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The Government is Turning Up the HEAT on Hospice Providers

According to a report issued by the Department of Health & Human Services (HHS) and the Department of Justice (DOJ), between 2005 and 2011, Medicare spending on hospice care for nursing home residents increased by 70 percent.¹ As a result of this increased spending, hospice reimbursement has come under scrutiny, particularly since the formation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) in May 2009 by HHS and the DOJ. During 2012 alone, the federal government won or negotiated over \$3 billion in health care fraud judgments and settlements.² This article will discuss some of the publications issued by the HHS Office of Inspector General (OIG) that provide a window into where enforcement will be focused, as well as recent investigations, cases and settlements in the hospice world.

General Inpatient Care

The OIG recently released a report focusing on hospice general inpatient care (GIP), under which short-term pain control or symptom management that cannot be managed in other settings is provided in an inpatient facility (a Medicare-certified hospice inpatient unit, a hospital or a Skilled Nursing Facility (SNF)).³ The report noted that the “Centers for Medicare & Medicaid (CMS) staff expressed concerns about possible misuse of GIP, such as care being billed for but not provided, long lengths of stay, and beneficiaries receiving care unnecessarily.” Medicare paid \$1.1 billion for GIP in 2011, mostly for care provided in hospice inpatient units. Twenty-three percent of hospice beneficiaries in 2011 received GIP, with one-third of the stays exceeding five days. Conversely, 27 percent of Medicare hospices did not provide any GIP, and some of these hospices did not provide any level of hospice care other than routine home care.

In the report, the OIG indicated that it is committed to further review of long lengths of stay and the use of GIP in inpatient units, and will conduct a medical record review to assess the appropriateness of GIP provided in different settings. The OIG also suggested that CMS focus on hospices that do not provide GIP to ensure those hospices are offering the necessary levels of care to beneficiaries. Moreover, the report cited that in December 2011 the DOJ reached a \$2.7 million settlement in a qui tam action filed against Arkansas Hospice, Inc., for allegedly billing Medicare for GIP when beneficiaries actually received routine home care, which has a lower reimbursement rate. This settlement is a clear indication that the DOJ and OIG are serious about auditing GIP claims and joining suits to recover alleged false claims.



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Hospice Marketing Practices and Financial Relationships with Nursing Facilities

In addition to GIP, in its 2013 Work Plan, the OIG stated it will focus on hospice marketing practices and financial relationships with nursing facilities. The OIG's Office of Evaluation and Inspections (OEI) was tasked with reviewing marketing materials and practices by hospices to determine if they are overly aggressive or incorrectly define the Medicare hospice benefit and eligibility criteria. In a 2009 report, the OIG found that 82 percent of hospice claims for nursing facility beneficiaries did not meet Medicare coverage requirements.⁴

This is not a new area of concern for the OIG. The OIG issued a report in July 2011 that focused on the relationships between hospices and nursing homes.⁵ The report found that almost 300 of the hospices surveyed had more than two-thirds of their beneficiaries residing in nursing facilities in 2009 (referred to as "high-percentage hospices"). The OIG pointed out in the report that 72 percent of high percentage hospices were for-profit, compared to 56 percent of all hospices, and that for-profit hospices, on average, were reimbursed 29 percent more per beneficiary than nonprofit hospices and 53 percent more per beneficiary than government-owned hospices. The OIG's recommendation was that CMS monitor high percentage hospices closely and examine whether these hospices are meeting Medicare requirements. It is clear that the OIG will be keeping a watchful eye on marketing practices targeting hospice beneficiaries, as well as on high reimbursement care administered in the hospice environment.

Recent Hospice Enforcement Actions

The increased scrutiny and examination of hospice activities referenced above has resulted in significant actions and recoveries by the DOJ and OIG. In May 2013, the DOJ filed suit against Vitas Innovative Hospice Care (Vitas), the nation's largest for-profit hospice chain, alleging false Medicare billings for hospice services.

