The Secret to My Success
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Agenda
Summary of Fraud and Abuse Laws
MedPac 2010 Report
2007 OIG Report
2010 OIG Report
OIG Work Plan
How to Avoid Problems
Basic Federal Fraud and Abuse Laws

Brief overview of the following laws:

The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b);

Physician Self-Referral Law (Stark), 42 U.S.C. § 1395nn;

The Civil Monetary Penalties Statute, 42 U.S.C. § 1320a-7a; and,


Anti-Kickback Statute

Prohibits offering, paying, soliciting or receiving anything of value in return for referrals of patients or inducing purchases, leases or orders paid for by a Federal health care program

Penalties:

• Criminal – imprisonment for up to 5 years and/or fines up to $25,000/offense
• Civil – CMP $50,000/offense, treble damages
• Exclusion

Health Reform: violation of AKS = false claim under FCA

IMPORTANT: both sides of the “transaction” are committing a felony
The Physician Self Referral (Stark) Law

The Stark Law prohibits physician referrals of certain services to entities with which the physician has a financial relationship.

- Applies to referrals of “Designated Health Services”
- Home Health services are DHS
- Hospice services are not DHS

Penalties:
- Civil sanctions only
- Denial of payment
- Recoupment
- CMP up to $15,000/bill or claim
- CMP up to $100,000/circumvention scheme
- Exclusion
- Bootstrap FCA violation

Civil Monetary Penalties Statute

Allows the Federal Government to impose monetary penalties on providers for a number of activities:

- Anti-Kickback violations
- Stark violations
- Beneficiary inducements

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False Claims Act

Main fraud enforcement tool for Fraud and Abuse violations.

Allows private citizens to bring actions on behalf of the federal government (whistleblower).

Prohibits knowingly submitting or causing the submission of false/fraudulent claims to the U.S. Government.

False Claims Act

Fraudulent Conduct:
- Up-coding
- Ghost patients
- Kickbacks
- Unbundling claims
- Lack of medical necessity

Violations:
- Treble damages
- $5,000 - $11,000 per false claim

Nursing Home & Hospice Relationships

Over the last few years, Hospice providers have been given a false sense of security, because of the inordinate focus on home health.

While home health has been heavily targeted, hospices have undergone relatively little scrutiny.
Nursing Home & Hospice Relationships

We are beginning to see a shift in CMS and OIG’s view of hospice providers.

This is being driven by several factors:

- Growth in hospice spending
- Growth in number of hospice patients
- Growth in number of for profit providers

Nursing Home & Hospice Relationships

MedPAC and OIG have both issued reports over the last five years raising concerns about hospice utilization, relationships with referral sources, and similar issues.

This means hospice scrutiny is increasing.

Nursing Home & Hospice Relationships

OIG has long been suspicious of hospice relationships with nursing homes.

OIG has issued several fraud alerts and bulletins raising concerns about relationships between hospices and facilities.

This suspicion has taken a new turn with the report issued this past summer.
Nursing Home & Hospice Relationships

This report comes shortly after MedPACs 2010 Report to Congress.

MedPAC’s report raised several concerns that are echoed in OIG’s report.

MedPAC 2010

MedPAC noted, with concern, the increase in for-profit hospices.

It also noted an increase in non-cancer diagnoses and an increase in average length of stay on hospice benefit.

MedPAC concluded that the length of stay increase was due, in part, to targeting specific types of patients.

OIG 2007

In a 2007 report, OIG noted that hospice beneficiaries in nursing homes were more than twice as likely as other beneficiaries to have terminal diagnoses of ill-defined conditions, mental disorders, or Alzheimer’s.

They also tended to stay on the benefit longer.
In July, OIG issued a new report. This report “pulls together” several points from the prior reports. This report is another signal that scrutiny is going to keep increasing.

OIG’s July 2011 report titled “Medicare Hospices that Focus on Nursing Home Residents” expands upon the targeting theme raised by MedPAC.

OIG examines a new trend in hospice care – for-profit hospices that focus on nursing home residents.

Findings:

- Grew by 53% in other settings.
- Number of hospice beneficiaries in nursing facilities grew by 40% over the same period.
OIG 2011

Findings:

In 2009 31% of all hospice beneficiaries resided in a nursing facility.

OIG 2011

Findings:

Report identified a category of “high-percentage” hospices – hospice with more than 2/3 of their patients in nursing facilities.

More than 72% of these high-percentage hospices were “for profit.”

OIG 2011

Findings:

Report notes that 56% of hospices overall are for-profit.

NOTE: CMS appears to be more suspicious of “for-profit” hospices.
Findings:

High percentage hospices received more payments per beneficiary and served beneficiaries who spent more time (three weeks on average) on the hospice benefit.

28% of high-percentage hospice beneficiaries spent 6 months or more on hospice.

