ABUSE IN HOSPICE: Under the Microscope

Weatherbee Hospice Regulatory Boot Camp



Howard J. Young, Esq.
Morgan Lewis & Bockius

Hospice Services – Doing Good

- skilled nursing services
- drugs and biologicals for pain control and symptom management
- physical, occupational, and speech therapy
- counseling (dietary, spiritual, family bereavement, and other counseling services)
- home health aide and homemaker services
- short-term inpatient care
- inpatient respite care
- other services necessary for the palliation and management of the terminal illness

A Heightened Focus on Fraud/Abuse

Hospice On the Enforcement Radar Screen

WHY?

- Optics – emergence of "for profit" hospice
- Data mining – searching for aberrant patterns
- Law enforcement (DOJ, OIG, AGs, MFCU) now have experience with hospice investigations
- Whistleblowers – False Claims Act
- Budget pressures and growth of hospice expenditures
- ZPICs and Recovery Audit contractors
- Part A MAC reviews and OIG spotlight/audits

Hospice Industry Overview*

- Medicare hospice payments = $13.8 billion in 2011 (over 4x the 2000 amount)
- 1.2 million Medicare patients per year
- 3,585 hospices
- Supply of hospices in U.S. grew 59% between 2000 and 2011, with for-profits accounting for almost all such growth
- ALOS grew from 54 days to 86 days between '00 and '11
- Relatively low barrier to entry – access to capital – and continued growth in # of hospices (2.5% in 2011)
- But relatively low margins – 7.4% in '09 and 7.5% in '10; projected 6.3 in 2013

** Source – MedPac March 2013 Report to Congress*

Realities and Challenges

- LCD Guidelines can be poor predictors of mortality
- Non-cancer Dx admissions have grown
- Nursing home relationships more complex and common and pressures remain to coordinate care
  - OIG continues to raise concerns (FY '11, '12 & '13 Work Plans) and issued a May 2013 Report on billing issues related to hospice general inpatient care
- In certain communities, competition among hospice providers is intense
- New F2F rules require greater physician involvement when many physicians feel more stretched than ever
- Regulatory changes outlined in FY 2014 Proposed Rulemaking

Federal and State Regulatory Challenges

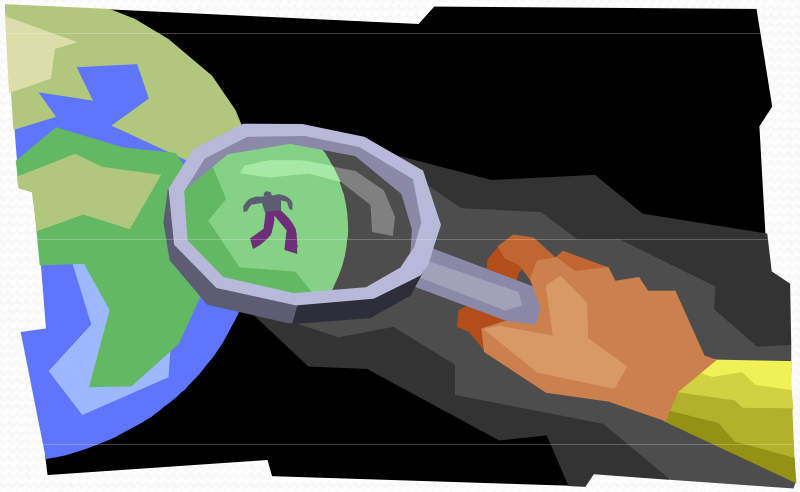
- Federal Regulatory Issues
  - FY 2014 Hospice Rule (Aug. 7, 2013)
    - Eliminates failure to thrive and debility as primary diagnoses
    - On or after 10/01/14, such claims will be returned with request for more specific Dx – seeking "additional clarity"
  - CMS Guidance to States
    - Recommends state survey and certification agencies put hospices applying to be new Medicare providers in the lowest tier of workload priorities.
- State Regulatory Issues
  - Different certification periods than Medicare.
  - Staffing ratio requirements in some states

