Legal Aspects of Hospice

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Legal Aspects of Hospice: Objectives

- To be aware of the OIG's priorities with respect to the ongoing monitoring and evaluation of hospices.
- To be aware of the most common deficiencies identified by the OIG in hospices nationwide.
- To be aware of recent enforcement actions taken by the DOJ and whistleblowers with respect to hospices.
- To understand the requirements and risks associated with applying for and obtaining funds through the Paycheck Protection Program and/or the Provider Relief Fund.

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U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
FY2017 TO THE PRESENT:
WORK PLANS, AUDITS & REPORTS

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OIG WORK PLAN: FY2017

- OIG noted that it has been focusing its efforts on identifying and offering recommendations to reduce improper payments, prevent and deter fraud, and foster economical payment policies.
- OIG indicated that future planning efforts for **FY2017 and beyond** will include additional oversight of hospice care, including oversight of certification surveys and hospice-worker licensure requirements.
- OIG stated that it would review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements; and would determine whether registered nurses made required on-site visits to the homes of Medicare beneficiaries who were in hospice care.
- Effective **FY2018**, OIG is no longer publishing an annual work plan. Instead, the OIG website is updated monthly to ensure it more closely aligns with the work planning process.

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OIG WORK PLAN: FY2018 ONWARD

- In June 2018, OIG issued a Monthly Work Plan Update titled **"Medicare Payments Made Outside the Hospice Benefit."**
  - Pursuant to 42 C.F.R. § 418.24(d), a hospice beneficiary waives all rights to Medicare payments for any services that are related to the treatment of the terminal condition for which hospice care was elected.
    - The hospice agency assumes responsibility for medical care related to the beneficiary's terminal illness and related conditions, while Medicare continues to pay for covered medical services that are not related to the terminal illness.
  - OIG noted that in prior reviews, it has identified separate payments that should have been covered under the per diem payments made to hospice organizations.

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OIG WORK PLAN: FY2018 ONWARD (continued)

- In the 2018 Work Plan Update, OIG indicated that it would produce summary data on all Medicare payments made outside the hospice benefit, without determining the appropriateness of such payments, for beneficiaries who are under hospice care.
- OIG stated that it would also conduct separate reviews of selected individual categories of services (e.g., DMEPOS, physician services), to determine whether payments made outside of the hospice benefit complied with applicable federal requirements. This report is expected to be issued sometime in 2020.

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OIG REPORTS: FY2019

- On July 3, 2019, OIG issued two reports evaluating vulnerabilities in hospice care:

  (1) Hospice Deficiencies Pose Risks to Medicare Beneficiaries

  (2) Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries From Harm

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OIG REPORTS: FY2019 (continued)

- ***"Hospice Deficiencies Pose Risks to Medicare Beneficiaries" (Report No. OEI-02-17-00020)***
  - OIG evaluated CMS's deficiency and complaint data from 2012 through 2016, as well as data from State agencies and accrediting organizations, for nearly all hospices that provided care to Medicare beneficiaries (a total of 4,563 hospices).
  - Of those surveyed, 87% had at least one deficiency (meaning, they failed to meet at least one requirement for participating in the Medicare program), and 20% had a serious deficiency (meaning, the hospice's capacity to furnish adequate care was substantially limited, or the health and safety of beneficiaries were in jeopardy).
  - One-third of all hospices that provided care to Medicare beneficiaries had complaints filed against them. For almost half of these hospices, the complaints were severe.

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OIG REPORTS: FY2019 (continued)

- The most common types of deficiencies identified by OIG were:
  - Hospices had poor care planning and failed to ensure that they provided the services called for in the care plans that they established. Hospices also failed to ensure that the care plans were appropriately individualized.
  - Hospices failed to properly train or manage aide staff. Some hospices failed to ensure that hospice aides were supervised or given patient-specific care instructions, while others failed to ensure that hospice aides were competent to provide care.
  - Hospices failed to include key content in the comprehensive patient assessments, which dictates a beneficiary's care. Hospices also failed to update assessments within the required timeframe (i.e., at least every 15 days or as frequently as the patient's condition requires).

