**Program Overview**

- **Trends** in enforcement: 2013-present
  - Who is initiating enforcement actions?
  - What types of actions are being initiated?
  - What are the substantive issues and bases for enforcement?
  - Future trends and issues.

**Program Overview - Trends**

- Soup to Nuts Enforcement
  - Increase in number of Hospice Providers and Medicare/Medicaid expenditures on hospice.
  - Recovery of overpayments
  - Part D and other duplicate payments
  - Aggressive pursuit of fraud and false claims violations

**Trends**

- More whistleblower suits
  - ACA relaxed the standards for whistleblowers.
- State actions parallel to federal
- Some reorganization of enforcement entities
- Detailed and increased information gathering
  - Quality measures
  - Cost report revisions capture and isolate data
  - CR 8358 Claim Data
  - Future payment reform

**DOJ/HHS Joint Efforts**

- Joint release of the Health Care Fraud and Abuse Control Program (2/26/14).
  - Gov’t recovered $4.3 Billion in FY 2013 (up from $4.2B in FY 2012).
  - $8.10 recovered for every dollar spent in the last 3 years on fraud investigations/enforcement.
  - Fifth consecutive year of increased recoveries.
  - Substantial part as a result of HEAT initiative, and new and expanded authority under the ACA.
DOJ/HHS Statistics for FY 2013

• HEAT Medicare Strike Force teams:
  • Filed 137 cases
  • Charged 345 individuals
  • Secured 234 guilty pleas, and
  • 46 jury trial convictions (ave. prison time = 52 months).
  • May 2013 “takedown” in 8 cities, against 89 individuals, involving schemes totaling approx. $223 million in false claims.
  • Suspended or took other administrative action against 18 providers.

• Department of Justice:
  • Opened 1,013 new criminal health care fraud investigations, involving 1,910 potential defendants.
  • 718 defendants convicted of fraud-related crimes.
  • Opened 1,083 new civil fraud investigations.

DOJ Press Releases - FCA

• Hospice Few False Claims 1/1/12 to date:
  • 2 in each of 2012 and 2013
  • All 4 initiated by whistleblowers
  • 3 for-profit hospices (some large, multi-state chains)
  • All 4 alleged hospice submitted claims for hospice services furnished to individuals who were not terminally ill.
  • 1 alleged billing at higher level of service than warranted.
  • 2 alleged falsifying records.
  • 3 alleged failure to discharge/delayed discharges.

DOJ Press Releases FCA

• FCA Cont’d.
  • 2 noted no compliance plan/failure to follow plan.
  • 2 noted aggressive marketing practices, mandatory quotas and bonuses to employees, and internal pressure.
  • 3 involved some combination of DOJ, Local US Attorney Offices, and HHS OIG, FBI.
  • 3 settled ($3 - 12 million) + Corporate Integrity Agreement (1 exclusion)

US HHS - OIG

• No Civil Monetary Penalties, Exclusions/Fraudulent Claims or Kickbacks related to hospice (2013 – present)

Vitas Hospice (Chemed)

• 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.
  • Discouraged discharges even when patients were no longer hospice eligible.
Vitas

- 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.
- CHC billing Statistics Out of Line with Averages, per DOJ
- Vitas denies allegations and will vigorously defend.

AseraCare Hospice

- (Alabama) Qui Tam (FCA) – relators were former employees.
- Allegations:
  - Submitted claims to Medicare for hospice care for patients who were not terminally ill.
  - Non-cancer patients (unpredictable disease progression).
  - 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

- Signed admissions paperwork 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.

HHS-OIG State Actions - New

- 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.
  - Paid kickbacks to doctors and others for referrals.
  - Attempted to mask kickbacks as payments for services (Medical Directors, advisors or hospice physicians).
  - Alteration of clinical records.
  - Diverted hospice funds for personal use.
  - Government to seek $14.3 million in restitution.

HHS-OIG State Actions

- Same Provider (HCH)
  - 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.

HHS-OIG State Actions

- FLORIDA – non-profit hospice settlement for $1 million for submitting false claims to Medicare and Medicaid for patients who were not terminally ill. Also entered into a corporate integrity agreement.
  - Also alleged staff admission quotas, delay/discourage appropriate discharges, no compliance program, provided kickbacks in the form of free services to nursing facilities for referrals.
  - Whistleblower suit.
HHS-OIG State Actions

- ILLINOIS – Charges filed against Hospice owner. Also attorney, corporate agent, and administrator, and agent and corporate secretary of a nursing home company.
- Allegations:
  - Billing for GIP care when not warranted, and without physician approval. Paid bonuses to employees based on GIP services under their supervision.
  - Ignoring prior review of GIP services by outside consultant and internal audit.
  - Employees had already reported fraudulent billing and marketing practices.
  - Excessive numbers of long LOS patients when compared to national averages.

