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Strengthening the relationship between DOJ attorneys and compliance professionals

an interview with
Michael D. Granston

> Healthcare providers have come to realize that not only are strong compliance programs good for business by enhancing employees' awareness of their legal obligations, but they also promote internal reporting by giving potential whistleblowers a mechanism to voice their concerns.

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by David R. Hoffman, JD, FCPP

Hospice fraud: The ultimate betrayal of trust

» In-patient and outpatient hospice fraud is a cruel betrayal of trust that cannot be remedied by an apology.
» Recent hospice fraud prosecutions and settlements evidence vulnerabilities in the regulatory system.
» Falsification of records makes monitoring of hospice fraud challenging.
» Monitoring by an IRO for a hospice provider under a CIA may not uncover non-compliant conduct.
» Medical necessity compliance review of hospice cases may require third-party clinical review.

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When you hear the word *hospice*, what is your reaction? A difficult end-of-life decision needs to be discussed; caring and compassionate healthcare personnel will be providing compliant care; the death of a loved one will occur with dignity. I have engaged in this decision-making process and that is why I was so disturbed when two published articles appeared within days in October 2017—one detailing a $75 million settlement with Vitas Hospice Services, LLC and Vitas Healthcare Corporation[1] and the other describing how hospice patients are being "abandoned" by hospice providers.[2]


Hoffman

The fraud settlement resolved allegations that "between 2002 and 2013 Vitas knowingly submitted or caused to be submitted false claims to Medicare for services to hospice patients who were not terminally ill."[3] The government also alleged that the defendants "rewarded employees with bonuses for the number of patients receiving hospice services without regard to whether they were terminally ill and whether they would have benefited from continuing curative care."[4]

The government also alleged false claims submission based on the billing of continuous home care services, the highest reimbursable daily rate that Medicare pays to hospice providers, for patients who did not experience acute medical symptoms causing a brief period of crisis. The allegations stated that goals were set for the number of continuous home care days billed to Medicare and that "aggressive marketing tactics" were implemented while staff were "pressured… to increase volume of claims, without regard to whether the patients actually required this level of crisis care."[5] The defendants denied any liability pertaining to any of the alleged conduct.

As if these allegations were not troubling enough:

> [a] KHN analysis of 20,000 government inspection records reveals that missed visits and neglect are common for patients dying at home…. For instance, data show many hospices fail to provide extra care in times of crisis…21 percent of hospices which together served over 84,000 patients, failed to provide either form of crisis care in 2015, according to CMS.[6]

The KHN article also described families who have suffered gut-wrenching disappointment and emotional suffering based on failures of hospice care delivery coupled with an apparent lack of regulatory oversight and enforcement to address those failures. These failures are not easily remedied and certainly a simple apology by the hospice provider does not suffice.

In 2017, the CEO for the largest hospice company in Illinois, Passages Hospice LLC, was sentenced to 6½ years in federal prison for paying kickbacks to nursing homes and providing bonuses to employees (also convicted) who participated in the fraudulent scheme to defraud Medicare by designating nursing home residents as close to death, including many who were not that sick and had years to live.[7] "This higher level of care, known as 'general inpatient' services, or GIP, would boost Passages' Medicare reimbursement from an average of about $150 per day to well over $600 for each patient."[8]

Another significant hospice fraud civil settlement was reached in November 2017 (disclosed in May 2018) with Treasure Coast Hospice and its parent organization Treasure Health. The alleged wrongdoing occurred from 2005 to 2011 and included claims of falsifying physician signatures, backdating medical records, and misdiagnosing patients as terminally ill.[9] Of note, the provider claimed that this case was solely about documentation. Specifically, the chairman of the hospice's board of directors was quoted as saying:

> In a routine review of patient records in 2014, the government asserted that Treasure Coast Hospice did not provide sufficient documentation for the care that was delivered to certain patients during the period from 2005 to 2011. The actual care that was provided to patients was never in question; this has been a dispute over documentation.[10]