Billing Rules – Dot Those i's

- Many traps for unwary
  - Technical compliance on certifications of terminal illness (CTIs)
  - Eligibility determinations
  - EMR – "cloning" and "drop down" features
  - Coverage for continuous care
  - GIP – 24 hour RN on-site and documentation of skilled care
  - MACs, ZPICs, BISCs, RAs (f/k/a RACs) all looking
- Drugs/supplies/care "related to terminal illness"
- Hospice compliance functions often leanly staffed

Cost Pressures on the System – What Does This Mean for Hospice?

CHALLENGES . . .



. . . And Opportunity!

- Some hospices will struggle with payment cuts/regulatory burdens and  scrutiny
- Forced to improve care coordination
- Forced to improve documentation systems
- Forced to manage cap liability more effectively
- Some will emerge stronger
- Where does compliance fit in?

So what is the government looking at and how are they looking?

Front End: Enrollment Screening

- CMS hospice enrollment
  - Compliance with Federal and state requirements
  - License verification
  - Enrollment database checks
  - Pre and post-enrollment **unannounced** site visits
- Hospices deemed “moderate risk" providers
  - deemed “High Risk” if program integrity issues in prior 10 years
- New screening procedures became effective March 23, 2012
- **DON’T FORGET EXCLUSION SCREENING!! See new OIG Bulletin on Exclusion May 2013**

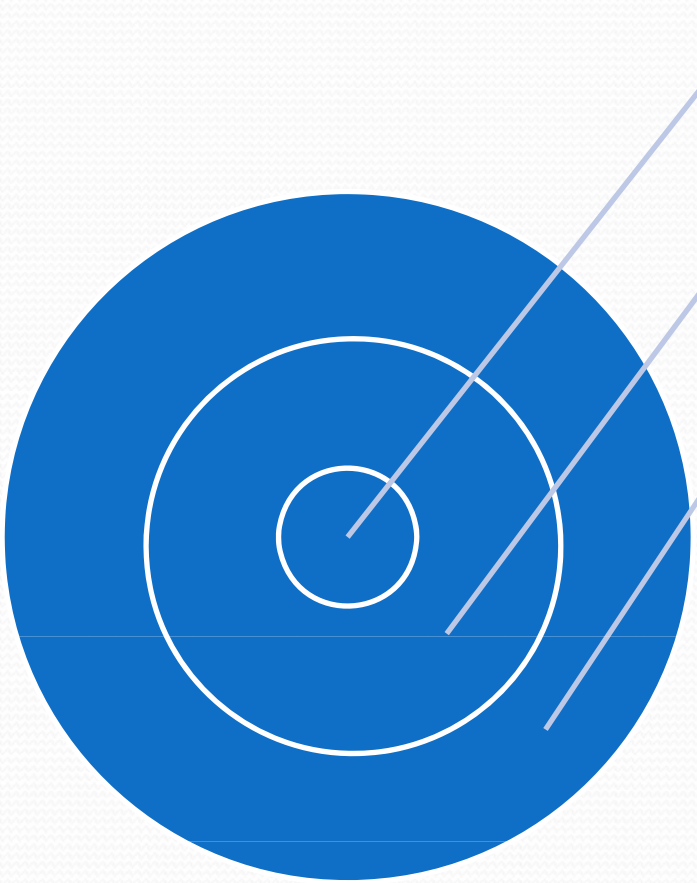
Pre-Pay Audit and Other Activity

- ZPICs are doing more on pre-pay basis, including Medicare Condition of Participation reviews
- MACs and ADRs
- PEPPER reports
  - Opportunity to see how your hospice stacks up
  - CMS will expect that you review and study your PEPPER reports

