ENFORCEMENT, COMPLIANCE, & LONG TERM CARE: HOME HEALTH, HOSPICE, & NURSING HOMES

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MEDICARE BENEFITS

- **Medicare long term care benefits** cover a broad spectrum of services including hospice, home health, eligible skilled nursing care in a skilled nursing facility, long term care hospital services, etc.
  - **Medicare skilled nursing care benefits** cover the nursing home room, care, medications, and physical, occupational, and speech-language pathology services, among numerous other social services.
- **Medicare hospice benefits** cover care for eligible beneficiaries who have been diagnosed with a terminal illness. In electing hospice, a Medicare beneficiary waives all rights to Medicare services that are related to treatment of the terminal condition.
- **Medicare home health benefits** cover eligible home health services like intermittent skilled nursing care, physical therapy, speech language pathology services, continued occupational services, etc. for Medicare beneficiaries that are homebound.

Overview of Recent Enforcement Trends: False Claims Act Developments	Administrative Highlights: OIG Work Plan 2017	Best Practices for Auditing and Monitoring OR Quality of Care Focus?

ENFORCEMENT, COMPLIANCE & LONG TERM CARE AGENDA

OVERVIEW OF RECENT ENFORCEMENT TRENDS: FALSE CLAIMS ACT DEVELOPMENTS

OVERVIEW OF RECENT ENFORCEMENT EFFORTS

- Many forms of enforcement:
- False Claims Act Litigation and Settlements
- Criminal Strike Forces – located in certain geographic cities/regions
- HHS-OIG Efforts
  - CMS Moratoriums on HHA Enrollments, 81 Fed. Reg. 5444-5447 (Feb. 2, 2016)
- Data Analysis
  - OIG Data Brief "Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases" (June 2016)

OVERVIEW OF RECENT ENFORCEMENT TRENDS

- In FY16, the Department of Justice:
  - Recovered over $2.5 billion in health care fraud matters
  - Convicted 658 defendants of health care fraud offenses
  - DOJ opened 930 new civil health care fraud investigations and had 1,422 civil health care fraud matters pending
- In FY16, the U.S. Department of Health and Human Services Office of the Inspector General:
  - Took criminal action against 765 individuals or entities
  - Took civil action (including false claims, unjust enrichment, civil monetary penalties, and administrative recoveries) against 690 parties
  - Excluded 3,635 individuals and entities from the federal health care programs

The Department of Health and Human Services and The Department of Justice, Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2016

OVERVIEW OF RECENT ENFORCEMENT TRENDS

- Common False Claims Act theories of liability in the area of hospice, home health, and long term care include:
  - Medical Necessity – Eligibility for the Billed Service
  - Length of Stay/Service
  - Level of Care – Upcoding to higher levels of care
  - Improper or Complete Absence of Qualified Personnel Rendering Service
  - Poor Quality of Care – Worthless Services

RECENT HOSPICE ENFORCEMENT TRENDS

Good Shepherd Hospice (February 2015)

- Agreed to pay $4 million to resolve allegations that the company submitted false claims for hospice patients who were not terminally ill.
- Among other things, allegedly hired medical directors based on their ability to refer patients, focusing particularly on medical directors with ties to nursing homes, which were seen as an easy source of patient referrals.

Covenant Hospice (June 2015)

- $10 million paid for billing general inpatient care rather than routine home care.

St. Joseph Hospice (September 2015)

- $5.86 million paid for alleged billing of continuous home care hospice, rather than routine home care.

RECENT HOSPICE ENFORCEMENT TRENDS

- *United States of America v. Evercare Hospice and Palliative Care*
  - In July 2016, Evercare agreed to pay $18M to resolve FCA allegations that it admitted and recertified patients for hospice care who were not eligible for such care because they were not terminally ill.
  - U.S. alleged that Evercare's business practices, which included discouraging physicians from recommending that ineligible patients be discharged, were designed to maximize number of patients for whom it could bill Medicare without regard to patients' eligibility for hospice
- *United States of America v. Serenity Hospice and Palliative Care*
  - In October 2015, Serenity agreed to pay $2.2M to resolve FCA allegations that it admitted patients that did not have a six month or less prognosis
  - HHS-OIG entered into a 5 year Corporate Integrity Agreement with provider and excluded individuals

RECENT HOSPICE ENFORCEMENT ACTIONS

United States of America, et al. v. AseraCare Hospice, et al. (N.D. Ala.)