The relators in this *qui tam* matter were two physicians who left the hospice company in 2011, and they tell a very different story. They alleged that:

> employees were trained to falsify patient-care notes to make stable but chronically ill patients appear terminally ill. They also allegedly were trained to underestimate patients' life expectancies in order to keep them eligible for Medicare benefits, which are available to patients expected to live less than six months.[11]

The Treasure Health matter settled for $2.5 million, which appears to be based on an "ability to pay" basis and the imposition of a Corporate Integrity Agreement (CIA) by the Office of Inspector General for the Department of Health and Human Services. The CIA requires the usual structural and procedural compliance requirements and the retention of an Independent Review Organization (IRO). The IRO's "Claims Review" function includes Eligibility Review and an Appropriate Level of Services Review. Both of these reviews consist of an in-depth evaluation of the "medical necessity" for the use of hospice services through a medical record review by the IRO. Although this approach may appear to be effective, hospice fraud cases are based usually, in part, on the falsification of records. Therefore, continued non-compliant conduct may continue, because chart review may not capture suspicious conduct, even while the provider is under a CIA. Therefore, the provider's internal compliance processes must be vigilant in addressing potential falsification of records concerns.

Steps to take

To that end, the monitoring function of the Compliance department at a hospice services provider must include:

- a review of incentives and bonus structure for all employees to ensure alignment with quality and compliance,
- accuracy of physician certifications of terminal illness on a continuing basis, and
- staff surveys/interviews to ensure that there is a "culture of compliance" that would ensure that falsification of records would be reported and addressed.

Specifically, if the demand by owners or management is to fill the hospice beds or maximize reimbursement or enrollment in any setting, and those demands are tied to compensation in any way, there is misalignment between compliance concerns and business demands. Next, it would be prudent for a hospice provider to retain a third-party clinical expert to interview staff and patients and review documentation to ensure that the clinical evidence being used to certify a patient as hospice-eligible is true and correct and, in fact, justifies the patient being certified as needing hospice services. Finally, communication with staff is vital in ensuring that a culture of compliance exists within the company.

An effective compliance program should highlight the use of the compliance hotline to contact the Compliance department if there is a concern over improper eligibility for or provision of hospice services. Additionally, focused educational sessions on hospice fraud and its ramifications to the organization and the individuals engaged in falsification of records and other fraudulent conduct will be useful in reducing the likelihood of this conduct going undetected.

Of note, falsification of records violates state and federal criminal statutes and must be viewed as the most extreme violation of a healthcare provider's Code of Conduct, with automatic termination of employment and reporting to relevant licensing boards. More importantly, constant monitoring and oversight of quality metrics, medical necessity determinations and hospice certifications, and patient satisfaction must be a part of the Compliance Committee's monthly data review to ensure that the trust placed in hospice providers at the most vulnerable time in our lives is not betrayed.

1. Department of Justice, Justice News press release: "Chemed Corp. and Vitas Hospice Services Agree to Pay $75 Million to Resolve False Claims Act Allegations Relating to Billing for Ineligible Patients and Inflated Levels of Care" October 30, 2017. Available at https://bit.ly/2yszoSp
2. JoNel Aleccia and Melissa Bailey: "'No One is Coming': Hospice Patients Abandoned At Death's Door" *Kaiser Health News*; October 26, 2017. Available at https://bit.ly/2lii6RV
3. Ibid, Ref #1.
4. Idem.
5. Idem.
6. Ibid, Ref #2
7. David Jackson and Gary Marx: "Hospice CEO gets 6 ½ years for fraud scheme" *Chicago Tribune*; March 7, 2017. Available at https://trib.in/2m0gIiA
8. Idem.
9. Lisa Broadt: "Treasure Coast Hospice allegedly defrauded Medicare, misdiagnosed patients" *TCPalm.com*; May 18, 2018. Available at https://bit.ly/2tFOEqI
10. Idem.
11. Idem.