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OIG REPORTS: FY2019 (continued)

- OIG identified a number of additional deficiencies:
  - Some hospices did not properly vet their staff and put beneficiaries' safety at risk.
  - Hospices did not always address needs, putting some beneficiaries at risk of suffering unnecessary pain and distress.
  - Some hospices did not coordinate beneficiaries' care, at times keeping their physicians uninformed.
  - Some hospices failed to maintain quality control programs, creating possible hazards *(e.g., in one case, a hospice failed to maintain an infection control program, which has become a significant focus of surveyors in light of COVID-19).*

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OIG REPORTS: FY2019 (continued)

- As a result, OIG recommended that CMS take the following actions:
  - Expand the deficiency data that accrediting organizations report to CMS and use these data (in conjunction with data from State agencies) to strengthen its oversight of hospices.
  - Identify hospices with persistent problems (e.g., those with high numbers of deficiencies in multiple years), as well as track basic measures and identify, on a national scale, issues and trends that warrant further examination across all hospices.
  - Seek the statutory authority to provide publicly information from surveys conducted by accrediting organizations to inform beneficiaries about hospices that have provided poor care.
  - Make individual State agency survey reports more readily available and accessible for beneficiaries.
  - Educate hospices about the requirements associated with care planning, aide services, patient assessments, and quality care.
  - Develop a special initiative to identify and target hospices with a history of serious deficiencies, which should include the provision of education and technical assistance.

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OIG REPORTS: FY2019 (continued)

- ***"Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries From Harm" (Report No. OEI-02-17-00021)***
  - OIG evaluated 12 cases in which hospice beneficiaries suffered significant harm, either as a result of hospices providing poor care to beneficiaries or from abuse by caregivers or others and the hospice failing to take action.
  - OIG determined that such vulnerabilities exist for hospice beneficiaries because:
    - There are insufficient reporting requirements for hospices (to CMS, State Agencies, or the authorities).
    - There are limited reporting requirements for surveyors.
    - Beneficiaries and caregivers face significant obstacles to making complaints.
    - Hospices do not always face serious consequences for harming beneficiaries (e.g., surveyors do not always site "immediate jeopardy" in cases of significant harm; hospices' plan of correction are not designed to address underlying issues; and, other than termination, CMS has no penalties to hold hospices accountable for harming beneficiaries).

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OIG REPORTS: FY2019 (continued)

- As a result, OIG recommended that CMS take the following actions:
  - Strengthen the hospice Conditions of Participation related to reporting abuse, neglect and other harm (42 C.F.R. 418.52(b)(4)), **requiring** hospices to report suspected harm (regardless of the perpetrator) to CMS and law enforcement, if appropriate, within short time frames.
  - Strengthen the hospice Conditions of Participation to require hospices to develop written policies and procedures for investigating and reporting suspicions of abuse, neglect and other harm, including the development of training for employees regarding the identification of signs of abuse, neglect and other harm and their obligation to report such instances.
  - Revise the State Operations Manual to incorporate instructions for surveyors to contact law enforcement when they suspect a crime was committed, regardless of a finding of immediate jeopardy.

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OIG REPORTS: FY2019 (continued)

- Monitor surveyors' use of immediate jeopardy citations to ensure that it is being used to identify the most serious cases of harm, and should consider implementing a hospice-specific subpart to its guidance to clarify what constitutes an "immediate jeopardy situation" in the hospice setting.
- Improve the process for making complaints and make it more accessible to beneficiaries and their caregivers (for instance, by creating an online, standardized, centralized complaint form).
- Work with hospices to provide information about making complaints (i.e., relevant phone numbers, websites, and forms) to beneficiaries and their caregivers, and include information about making complaints in its educational materials explaining the hospice benefit.

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OIG REPORTS: FY2019 (continued)

- On November 18, 2019, OIG issued a third report titled **"Registered Nurses Did Not Always Visit Medicare Beneficiaries' Homes At Least Once Every 14 Days To Assess The Qualify Of Care And Services Provided By Hospice Aides."** (Report No. A-09-18-03022).
  - As indicated in the first slide, this was an objective set forth in the OIG's FY2017 Work Plan.
  - OIG's audit found that registered nurses did not always visit hospice beneficiaries' homes at least once every 14 days to assess the quality of care and services provided by hospice aides, or document the visits in accordance with federal requirements.
  - OIG blamed these deficiencies on hospices' lack of oversight, scheduling errors, employee turnover, and the registered nurses not being aware of the 14-day supervisory visit requirement.
  - As a result of these deficiencies, OIG concluded there was no assurance that beneficiaries admitted to those hospices received the appropriate care while in hospice care.