- AseraCare admitted patients to hospice where the medical records documented the patients were not terminally ill, i.e., did not have a six month or less prognosis
- Bifurcated jury trial: (1) falsity of the claims and then (2) other FCA elements including knowledge
- Phase I jury verdict: On October 15, 2015, the jury largely sided with the government, finding that 104 of the 121 submitted claims were objectively false.
- November 2, 2015: court formally vacated the jury's verdict and granted AseraCare's motion for a new trial and reopened summary judgment arguments
- March 31, 2016: the court granted summary judgment in favor of AseraCare

RECENT HOSPICE ENFORCEMENT EFFORTS

United States of America, et al. v. AseraCare Hospice, et al. (11th Circuit)

- U.S. appealed District Court dismissal of the case on summary judgment post phase I jury verdict
- U.S. argument that district court's ruling is based on a fundamentally flawed view of what it means for a claim to be "false" under the FCA
- Jury properly relied on documentation in medical records to determine if claim is false
- Evidence of good faith disagreement is relevant to scienter but does not negate falsity

RECENT HOSPICE ENFORCEMENT TRENDS

- *U.S. ex rel. Wall v. Vista Hospice Care, Inc.*
  - June 20, 2016 court (N.D. Tex.) granted summary judgment in favor of the hospice.
  - Agreed with AseraCare district court that the opinion of one medical expert alone cannot prove falsity without further evidence of an objective falsehood.
  - Rejected relator's attempt to use statistical sampling finding: "the underlying determination of eligibility for hospice is inherently subjective, patient-specific, and dependent on the judgment of involved physicians."

RECENT HOSPICE ENFORCEMENT TRENDS

- *United States of America, et al. v. Vitas Hospice Services LLC, et al.*
  - DOJ intervened in the case against the largest for profit hospice chain in the U.S.
  - DOJ pursued two theories of liability: (1) patients admitted and recertified to hospice who were not terminally ill and (2) patients were billed at higher levels of care when such care was not necessary, not rendered, or not performed in accordance with Medicare requirements
  - Pending settlement

RECENT HOME HEALTH ENFORCEMENT TRENDS

- *Amedisys* (April 2014)
  - Allegedly billed Medicare for nursing and therapy services that were not medically necessary or provided to patients who were not homebound, and otherwise misrepresented patients' conditions to increase Medicare payments
  - Alleged management pressure on nurses and therapists to provide care based on financial benefits rather than needs of patients
  - Paid $150M to resolve FCA liability
- *Careall Companies* (November 2014)
  - Allegedly overstated severity of patient medical conditions, billed for medically unnecessary services and billed for non-homebound patients
  - Paid $25M to resolve FCA liability

RECENT HOME HEALTH ENFORCEMENT TRENDS

- *Res Care Iowa* (February 2015)
  - Agreed to pay $5.63 million to resolve claims it violated the FCA by submitting false home healthcare billings to Medicare and Medicaid.
  - Between 2009-2014, the company failed to obtain required physician certifications of medical necessity, order for specific types and amount of services and, after 2011, face-to-face documentation.
- *A Plus* (February 2015)
  - Home health agency, two owners, and seven physicians and spouses agree to pay over $3 million.
  - Alleged Stark/Anti-Kickback violations based on payments to physicians' spouses for sham marketing positions to get referrals.
- *Nurses' Registry, Vicki House and Estate of Lennie House* (July 2015)
  - $17 million settlement to resolve allegations of billing for medically unnecessary home health care services and services tainted by kickbacks.

RECENT HOME HEALTH ENFORCEMENT TRENDS

- *Nurses' Registry and Home Health Corporation of Lexington, Kentucky* (October 2015)
  - Allegedly billed Medicare for medically unnecessary home health services and services tainted by kickbacks
  - Paid $16M to resolve FCA liability
- *Home Health Care of East Tennessee, Inc.* (September 2017)
  - $1.8 million paid for billing services that failed to meet Medicare coverage and payment requirements due to false or invalid certifications. Additional allegations of Stark Law violations.

RECENT LONG TERM CARE ENFORCEMENT TRENDS

- *Kindred Healthcare, Inc./RehabCare Group* (January 2016)
  - Allegedly billed for rehabilitation services that were not reasonable, necessary, or that never occurred
  - RehabCare is the largest provider of therapy in the United States contracting with more than 1,000 SNFs in 44 states
  - Paid $125M to resolve FCA liability

RECENT LONG TERM CARE ENFORCEMENT TRENDS

- *U.S. ex rel. Martin v. Life Care Centers of America* (October 2016)
  - Allegedly billed Medicare for medically unnecessary and/or unskilled therapy services and pressured therapists to target Ultra High RUG levels without regard to the individualized needs of the patients.
  - Seminal case in district court upholding use of statistical sampling
  - Paid $145M to resolve FCA liability

RECENT LONG TERM CARE ENFORCEMENT TRENDS

- *United States ex rel. Ruckh v. CMCII, LLC,* M.D. Fla. No. 11-cv-1303 (Dec. 2016)
  - RN who worked as a consultant at two Consulate managed SNFs filed qui tam action alleging violation of FCA.
  - Court held that Consulate and several other Consulate-managed nursing home entities violated the False Claims Act in submitting upcoded claims to Medicare/Medicaid.
  - Judgment for $331 million for illegally upcoding Medicare claims for patient therapy services.

