# FRAUD AND ABUSE IN HOSPICE:
## Under the Microscope
Hospice Regulatory Boot Camp

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# 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 Industry Overview*

- Medicare hospice payments > $12 billion in 2009 (4x the 2000 amount)
- 1.1 million patients per year
- 3,500 hospices
- Supply of hospices in U.S. grew 50% between 2000 and 2009, with for-profits accounting for almost all growth
- ALOS grew from 54 days to 86 days between '00 and '09
- Relatively low barrier to entry – access to capital despite economic conditions/tight credit market
- But relatively low margins – 5.1% in '08 and 4.2% in '09

** Source – MedPac March 2011 Report to Congress*

# Hospice is On the Radar Screen

- Gone are the days when hospices face much less scrutiny than large providers (e.g., hospitals)
- WHY?
  - Data mining – searching for aberrant patterns
  - Law enforcement (DOJ, OIG, AGs, MFCU) now have experience with hospice investigations
  - Whistleblowers – False Claims Act
    - Cases beget cases
  - ZPICs (RACs to come)
  - Part A MAC reviews and OIG audits

# Realities and Challenges

- LCD Guidelines are often poor predictors of mortality
- Non cancer Dx admissions have grown
- Nursing home relationships have grown more complex, common and pressures remain to coordinate care
  - OIG continues to raise concerns (2011 Work Plan study)
- In certain communities, competition among hospice providers is intense
- New rules require greater physician involvement when many physicians feel more stretched than ever

# Simple Reimbursement Model?

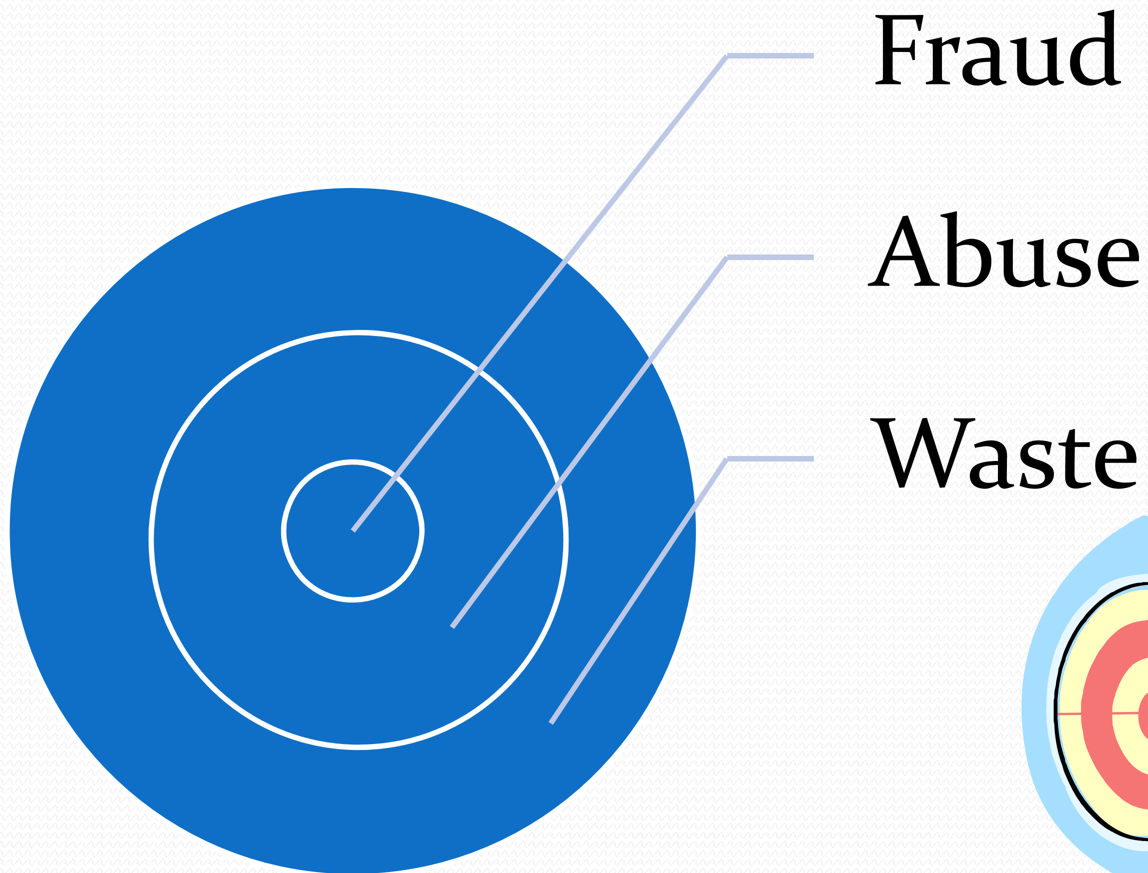
- Four payment categories based on level of care:
  - Routine home care
  - Continuous home care
  - Inpatient respite care
  - General inpatient care
- But many traps for unwary
  - Technical compliance on certifications of terminal illness (CTIs)
  - Eligibility determinations
- Hospice compliance functions often leanly staffed