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OIG STRATEGIC PLAN: 2020-2025

- OIG issued a Strategic Plan that sets forth a roadmap in planning and conducting oversight work over the next five years.
- OIG has identified program integrity for home and community-based services as a top management challenge for HHS, issuing over 30 audits and evaluations and recommending the recovery of over $700 million.
- As a result, OIG will build on its current oversight work to promote patient safety and accuracy of payments in home and community settings, including hospices.
- OIG seeks to reduce fraud, waste and abuse and enhance program integrity in home and community settings through outreach, education, audits, evaluations, inspections, investigations, and administrative enforcement, in collaboration with CMS, Medicaid Fraud Control Units, DOJ, the Administration for Community Living, and HHS Office of Civil Rights.

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Key Takeaways

- Through the OIG's Work Plans and Reports, the OIG emphasizes the importance of ensuring that hospice staff is well trained on Medicare requirements, including making home visits to beneficiaries and preparing and complying with individualized plans of care, in order to improve the quality of hospice care.
- The OIG also emphasizes the importance of training staff to identify and report instances of abuse and neglect, as well as to ensure beneficiaries and their caregivers have access to and understand the various reporting mechanisms.

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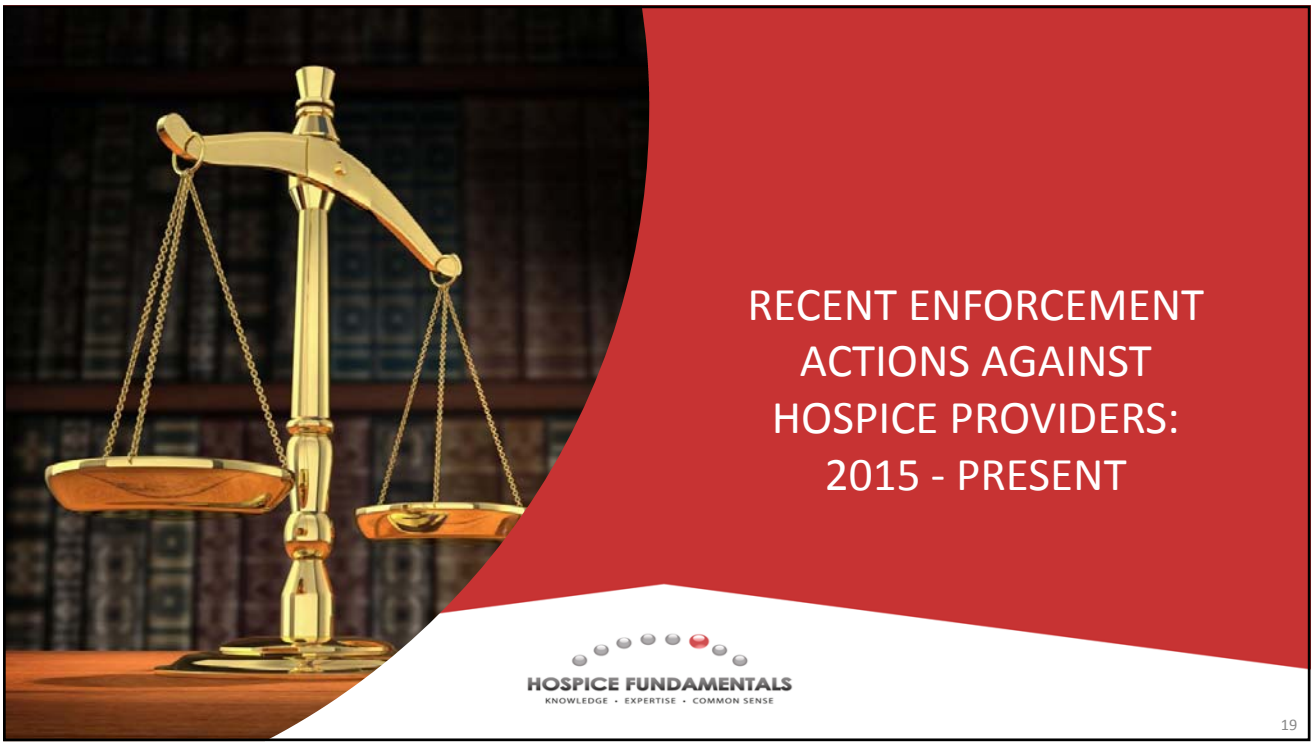

TRENDS IN RECENT ENFORCEMENT ACTIONS

- Over the past five years, there have been at least six cases that were either settled with the DOJ or in which a jury found defendants guilty of False Claims Act allegations.
- As evidenced through these cases, the DOJ (often with the help of qui tam relators) has taken significant enforcement action against hospices that admit patients who are not terminally ill and did not qualify for the hospice benefit.