OIG and State Exclusion Actions

- Exclusion of persons and entities
- **www.oig.hhs.gov**
- Screen upon hire, and periodically thereafter (up to monthly)
- Policy on immediate reporting of proposed exclusion
- No Medicare/Medicaid payment for services furnished by excluded person (including admin services)
- Very large potential refund liability
- FCA and civil monetary penalty liability for knowingly employing or contracting with excluded person

Government Hospice Target Areas



Fraud

Abuse

Waste

Hospice "Fraud" Focus Areas

- "Knowingly" admitting clinically ineligible patients/failure to discharge (long LOS)
- Kickback arrangements with referral sources (e.g., nursing homes, ALFs, physicians, etc.)
- Bad billing (e.g., woefully deficient CTIs)
- Substandard care resulting in patient harm
- Medically unnecessary level of service (e.g., continuous care or GIP when only RHC appropriate)
- Arrangements with nursing homes (OIG Hot Topic) and "high percentage" hospices

OIG Focus on General Inpatient (GIP) and Continuous Care

- HHS OIG Issued a report in May 2013 on Hospice GIP Care in the Medicare Program
  - Longer lengths of stay and greater utilization of GIP warrant "further concern."
- OIG Office of Evaluations and Inspections (OIG OEI) Medical Record Reviews
  - OIG sent out requests for GIP medical records on May 15, 2013
- AR based hospice settled a *qui tam* suit filed under the False Claims Act for $2.7 million in December 2011.
- Continuous Care – large publicly traded hospice settled for $25 million in March 2012 and another was sued by DOJ in May 2013.

ZPIC Overview

- Combined oversight of all Medicare providers (Medicare Parts A & B), Managed Care (Part C), Part D Medicare Prescription Drug Plans, and Medicare and Medicaid Data Matching
- Consolidated benefit integrity activities in a few contractors across seven zones to cover:
  - Medical chart review
  - Data analysis
  - Medicare evidence-based policy auditing
- They are not Medicare or Medicaid RACs

ZPIC Overview (cont'd)

- **Zone 1 – Safeguard Services LLC**: CA, NV, American Samoa, Guam, HI and the Mariana Islands.
- **Zone 2 – NCI, Inc.** (previously **AdvanceMed): AK**, WA, OR, MT, ID, WY, UT, AZ, ND, SD, NE, KS, IA, MO.
- **Zone 3 – Cahaba Safeguard Administrators (just awarded April '10):** MN, WI, IL, IN, MI, OH and KY.
- **Zone 4 – Health Integrity:** CO, NM, OK, TX.
- **Zone 5 – NCI, Inc.** (previously **AdvanceMed:** AL, AR, GA, LA, MS, NC, SC, TN, VA and WV.
- **Zone 6 – Cahaba Safeguard Administrators**: PA, NY, MD, DC, DE and ME, MA, NJ, CT, RI, NH and VT.
- **Zone 7 – SafeGuard Services LLC:** FL, PR and VI.

ZPIC Overview (cont'd)

- For-profit contractors
- Paid on contractual basis (approx. $67 million), rather than contingent fee, like RAs
- Fraud detection and deterrence
- Statistical sampling and extrapolation of damages
- Starting to look at COPs and asking for CAPs

Consequences of ZPIC Audit

- Pre- and post-payment reviews
- **Suspension of payment**
- Denial of payment
- Revocation of Medicare provider number
- Referral to MAC for recoupment of "overpayments"
  - Appeal rights then kick in
- Referral to HHS-OIG or DOJ if potential fraud
  - Criminal prosecution
  - Civil prosecution
  - Civil monetary penalty
  - Administrative sanctions

What to Expect with ZPIC Audit

- ✓Unannounced requests
- ✓Clinical documentation demands and timeline
- ✓Rigorous data analysis
- ✓Delayed response following production of documents (although ZPICs getting faster)
- ✓Potential for conflicting interpretation of Medicare coverage guidelines