ADMINISTRATIVE HIGHLIGHTS: OIG WORK PLAN 2017

ADMINISTRATIVE HIGHLIGHT OVERVIEW

Annual OIG Work Plans are published by HHS-OIG as a preview of:

- New and ongoing reviews and activities OIG plans to pursue
- Identification of vulnerable federal health care programs and services
- Evaluation of payment data and trends
- Recommendations for change and improvement

OIG WORK PLAN 2017: HOSPICE

- Protecting the Medicare Hospice benefit
  - Hospice is responsible for care related to the hospice diagnosis and any other related conditions
  - Nursing visit frequency to oversee the hospice care
  - Specific identification of improving election statements and certifications of terminal illnesses

OIG WORK PLAN 2017: HOSPICE

- Election Statement Requirements:
  - Electing to use the Medicare Hospice benefit
  - Waiving Medicare coverage for the terminal condition/related conditions except the care provided by hospice
  - Palliative in nature, not curative
  - Right to revoke the hospice benefit at any time or the hospice may discharge the beneficiary

OIG WORK PLAN 2017: HOSPICE

- Do your Medical Directors' Certificates of Terminal Illness (COTIs) stand up?
- Department of Health and Human Services OIG publication "Hospices Should Improve Their Election Statements and Certifications of Terminal Illness" Sept 2016
  - 14% of GIP stays, certifying physician did not meet all requirements
  - 12% of election statements did not specify waived coverage
  - 19% of GIP stays lacked evidence that the hospice patient was electing the Medicare hospice benefit

OIG WORK PLAN 2017: HOME HEALTH AGENCIES

- Home Health Agencies (HHA) providing accurate information to State agencies for recertification surveys
- Compliance with Medicare requirements
  - Homebound status
  - Skilled needs

OIG WORK PLAN 2017: HOME HEALTH AGENCIES

- Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases (June 2016)
  - Almost 500 HHAs and more than 16,500 physicians had an unusually high percentage of home health episodes for which the beneficiary had no recent visits with the supervising physician
  - More than 1,700 physicians had an unusually high percentage of home health episodes that were not preceded by a hospital or nursing home stay
  - Almost 800 HHAs and 4,000 physicians had an unusually high percentage of beneficiaries with multiple home health readmissions in a short period of time

OIG WORK PLAN 2017: SKILLED NURSING FACILITIES (SNFS)

- Adverse events in rehabilitation hospitals: National Incidence Among Medicare Beneficiaries (July 2016)
- "Adverse event" describes harm to a patient as a result of medical care, including the failure to provide needed care.
- Findings included:
  - An estimated 29 percent of Medicare patients in rehab hospitals experienced adverse or temporary harm events
  - Forty-six percent of adverse and temporary harm events were preventable
  - Nearly one-quarter of the Medicare patients who experienced an adverse or temporary harm event in a rehab hospital were transferred to an acute-care hospital for treatment

OTHER OIG AREAS OF INTEREST

- Increase frequency of surveys
- Payment policy revision (targeting certain diagnoses, nursing facility patients)
- Prepayment reviews for lengthy GIP stays

OIG AREAS OF INTEREST

OIG Special Fraud Alert June 19, 2015

- The OIG emphasized a shift in government enforcement to actions against individual physicians rather than actions primarily targeting affiliated provider entities.
- Physician Compensation May Result in Significant Liability:
  - OIG is looking at doctors on the receiving end of the kickback.

OIG AREAS OF INTEREST

Marketing Practices

- Payments tied to admissions or census goals raise a red flag
- Employees involved in admissions should not receive census based payments
- Be careful how you talk about census goals

BEST PRACTICES FOR AUDITING AND MONITORING OR QUALITY OF CARE FOCUS?

HOSPICE

Program for Evaluating Payment Patterns Electronic Report (PEPPER)

- Live D/C rate (no longer eligible, revocation, LOS)
- RHC in ALFs or SNFs
- Claims with a single diagnosis code
- No GIP or CC billed
- LOS for routine patients
- LOS for GIP claims
- Eligibility audits
- Visit frequency
- Medication coverage

HOSPICE

Other Areas to Audit to Identify Vulnerabilities

- HR files
- Payroll (expenses)
- Medical Directors under contract
  - Number of medical directors
  - Fair market value of services actually provided/evidence of work being done
  - Link to referrals
- Live discharge audit
  - Revocation form
  - Advance Beneficiary Notice (ABN)
- Contracted services

Interview key individuals

- Medical Director
- Volunteer Coordinator
- Bereavement Coordinator

BACK TO BASICS

- Identified in the Federal Register
- Main areas of concern include:
  - Billing
  - Conditions of Participation (CoPs)
  - Marketing hospice
  - Hospice in the nursing home

REFERENCES

- https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2017.pdf
- https://www.nhpco.org/sites/default/files/public/regulatory/OIG_FY2017_WorkPlan.pdf
- https://oig.hhs.gov/reports-and-publications/archives/workplan/2017/HHS%20OIG%20Work%20Plan%202017.pdf

QUESTIONS?

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