RECENT ENFORCEMENT ACTIONS

- On **January 14, 2020**, the U.S. Government filed an Information against Anita and Jai Vijay, alleging that Anita, a Social Services Director at a Skilled Nursing and Assisted Living Facility, steered beneficiary referrals to specific home health and hospice agencies following their discharge from the facility.
  - In exchange, the home health and hospice agencies paid cash kickbacks to Anita and her husband, Jay.
  - The agencies' owners paid Anita and Jay kickbacks for the referral of approximately 60 beneficiaries, for which Medicare paid the agencies about $400,000 for services they purportedly provided to the beneficiaries.
- On February 6, 2020, Jai Vijay plead guilty to conspiracy with the owners of the agencies to pay and receive illegal kickbacks in exchange for Medicare beneficiary referrals, and is facing a maximum statutory penalty of five years in prison and a fine of $250,000.00 or twice the gross loss or gain. The case against Anita is ongoing.

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RECENT ENFORCEMENT ACTIONS

- **On November 6, 2019**, a federal jury found three individuals associated with dozens of hospice and home health companies guilty for their roles in a $154 million health care fraud scheme that included the submission of false and fraudulent claims for hospice and other health care services.
- One of the defendants owned the Merida Group, a large health care company, and another defendant, who was the mayor of Rio Bravo, Texas, was the medical director of the group.
- The Merida Group allegedly enrolled patients with long-term incurable diseases at group homes, nursing homes, and housing projects by falsely telling them they had less than six months to live, and sent chaplains to lie to the patients and discuss last rites and preparation for their imminent death (when in fact, the patients were not suffering from a terminal illness – some patients were even walking, driving and coaching athletic sporting events).
- The medical director also accepted kickbacks for hospice patients from his mayoral office and elsewhere.
- Sentencing is set for sometime this summer.

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RECENT ENFORCEMENT ACTIONS

- On **December 13, 2018**, the DOJ announced that SouthernCare, Inc. agreed to pay $5,863,426 to resolve allegations that the company violated the False Claims Act by submitting claims to Medicare for hospice services that was medically unnecessary or lacked documentation. The qui tam relators had alleged that SouthernCare admitted patients into hospice who were not terminally ill and lacked appropriate medical documentation showing such an illness.

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RECENT ENFORCEMENT ACTIONS

- On **October 30, 2017**, Chemed Corp. and Vitas Hospice Services, LLC, ("Vitas") agreed to pay $75 million to resolve a lawsuit alleging they violated the False Claims Act for submitting false claims for hospice services to Medicare.
  - The Government alleged that Vitas knowingly submitted or caused to be submitted false claims to Medicare for services to hospice patients who were not terminally ill and thus did not qualify for the hospice benefit.
  - The Government also alleged that the defendants rewarded employees with bonuses for the number of patients receiving hospice services, without regarding to whether they were actually terminally ill and whether they would have benefitted from continuing curative care.

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RECENT ENFORCEMENT ACTIONS

- On **May 5, 2016**, two physicians were found guilty of federal health care fraud charges for falsely certifying that Medicare patients were terminally ill and qualified for hospice care when the vast majority were not actually dying. The defendants were sentenced to a 108-month prison sentence. The defendants appealed and their convictions were upheld by the Ninth Circuit on April 26, 2019.

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RECENT ENFORCEMENT ACTIONS

- In **2016**, the U.S. Government and the State of Georgia, brought a *qui tam* action against STG Healthcare of Atlanta, Inc. ("STG"), alleging that STG submitted claims for patients who were not terminally ill.
  - The Government alleged that between 2013 and 2017, STG set aggressive goals for enrolling patients and failed to properly supervise the admission practices of its staff and medical directors, resulting in the submission of claims for ineligible patients.
  - The Government also alleged that STG submitted or caused to be submitted claims to Medicare and Medicaid for services provided to individuals referred by a physician who STG paid to be a "back up" medical director, but who did not serve as a legitimate hospice physician.
- On March 4, 2020, the DOJ announced that STG and two of its senior executives agreed to pay **$1.75 million** to resolve allegations that STG submitted to caused the submission of false claims to Medicare and Medicaid for patients who were not eligible for the hospice benefit and that resulted from STG's provision of unlawful payments to a referring physician in violation of the Antikickback Statutes.