ZPIC/RAC "Preparedness" Strategy

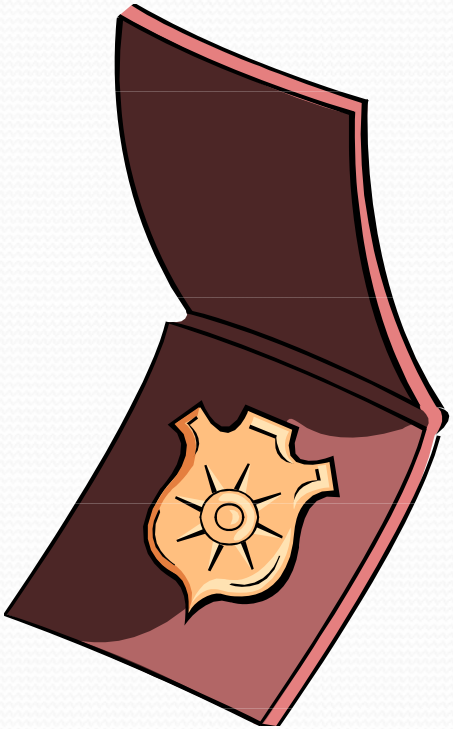
Document

- Medical necessity/eligibility
- Conditions of participation
- Technical billing compliance
- Organized files!
- Compliance plan
- Self-audits of risk areas and vulnerabilities

Defend

- Prepare well-crafted, timely response
- Produce documentary evidence, supplemented by attestations/affidavits
- Involve legal counsel early
- Challenge use of extrapolation
- Appeal

Government Enforcement Basics



U.S. Healthcare Fraud Stats*

- FY '10 – 1,110 new criminal investigations; 3,118 potential defendants; 743 criminal health care fraud convictions
- 1,069 pending civil health fraud matters; 942 new investigations
- $4.2 billion in federal health care fraud recoveries
  - Relators paid over $419 million
  - Over $18 billion collected since HCFAC began in 1997
  - 2,662 exclusion (2011) (down from 3,340 exclusions in 2010)
  - $4.9 in recoveries for every $1 spent (high ROI)
  - $608 million in HHS and DOJ funding for healthcare fraud

*FY 2011 DOJ/HHS HCFAC Report

Health Care Fraud Investigations: Understand the Different Avenues

Forum	Tools	Players
Criminal	GJ subpoenas, search warrants, subpoenas, surveillance (wiretaps)	DOJ, FBI, OIG, MFCU, AG
Civil	subpoenas, CIDs, document requests, medical record review	DOJ, Relators, OIG, MFCU, AG
Administrative	Administrative subpoenas, audit requests, contractor audits, OIG audits	MACs, OIG, ZPICS, RACs

- Parallel Investigations – all of the above

Anatomy of Investigation

- *Qui Tam* Complaint – what does DOJ do?
- Criminal or civil – how does DOJ decide?
- Role of investigators – DOJ investigators, auditors, OIG special agents, FBI, others
- DOJ and CMS' use of contractors, sub-contractors, experts
  - ZPIC "investigators"
- State AGs/MFCU investigators

State Hospice Investigations

- States are increasingly active in hospice reviews
- Medicaid expenditures
- Room and Board pass-through (e.g., MassHealth audits)
- Also looking at hospice eligibility issues
- State Attorneys General units (Medicaid Fraud Control Units /"MFCUs") teaming with Feds
- Medicaid RAC target?
  - DME and pharmacy items associated with hospice
- CMS contractors focused on Medicaid (Health Integrity)

DOJ Investigations/Settlements

- Late 1990's: Operation Restore Trust
- 2000: Mich. Physician (kickbacks from hospice – criminal conviction)
- 2005: $599k settlement (AL) for ineligible patients
- 2006: large hospice chain - $12.9 million settlement with DOJ/OIG and 5 year CIA (ineligible patients coupled with aggressive marketing)
- 2008: Texas hospice $500K settlement and 5 year CIA – misrepresentation of patients' condition to certifying physicians