Key Issue for all providers: Report notes that high-percentage hospices served patients with diagnoses of ill-defined conditions such as: failure to thrive; senility without psychosis; unspecified debility; Report also mentions Alzheimer’s and “mental disorders.”

Report notes that these patients tend to receive less complex care.

Translation: It costs the provider less to provide the patient care while keeping the patient on the benefit longer. Daily Medicare payment is lower, but provider receives a lot more overall.
OIG 2011

To OIG, this report confirmed something it had long suspected – hospices were “bending the rules” to admit SNF patients.

OIG also concludes hospices are targeting these patients, due to increased length of stay.

OIG 2011

OIG recommended a change in hospice reimbursement and that CMS monitor high percentage hospices.

Translation: Pay you less and watch you more. This makes your marketing and admissions policies even more important.

2011 and 2012 OIG WORKPLAN

In addition to the multiple reports issued on the topic of questionable patient admissions, in the last two OIG Workplans, OIG has specifically mentioned hospice care in facilities as an area of focus.

That is a lot of OIG/CMS emphasis on this area.
What does This Mean for Us?
OIG and CMS are concerned about the types of patients you serve in facilities and why you serve them.

Need to be aware of the patients the SNF is “referring.” OIG has said SNF can benefit financially from moving patients to hospice.

What does This Mean for Us?
Providers need to assess what patients they are serving and why.

Growth in census that is, according to OIG, inappropriate, will cost you more than you gain.

What does This Mean for Us?
First Question: Are they terminally ill? Physician certification of life expectancy of six months.

This is not an exact science, but accepting patients with ill-defined diagnoses is a red flag.
What does This Mean for Us?

How it can come up: Referral from facility. Facility prefers to move patients to hospice. It can improve their bottom line if they can shift costs to hospice per diem.

Hospice is willing to take patient to increase census and as a "favor" to the facility. Hospice feels pressure to take them.

What does This Mean for Us?

Hospice may also be willing to take patients knowing they are less intensive and likely to be on hospice longer.

Hospice marketers may be "broadening" the scope of patients hospice can take to increase admits to achieve bonuses.

What does This Mean for Us?

Second question: What does my overall patient census look like?

Do you have a high percentage of non-cancer non-specific terminal patients?

Do you have a longer length of stay in the facility, on average, than out?

Is care provided differently in the facility than at home?
What does This Mean for Us?

Third Question: Marketing to facilities.

What are your marketing goals?

How are your marketers rewarded?

How well do your marketers understand the hospice benefit?

Marketing staff bonuses: You can pay bonuses to bonafide employees who perform marketing.

Structure of bonuses: OIG objects to bonuses based upon length of stay.

What does This Mean for Us?

Third Question: Marketing to facilities.

If you incentivize your staff to pursue “high dollar” patients, you will likely end up with the type of patients that will raise red flags with OIG.
Related Issue: Appropriateness of Marketing Materials

Hospice Marketing Materials may increase inappropriate referrals such as those referenced in the 2011 OIG report and earlier reports.

Related Issue: Appropriateness of Marketing Materials

MedPAC’s 2010 report to Congress raised a specific concern about inappropriate marketing materials and admission of “non-terminal” patients to hospice. They recommended OIG look for a correlation between length of stay and deficiencies in marketing and/or admissions practices.

Related Issue: Appropriateness of Marketing Materials

If the materials do not make it clear what purpose of hospice is or what the eligibility requirements are, SNF may increase number of inappropriate referrals. Patients may be more willing to elect hospice inappropriately, because they are unaware of the requirements.
Marketing Staff Issue: Appropriateness of Marketing Materials (cont’d)

Marketing materials are considered inappropriate when they:

- Fail to explain eligibility for benefit – especially need for “terminal illness.”
- Fail to explain electing hospice = foregoing curative treatment.

Marketing Staff Issue: Looking at files of residents

Some hospice providers will either ask for or be provided the opportunity to review the SNF’s files in order to “look for” potential hospice patients.

Hospice provider essentially looking through every SNF record to try to find hospice patients.

Marketing Staff Issue: Looking at files of residents

Looking at files of patients that are not your patients is a violation of HIPAA.

HIPAA allows disclosure to another provider for treatment, payment, and certain “healthcare operations.”
Marketing Staff Issue:
Looking at files of residents

Culling through the SNF’s files looking for patients does not amount to treatment, payment or operations.

Reviewing all of the SNF’s files is not a “consultation.”

Marketing Staff Issue:
Looking at files of residents

Eligibility requirement for hospice is clear – 6 month life expectancy. SNF should not need hospice to review files for it. SNF should be able to identify such patients.

Marketing Staff Issue:
Looking at files of residents

Question: If SNF is making this offer, are they wanting you to identify “non-specific” terminal patients?
Marketing Staff Issue: Looking at files of residents

Example: Hospice nurse comes to facility to provide ordered care to patient admitted to hospice. Hospice nurse notices a “nursing note” in the name of a nurse who works for another hospice.