Enforcement – ZPIC

- New UPICs = Unified Provider Integrity Contractors
  - Medicare ZPICs + Medicaid MACs
- Appeals Process taking too long.
- MACs will remain, but their integrity responsibilities 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

- “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 same
    - OMHA suspended assignment of ALJ appeal hearing for 2 years due to dramatic increase in number of appeals.
    - Current backlog of 460,000 cases, and 65 ALJs with 375,000 cases already assigned.

RACs

- Scaling back to allow completion of outstanding claims reviews before current contracts end.
- CMS will also analyze RAC policies to improve program.
  - Alternative payment arrangements
  - Identify true coding and documentation errors.
  - Lookback period under review, number of documents.
- Current:
  - 2/21/14 last day for RACs to send post-payment ADRs.
  - 2/28/14 last date MAC may send pre-payment ADR for RAC pre-payment review.
  - 6/1/14 last day RACs may send improper payment files to MACs for adjustment.

Medicare PIM Contractor Update

- 2/5/14 Program Integrity Manual CR 8425 (eff. 3/6/14)
- Allows MACs (CERT, RACs and ZPICs) discretion to deny “related” claims submitted before or after the claim being reviewed.
  - Related = documentation associated with one claim can be used to validate another claim.
  - Example: An inpatient claim/documentation is determined to be not reasonable and necessary – therefore the physician claim can be determined to be not reasonable and necessary.
  - Example: Diagnostic test claim/documentation is determined to be not reasonable and necessary – therefore the professional component of the claims is not reasonable and necessary.
  - Related claim denials are treated as routine or automated review.

GIP Services

- In connection with hospice payment reform and as an enforcement issue.
- Concerns over use, misuse, and underuse.
- Abt Hospice Technical Report (analyzed 2011 Cost Reports) concerns that some hospices showed no GIP costs, may be substituting CHCs for GIP.
GIP Services

- OIG Reports 2012-13
  - Response to concerns over GIP Services Utilization
    - Care billed but not provided; provided but not medically necessary
    - Long LOS (given intent of GIP is short-term)
  - Two Major Analyses (based on 2011 statistics)
    - 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).
      - 1/3 of GIP stays exceeded 5 days; 11% exceeded 10 days; 2% exceeded 21 days.

- OIG will continue to look at GIP and will report on medical review of 2012 GIP claims.
- 2013 OIG Report - Recommendations to CMS:
  - Focus on GIP in payment reform.
  - Develop quality measures related to hospices' ability to provide all levels of care.
  - Focus on hospices not providing GIP to ensure they are providing access to all needed levels of care.

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GIP Services

- 2013 OIG Report
  - Hospices that Provided no GIP at all in 2011.
  - Findings:
    - 27% of hospices (953) provided no GIP.
    - 12% (429) provided no GIP, CHC or Respite care.
    - 69% for-profit
    - 54% not-for-profit, and small (fewer than 90 beneficiaries).
  - Also looked at CHC and Respite Utilization
    - 68% of hospices that did not provide GIP also did not provide CHC
    - 62% of hospices that did not provide GIP also did not provide inpatient respite.

Debility & AFTT “Clarification”

- CMS 2014 Wage Index Rule
- Debility = leading NC diagnosis in 2011.
- Debility and AFTT are viewed as being the result of primary condition(s), not the primary conditions themselves.
- Concern that patients with these will not receive the full benefit of hospice services because "unspecified."

Debility/AFTT

- Should not be used as primary terminal diagnosis(es).
  - Can be secondary or co-morbidity (and should be used to support other primary diagnosis).
  - If patient died today, what would the cause of death be?
  - Will be RTP’d if primary after 10/1/14.
  - More diagnoses increases likelihood that all services will be "related" to the terminal illness and related conditions.
Relationships with Nursing Facilities

- Carryover from Prior Years’ OIG Work Plans.

- Hospice Marketing Practices and Financial Relationships with Nursing Facilities
  - Coverage requirements, inappropriate enrollment, and compensation.
  - Aggressive marketing of services to NF residents.

OIG 2014 Work Plan

- Hospice Services in ALFs – New!
- LOS Issue: ALF residents have the longest LOS in hospice care, and Med Pac states that this “bears further monitoring and examination.”
- Levels of care in ALF.
- Most common terminal illnesses.

Part D Prescription Drugs

- Concerns over Medicare Paying Twice for Prescription Drugs for Beneficiaries in Hospice (Part D).
- Long history of communications within CMS (Part D) and Part D Plan Sponsors.
- Aggressive pursuit of payments back to 2011 for all analgesics, and assumption that all drugs in 4 categories were related to terminal illness:
  - Analgesics
  - Anti-anxiety meds
  - Anti-emetic;
  - Laxatives.

Part D

- December 6 Memorandum to Hospice Industry.
  - While decisions on relatedness are unique to each patient, and must be made on an individualized basis, it is CMS’s general view that “hospices are required to provide virtually all the care that is needed by terminally ill patients” (i.e., most items and services are related to the terminal illness and related conditions.)
  - Need “clear evidence” documented by the hospice physician that items and services are not related (for separate billing).

CMS March 10, 2014 Guidance

- Response to industry comments on the 12/6/13 Memorandum.
- Some issues still outstanding.
- Future rulemaking will be required.
- April 9, 2014 Part C/D User Call
- Questions?