DOJ Settlements (Allegations)

- 2009: CA AG indictment of hospice owners – enrolling healthy patients through "cappers" – hospice lost license and closed
- 2009: Large hospice chain paid $26.7 million, 5 yr CIA; eligibility criteria, long LOS, aggressive marketing
- 2009: Hospital based hospice paid $1.83 million for failure to obtain CTIs from physicians

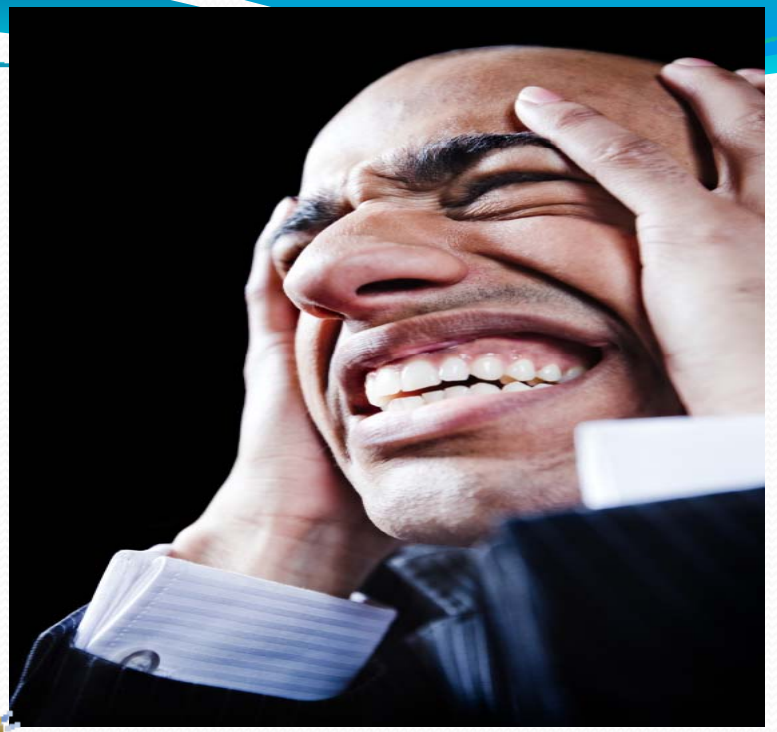
DOJ Settlements (allegations)

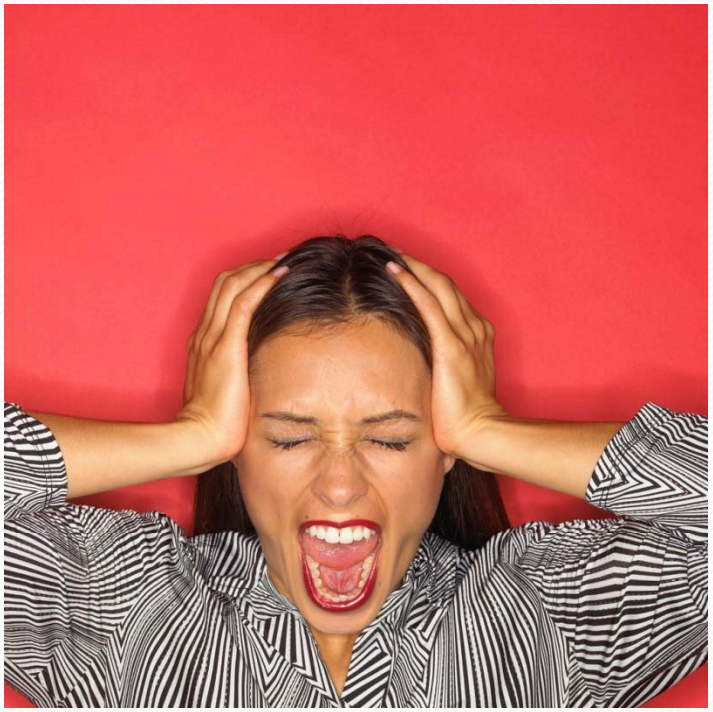
- June 2012: Kansas hospice - $6.1 million– LLOS, improper incentive comp to clinical employees, delayed live discharges, inadequate compliance
- Nov. 2012: S.C. Hospice and Owner - $1.3 million – LLOS
- March 2013: Arizona Hospice - $12 million -- ineligible patients, LLOS. CIA
- June 2013: Medical director of Philadelphia hospice convicted on five criminal counts related to violation of the federal anti-kickback statute.
- July 2013: FL Hospice - $1 million -- ineligible patients, delay in live discharges, bad incentive comp plan, kickbacks – free services to nursing homes.