So What Is Our Government Doing?

# FY '12 Medicare Proposed Rule

- Reduces Medicare payments to hospices by $80M for FY 2012
- Implements third year of a 7-year phase out, of the hospice wage index budget neutrality adjustment factor – total BNAF reduction in FY 2012 of 40%
- Changes methodology to calculate the statutory aggregate cap (after series of lawsuits)
- Revises F2F encounter for recertifications
- Implements hospice quality reporting program
- But where is PROGRAM INTEGRITY RULEMAKING?

# Government Hospice Target Areas



# Front End: Enrollment Screening

- Feb. 2, 2011 Final Rule implemented provider screening (arising from ACA)
  - Compliance with Federal and state requirements
  - License verification
  - Enrollment database checks
  - Pre and post-enrollment unannounced site visits
- Hospices deemed “moderate risk" providers
  - But→ deemed “High Risk” if program integrity issues in prior 10 years
- Applies to new hospice enrollees and hospices with revalidation occurring on or after March 25, 2011 and before March 23, 2012.
- All others, new screening procedures effective March 23, 2012.

# Primary Hospice Focus Areas

- Knowingly admitting clinically ineligible patients/failure to discharge (LLOS)
- Kickback arrangements with referral sources (e.g., nursing homes, 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)

# Hot "Program Integrity" Topics

- New CTI requirements – greater physician involvement:
  - Brief Narrative + attestation
  - F2F Encounter + attestation
- Zone Program Integrity Contractor (ZPIC) Audits
- Self-Disclosures to Resolve Identified Medicare Overpayments

# 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 RACs

# ZPIC Overview (cont'd)

- **Zone 1 –Safeguard Services LLC**: CA, NV, American Samoa, Guam, HI and the Mariana Islands.
- **Zone 2 –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 –AdvanceMed (n/k/a NCI, Inc.):** AL, AR, GA, LA, MS, NC, SC, TN, VA and WV.
- **Zone 6 – *Contract award pending***: 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)