Other Risk Areas

OIG has long been concerned about what hospices might offer or SNF’s might solicit in order for the hospice to gain access to the residents. Issues that have come up in the past:

- Hospice gaming the per diem and or contract payments.
- Hospice providing services covered by per diem
- Offering or requesting excessive supplies; Hospice providing free staffing, etc.

Nursing Home And Hospice Relationships Per Diem Issues

When a dual eligible patient elects hospice, Medicaid will pay the hospice a room and board per diem to pay to the SNF, the payment is 95% of the Medicaid rate.

As part of contract with hospice, SNF will request the hospice pay it 100%.

The SNF may then try to negotiate payments of other amounts for items and services covered by the per diem.
Paying the SNF more than 100% of the Medicaid Per Diem creates a potential AKS violation.

Paying 100% of the Per Diem and then paying extra for items covered under the per diem also creates an AKS risk.

See, Hospice and Nursing Home Contractual Relationships, OEI-05-95-00251, November 1997

Contract may allow hospice to pay ala carte for additional items or services not covered under the per diem, this includes non-core services provided by the SNF, providing medications for the terminal illness.

The terms of the “ala carte” arrangement can be source of compliance problems.

For example: paying more than fair market value for items.

Remember: Hospice is paid to care for the terminal diagnosis, SNF is given per diem for “day to day” non-terminal care.
Nursing Home and Hospice Issues: Other services risks

SNF “requesting” additional, unnecessary services.

Hospice has arrangement in place to use SNF staff for non-core services, such as therapy. SNF administrator requesting hospice order “palliative therapy” services for all patients. Results in additional income to SNF for services.

Issues: ordering and paying for medically unnecessary services; AKS.

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Nursing Home and Hospice Relationships

Another example – “continuous care” for all hospice patients in the facility.

SNFs have asked facilities to provide “continuous care” to hospice patients, regardless of whether they meet the continuous care criteria.

At the very end of a patient’s life or if the Medicare continuous care criteria are met, this may be okay.

HOWEVER: Providing 24 hour care to all patients in SNF – more likely a kickback.

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“HELPING OUT” AROUND THE FACILITY
Helping Out

This situation can come up in a number of ways.

- Facility staff may ask an aide or nurse to pitch in as a “professional courtesy.”
- A facility may request an agency provide staff to help out;
- An ALF may request agency personnel assess a patient and discuss services with them.

Helping Out (cont’d)

If you provide staff for free or below fair market value to a referral source to perform the duties normally performed by the referral source’s staff, you are providing them with something of value – staff.

Extra Supplies
Extra Supplies (cont’d)
Examples: Facility administrator requesting provider bring excessive amount of incontinence supplies.
Provider may need to provide this for patient, but providing more than your patient(s) can use is a kickback.

Extra Supplies (cont’d)
Facilities that make these requests do so, because they can defray their costs by having hospices (and HHAs) provide stuff.
"We need to get everything out of them we can."

Avoiding the problem
How to Avoid:
1. Education
2. Compliance Oversight
3. Admissions/Saying No
4. Monitoring
Avoiding the problem - Education

Your marketing staff should be aware of the services you provide and the eligibility requirements for hospice.

Compliance Training Should include:

1. Fraud and Abuse overview
2. Hospice eligibility training

Avoiding the problem - Oversight

Compliance Officer/Department should have oversight over marketing efforts.

Review new marketing materials before they are used, to ensure they adequately describe the benefit.

Review new marketing incentives and other programs, before they are implemented.

Avoiding the problem - Oversight

Your staff should know to whom to make a report of an inappropriate request or concern.
Avoiding the problem – Admissions/Saying No

Your clinical staff should be aware of the hospice eligibility requirements. These should be assessed on every admission.

If they feel a patient is not appropriate for hospice, they respond accordingly.

There should not be pressure to accept patients.

Avoiding the problem – Admissions/Saying No

Clinical judgment should never be second to financial pressure/census goals.

Avoiding the problem – Monitoring

Compliance should be routinely monitoring lengths of stay, facility v. at-home, diagnoses currently on census, etc.

May have legitimate reasons for patient population, but still need to know if you are “in the cross hairs.”
Avoiding the problem – Monitoring

CMS and OIG have said a lot about this issue. Providers should be proactive – it is better to identify a problem yourself than to have OIG catch it for you.

Conclusion

Hospice is coming under greater scrutiny than ever before. This scrutiny has a special focus on relationships with nursing and other facilities. Hospice providers need to be vigilant – as competition increase, so will the pressure to cut corners. Cutting corners may improve your bottom line in the short term, but in the long term it can result in many bad outcomes, including jail.

Conclusion

REMEMBER!!

The best way to deal with Fraud an Abuse problems is to not have the problems in the first place.
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