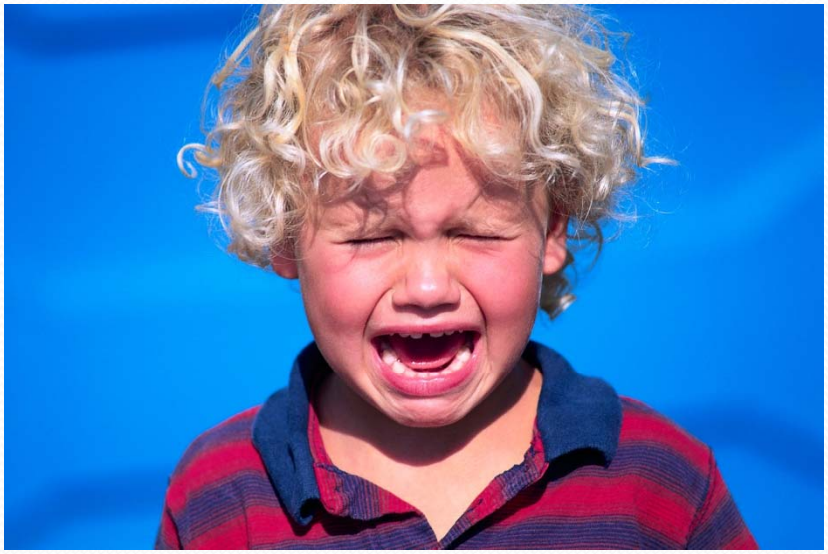
Internal Investigations/Reviews To Disclose or Not to Disclose?

- ACA section 6402 – mandatory refund within 60 days if identifying an overpayment
- If significant refund potential or inducements to refer, involve qualified counsel
- Voluntary disclosure options:
  - MACs
  - OIG
  - State Medicaid or AG (if Medicaid $)
  - DOJ/U.S. Attorney's Office

So does all this want to make you want to scream, cringe or cry?







Control What You Can

- Ensure nursing home (and other referral source) financial arrangements and marketing plans are reviewed by qualified legal counsel
- Ensure CTI process comports to requirements
  - signed/dated CTIs
  - Brief narrative
  - F2F compliance
- Educate/audit on adequate documentation/care plans
- Avoid compensation plans that incentivize long LOS admissions or discourage proper live discharges
- Conduct “hospice appropriateness” reviews

What to Avoid

- Bonus tied to new admissions or ADC for clinical staff (especially admission nurses)
- Any bonus tied to average length of stay
- Undue pressure on hospice staff to increase census to aggressive or unrealistic levels
- Marketing staff overruling/pressuring on admissions
- Undue delays in live discharges
- Allowing Medical Director to over-rely on hospice staff for clinical assessments; make sure IDT meetings are robust!
- Frequent discharges for hospitalizations and readmissions

Q & A

Contact Info

Howard J. Young
Morgan Lewis & Bockius
202.739.5461 (office)
202.320.9640 (mobile)
hyoung@morganlewis.com