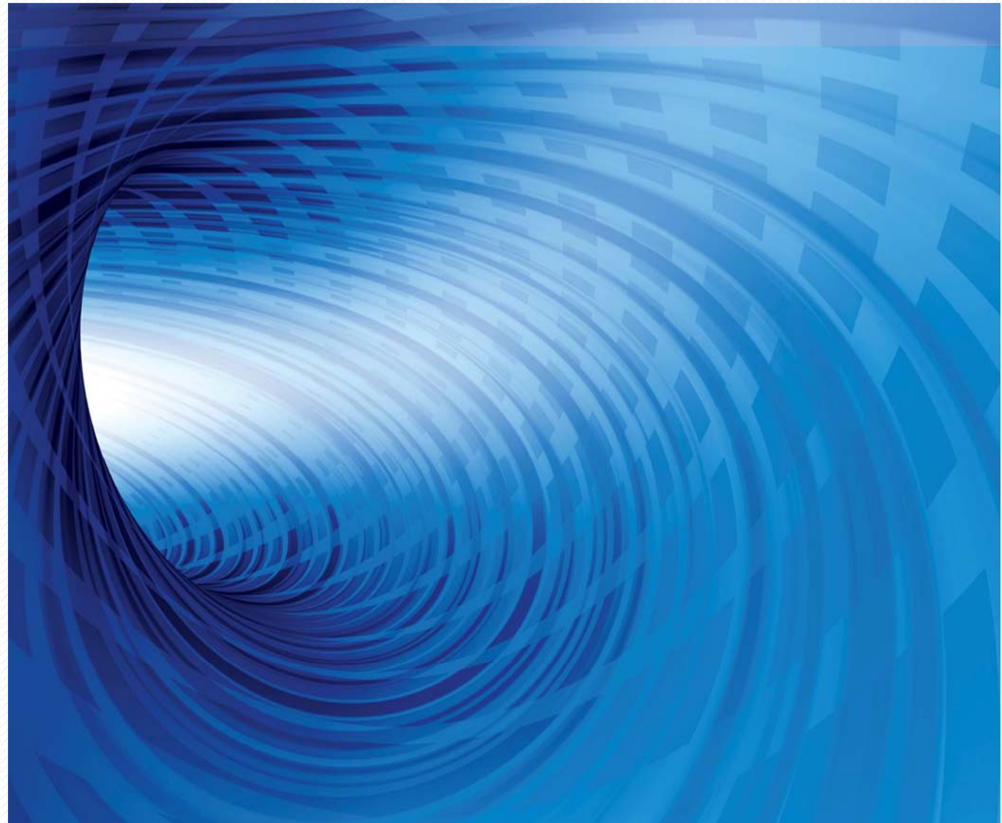
- For-profit contractors
- Paid on contractual basis (approx. $67 million), rather than contingent fee, like RACs
- Fraud detection and deterrence
- Statistical sampling and extrapolation of damages
- Starting to look at COPs and asking for CAPs

# 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

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



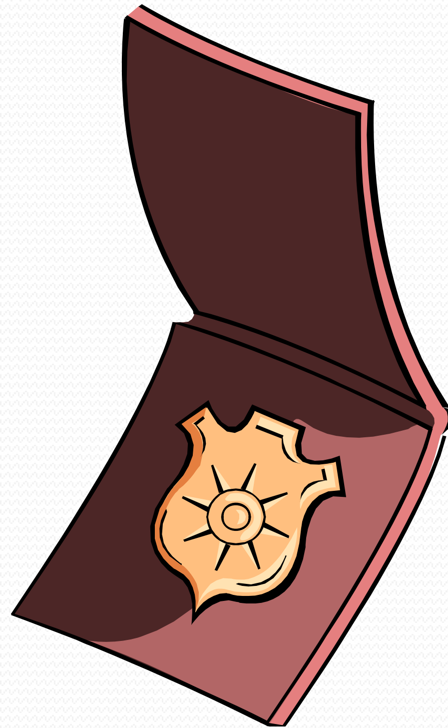
## Document

- 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 – 1,116 new criminal investigations; 2,095 potential defendants; 726 criminal health care fraud convictions
- 1,290 pending civil health fraud matters; 942 new investigations
- $4 billion in federal health care fraud recoveries
  - Relators paid over $300 million
  - Over $18 billion collected since HCFAC began in 1997
  - 3,340 exclusions in 2010
  - $37 billion in savings recommendations
  - $4.9 in recoveries for every $1 spent (high ROI)
  - $570 million in HHS and DOJ funding for healthcare fraud

* FY 2010 DOJ/HHSHCFAC 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

# Fraud 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

# Settlements/Investigations

- 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; patients allegedly did not meet eligibility criteria, LLOS, aggressive marketing to patients
- 2009 Hospital based hospice paid $1.83 million for failure to obtain CTIs from physicians
- Numerous ongoing, pending cases brought by government (some being litigated)

# 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
- Competing voluntary disclosure options:
  - MACs
  - OIG
  - State Medicaid or AG (if Medicaid $)
  - DOJ/U.S. Attorney's Office

# 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 LLOS 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

# Take a Deep Breath!

## Q & A

## Contact Info

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