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PROVIDER RELIEF & PAYCHECK PROTECTION PROGRAM FUNDS: ENFORCEMENT & ASSOCIATED RISKS

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PAYCHECK PROTECTION PROGRAM

- The Coronavirus Aid, Relief, and Economic Security Act ("CARES" Act) established the Paycheck Protection Program (or "PPP"), which is implemented by the Small Business Administration, with support from the Department of Treasury.
- Under the PPP, the Government authorized $659 billion in loans for small businesses starting April 3, 2020.
- All PPP loan terms are the same: 2-year loan up to $10 million, 1% fixed rate, and 6 months deferred payment of principal, interest and fees (but may be extended for up to one year).
- The business must have not more than 500 employees to qualify for a loan.

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PPP: CERTIFICATIONS

- In the **loan application**, the borrower must "certify" in **good faith** the following:
  - (1) The borrower was in operation on February 15, 2020 and had employees to whom it paid salaries and payroll taxes;
  - (2) The current economic uncertainty makes the loan necessary to support the ongoing operations of the business (which requires borrowers to take into account their current business activity and their ability to access other sources of liquidity sufficient to support their ongoing operations in a manner that is not significantly detrimental to the business);
  - (3) The funds will be used to retain workers and maintain payroll or make mortgage interest/lease and utility payments, and that not more than 25% of the forgiven amount would be for non-payroll costs;

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PPP: CERTIFICATIONS (continued)

  - (4) The borrower will provide the lender with documentation verifying the number of its full-time employees, the amount of its payroll, mortgage interest, rent and other utility payments during the eight-week period following the loan;
  - (5) The borrower has not and will not receive another loan under the PPP between February 15, 2020 and December 31, 2020; and
  - (6) The information in the loan application and supporting documents is true and accurate.
- The borrower must also attest to a number of certifications in the **loan forgiveness application**.
- **Attention to these certifications is extremely important given the severe penalties that are possible for submitting false or misleading certifications to the Government.**

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PPP: ENFORCEMENT

- Recent SBA guidance indicates that any applicant for a PPP loan less than $2 million will be deemed to have made a "good faith certification of need."
  - Loans larger than that amount may be subject to a government audit.
  - However, in a May 22, 2020 Interim Final Rule, the SBA stated it may review loans "of any size" to evaluate whether the borrower was eligible for a PPP loan; calculated the loan amount correctly; used the proceeds for allowable expenses; and is entitled to loan forgiveness.
- A recent PPP FAQ issued by the SBA provides some enforcement relief to borrowers outside of the $2 million monetary threshold.
  - If the SBA determines that a borrower "lacked an adequate basis" for the necessity certification, the stated remedy is to "seek repayment of the outstanding loan balance" and "inform the lender that the borrower is not eligible for loan forgiveness."
  - If the loan is repaid, the SBA "will not pursue administrative enforcement or referrals to other agencies based on its determination with respect to the certification concerning necessity of the loan request."
- Regardless, there is still the possibility of private whistleblower claims under the False Claims Act (31 U.S.C. § 3279).

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PPP: ENFORCEMENT (continued)

- On March 22, 2020, Attorney General William Barr directed all U.S. Attorneys to prioritize the investigation and prosecution of Coronavirus-related fraud schemes.
  - On May 15, 2020, the DOJ issued grand jury subpoenas to several large banks seeking records as part of a broader investigation into potential abuse of the PPP.
  - The DOJ has already brought criminal charges against borrowers it alleged lied about the state of their businesses and number of employees to secure a loan.
- Treasury Security Steven Mnuchin also warned that companies found to have lied to secure loans could face prosecution.

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PPP: ENFORCEMENT (continued)

- In sum, the submission of false information and certifications for a PPP loan or on the forgiveness application can subject the borrower to civil liability under the False Claims Act (whether initiated by the Government or a qui tam relator).
  - The FCA creates civil liability for anyone who knowingly submits a false claim, or causes another to submit a false claim, for money to the federal government. 31 U.S.C. § 3279.
  - Penalties are substantial, ranging from $5,000 to $10,00 for each false claim, plus three times the amount of damages actually suffered, and the costs of any civil action the Government brings to recover a penalty or damages.
  - The whistleblower may also recover between 15 to 30 percent of any recovery.
- A borrower may also face criminal exposure for "knowingly" making any false or fraudulent statements in the loan or forgiveness application, as well as for using the loan funds for unauthorized purposes. 18 U.S.C. § 1001 (false statements may subject a defendant to fines and imprisonment); 18 U.S.C. § 3571 (fines for individuals or organizations if found guilty of an "offense"); 18 U.S.C. § 1014 (fines/imprisonment for making a false statement to influence a bank or the SBA to lend money).
- Under the PPP, borrowers must keep in mind that even small, technical or logical mistakes on applications or certifications can be interpreted as fraud, even years after these funds are received. Extreme caution should be used to ensure the good faith and accuracy of all documentation submitted and certifications made.