The complaint against Vitas alleged that Vitas paid employees bonuses tied to the number of patients they enrolled for crisis care services when those services were not reasonably medically necessary. The complaint further alleged that Vitas used "aggressive marketing tactics and expected their employees to increase the number of crisis care claims submitted to Medicare, without regard to whether the crisis care services were appropriate."⁶ Finally, the complaint alleged that Vitas offered "intensive comfort care" services in one of its brochures and "misled patients and their families to believe that the Medicare hospice benefit would routinely cover around the clock care for hospice patients, absent the requisite acute medical symptoms resulting in brief periods of crisis."

In March 2013, Hospice of Arizona L.C., a hospice management company, agreed to pay \$12 million and enter into a corporate integrity agreement to resolve allegations that Hospice of Arizona, along with its related entity and parent corporation, submitted or caused the submission of false Medicare claims for patients who were ineligible to receive end of life benefits, or for whom the hospice submitted bills at a higher reimbursement than it was entitled. The government alleged that Hospice of Arizona pressured staff to find more patients eligible for Medicare, adopted procedures that delayed and discouraged staff from discharging patients from hospice when they were no longer appropriate for such services, and did not implement an adequate compliance program that might have addressed these problems. The allegations arose under a qui tam lawsuit filed by a former Hospice of Arizona employee. The former employee who filed the underlying qui tam action received \$1.8 million as her share. After reaching the settlement, Stuart F. Delery, Principal Deputy Assistant Attorney General for the DOJ's Civil Division, noted that "[T]his settlement is the result of the Justice Department's efforts to prevent misuse of the taxpayer-funded Medicare hospice program, which is intended to provide comfort and care to terminally ill persons at the end of their lives."⁷

Conclusion

It is clear that the DOJ and HHS will continue to target and pursue hospice care providers through the HEAT initiative. Hospice care providers should have strong compliance programs that address quality of care concerns, as well as implement and update their procedures for submitting claims to Medicare. Hospice care providers should also engage skilled resources to ensure hospice beneficiaries are properly enrolled and that claims are submitted for the accurate level of care. A culture of non-retaliation should be encouraged to avoid the potential for former or current employees to file qui tam lawsuits under the False Claims Act. The effects of a government investigation and whistleblower suit can be painful, not only from the payment of significant fines and negative publicity, but also the possibility of entering a corporate integrity agreement. Moreover, in certain cases, hospice providers can be excluded by HHS from Medicare or criminal indictments may be filed against the hospice provider pursuant to the federal health care fraud statute or the federal Anti-Kickback Statute.⁸

1 See The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011 at 48 (Feb. 2012), available at <http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2011.pdf>.

2 See The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012 at 1 (Feb. 2013), available at <https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf>.

3 See Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Medicare Hospice: Use of General Inpatient Care (No. OEI-02-10-00490, May 2013), available at <https://oig.hhs.gov/oei/reports/oei-02-10-00490.pdf>.

4 See Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Medicare Hospice Care For Beneficiaries In Nursing Facilities: Compliance With Medicare Coverage Requirements (No. OEI-02-06-00221, September 2009), available at <http://oig.hhs.gov/oei/reports/oei-02-06-00221.pdf>.

5 See Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Medicare Hospices That Focus On Nursing Facility Residents (No. OEI-02-10-00070, July 2011), available at <https://oig.hhs.gov/oei/reports/oei-02-10-00070.pdf>.

6 See *United States v. Vitas Hospice Services, LLC.*, et al. Case No. 4:13 cv-00449-BCW (W.D. Mo. May, 2013).

7 See Press Release, U.S. Dep't of Justice, Office of Pub. Affairs, Hospice of Arizona and Related Entities Pay \$12 Million to Resolve False Claims Act Allegations (Mar. 20, 2013), available at <http://www.justice.gov/opa/pr/2013/March/13-civ-326.html>.