PARTDPOLICY@cms.hhs.gov (indicate “Hospice” in subject line)

Part D Guidance

- Covered Under Part D: Drugs “completely unrelated to the terminal illness or related conditions; in other words, unrelated to the terminal prognosis.”
  - “Unusual and exceptional circumstances.”
Part D Guidance

- **Covered by Hospice**: meds used prior to hospice election and continuing after hospice election as part of hospice plan of care and benefit.
- **Covered by Beneficiary**:
  - meds discontinued upon hospice election and determined by IDG (after discussion with family and patient) that meds are no longer necessary and/or producing negative effects. Not covered under hospice benefit because not related to palliation or symptom management. Beneficiary wants to continue.
  - Meds not on hospice formulary where beneficiary refuses to try formulary drug.
  - Beneficiary may opt to assume responsibility. Recovery may be made against beneficiary.

Part D Guidance

- Part D Plan sponsors should place beneficiary-level prior authorization (PA) requirements on all drugs for beneficiaries who elect hospice.
- Guidance outlines procedures for prospective determinations of payment responsibility initiated by hospices.
  - Initiate communications prior to claims submission (e.g., at hospice election), to alert Part D Plan Sponsor.
  - Also at revocation/termination.
  - Hospice provides explanation of why drug is unrelated to terminal illness/related condition(s).
  - Sponsors should accept hospice documentation to satisfy PA requirements.

Part D Guidance

- Hospice Providers can identify beneficiary Part D plan through hospice pharmacy submitting a standard electronic eligibility query to CMS Transaction Facilitator.
- Query response identifies the plan sponsor and provides contact information.

Part D Guidance

- Part D Sponsors use standard PA process outlined in attachment to Guidance.
  - Begins when Part D sponsor receives pharmacy claim for hospice beneficiary and rejects the claims with a specific codes, indicating that product may be covered under Part A or that PA is required.
  - Sponsors should also use point of sale messaging stating that there is a hospice provider and PA is required (and including contact information).
  - Pharmacy receives claims reject coding and can contact beneficiary or prescriber to determine whether hospice should cover the drug(s).

Part D Guidance

- Forms and notice requirements are described in detail in Guidance, along with links to forms and instructions, and how to address atypical situations.
  - Verbal explanations of relatedness may be provided in some circumstances, with written follow up.
  - Need for coordination and communication when prescriber is not affiliated with hospice provider.
  - If hospice or prescriber refuses to respond, “Part A coverage cannot be ruled out,” and sponsor must inform beneficiary that the drug is not covered under Part D.

  - 24 hour (expedited) or 72 hour (standard) timeframes for exception requests.

Part D Guidance

- No standard PA form yet, but CMS Guidance has attachment including the data elements that it would expect to be used.
  - CMS seeking suggestions for revisions to the form.

  - Independent Reviewer – Not at this time, but under consideration for future rulemaking.
Part D Guidance

- **Retrospective Determinations of Responsibility**
  - If Part D Sponsor has already paid for the drug prior to receiving notice of beneficiary’s hospice election, it must perform a subsequent review of claims paid within the hospice election period and “should” conduct outreach to the hospice or prescriber to make retrospective determinations of payment responsibility.
  - CMS expects coordination between hospice and Plan Sponsor.

- **Part D Payment Recovery**
  - For periods pre-2014 (PA), hospices and Plan Sponsors should work together to determine responsibility.
  - If hospice responsibility, they parties should negotiate repayment.
  - If beneficiary responsibility, the Sponsor should notify beneficiary.
  - Work directly, but reverse and rebill may be necessary with LTC pharmacies.

Other Relatedness Issues

- **Nursing Facilities – Medicaid Supplies**
  - Incontinence Supplies, Aide Services
  - Included in Medicaid Room & Board payment
  - If related to terminal illness, hospice should provide.
  - Double payment issues?
  - Addressed by proposed reduction in payment for hospice patients in NFs?
  - When patients are also Medicaid, there is already a 5% reduction in payment (Room & Board).

- **Nursing Facility Patient – Wound Care**
  - Wounds present prior to hospice eligibility/election?
  - Related to terminal illness or related condition?
  - Related to bed bound status of patient due to terminal illness?
  - Related to or exacerbated by an unrelated condition?
  - Is care comfort-related?

Relatedness Issues

- **Therapy Services Furnished Concurrent with Hospice Services (PT/OT/SLP).**

- Related to terminal illness or related condition?

- Who provides the unrelated therapy - HHA, CORF/ORF, Therapist in Independent Practice?
  - Entities that own both HHA and Hospice are vulnerable to scrutiny.

- **Physician Part B Billing.**
  - Community physician, specialist, consultation, non-contracted MD.

- **Hospital Services (esp. ER).**

- Need to educate beneficiaries and families about use of outside providers and need to coordinate through hospice.

- Relatedness determinations individualized to each patient, but made by a team, headed by the hospice physician or Medical Director.
DISCLAIMER

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