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PROVIDER RELIEF FUND

- The CARES Act provides $100 billion in relief funds to hospitals and health care providers to aid in their coronavirus response ("Provider Relief Fund")
- The HHS has established six categories of Relief Funds:
  - General Distribution Relief Fund – Initial Round ($30 billion)
  - General Distribution Relief Fund – Second Round ($20 billion)
    - To be eligible for a General Distribution payment, providers must have billed Medicare fee-for-service (Parts A or B) in Calendar Year 2019, and must have provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020.
    - *However, HHS broadly views every patient as a possible case of COVID-19.*
  - Rural Distribution ($10 billion)
  - High-Impact Distribution ($12 billion)
  - Allocation for Skilled Nursing Facility ($4.9 billion)
  - Allocation for Tribal Hospitals, Clinics, and Urban Health Centers ($500 million)
  - Allocation for Safety Net Hospitals ($10 billion)
  - Medicaid and CHIP Distribution (approximately $15 billion)
  - *Note: Every health care provider who provided COVID-related treatment of uninsured patients on or after February 4, 2020 may also request claims reimbursement and will be reimbursed at Medicare rates, subject to available funding (FFCRA and Uninsured Distribution).*

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ATTESTATION

- Providers who receive funds must sign an attestation confirming receipt of the funds and agreeing to the Terms and Conditions of payment. Any provider who does not return payment within 90 days of receipt is viewed as accepting the Terms and Conditions.
  - A provider must attest for **each** of the Provider Relief Fund distributions received.
- Failure by a provider that received a payment from the Provider Relief Fund to comply with any term or condition can subject the provider to recoupment of some or all of the payment.
- Per the Terms and Conditions, all recipients will be required to submit documents to substantiate that these funds were used for increased healthcare-related expenses or lost revenue attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

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ATTESTATION (continued)

- Providers must also certify in the Terms and Conditions that all information provided as part of their application for payment, as well as all information and reports relating to the payment that it provides in the future at the request of the Secretary or OIG, are true, accurate, and complete.
  - Any deliberate omission, misrepresentation, or falsification of any information may be punishable by criminal, civil, or administrative penalties, including, but not limited to, revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment.
- HHS cautions that it will conduct significant anti-fraud monitoring of the distributed funds, and the OIG will provide oversight as required in the CARES Act to ensure that federal dollars are appropriately spent.

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REPORTING REQUIREMENTS

- Specific reporting obligations are also imposed on providers who receive more than $150,000.
- Per the Terms and Conditions, those providers must submit a report to the HHS Secretary and the Pandemic Response Accountability Committee no later than 10 days after the end of each calendar quarter.
- This report must contain the following:
  - The total amount of funds received;
  - Total amount of funds received that were expended; and
  - Detailed list of projects or activities for which large covered funds were expended or obligated including:
    - Name and description of the project or activity;
    - Estimated number of jobs created or retained by project or activity, if applicable; and
    - Information on any sub-contracts or sub-grants awarded by recipients, including compliance with Federal Funding Accountability and Transparency Act (which provides specific reporting requirements for sub-grants and sub-contracts).
- **HHS will review these reports to ensure compliance with payment Terms and Conditions.**
- **HHS will also ask recipients to submit future reports relating to the recipient's use of its Provider Relief Funds.**

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Actions of the Prudent Hospice™

- Hospice staff should well trained regarding Medicare hospice requirements, including evaluating beneficiaries to determine if they are eligible for the Medicare hospice benefit, establishing and following individualized plans of care, conducting on-site visits of beneficiaries at home, maintaining quality and infection control programs, and identifying and reporting cases of abuse and neglect.
- Recent enforcement trends emphasize the importance for hospices to ensure that their admissions policies reflect that beneficiaries must actually be eligible for the hospice benefit, and that patients who receive ongoing hospice services are actually terminally ill.

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Actions of the Prudent Hospice™

- Hospices that applied for a PPP loan should ensure that all certifications made in the loan application and forgiveness application are truthful and accurate.
- Hospices that received (and elected to retain) Provider Relief Funds should ensure they are familiar with the program's Terms and Conditions, and should retain documentation necessary in the event of an HHS audit and to comply with reporting requirements.

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Questions????

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To Contact Us

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