Home Health/Hospice Potential Fraud

Presented by

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Payment Systems for:

- Home Health (HH)
- Hospice
- Therapies (PT, OT, ST) with HH/Hospice
- Jimmo v. Sebelius Settlement Agreement
Why the Concern?

1. Between 2005 and 2011, Medicare spending on hospice care for nursing home residents increased 70%.

2. MedPAC [Medicare Payment Advisory Committee] report in March 2012 stated that the average length of stay for hospice users grew 59%:
   - 2000 (54 days) → 2010 (86 days)
Prospective Payment System (PPS)

- PPS is a Prospective Payment System
  - Medicare payment is made based on a predetermined, fixed amount

- PPS is Not a Fee Schedule
  - Fee Schedule is a complete listing of fees used by Medicare to pay doctors/suppliers
• Promotes efficiency:
  Better outcomes with lower total cost = higher profits

• Higher average costs = Higher future payment rates; constant profits
With HH PPS

- at least one service must be delivered before billing can occur

- a significant portion for the 60-day episode unit of payment is made at the beginning of the episode with as little as one visit delivered

HH PPS means a shift of the basis of payment from payment tied to a claim or distinct revenue or procedural code, to an episode (of care).
Home Health Prospective Payment System (HH PPS)

- The episode is the unit of payment for HH PPS.
- The episode payment is specific to one individual homebound beneficiary.
- It pays all Medicare covered home care that is reasonable and necessary for the patient’s care, including routine and non-routine supplies used by that beneficiary during the episode.
Home Health Prospective Payment System (HH PPS)

- The duration of a single full-length episode is 60 days.

- Episodes may be shorter than 60 days.

- Multiple episodes may be needed
  - E.g. Foley catheter
  - Wound care
OASIS (Outcome and Assessment Information Set) collects data on services provided during the episode. Use home health resources groups (HHRGs) DRGs (Diagnostic Related Group) used for inpatient payments. The total case-mix adjusted episode payment is based on elements of the OASIS data set including the therapy visits provided over the course of the episode.
Home Health Prospective Payment System (HH PPS)

- A case-mix adjusted payment for a 60-day episode is made using one of 153 HHRGs.

- Adjustments of Episode Payment - Low Utilization Payment Adjustments (LUPAs)
  - If an HHA provides four visits or less in an episode, they will be paid a standardized per visit payment instead of an episode payment for a 60-day period.

- The number of therapy visits provided can change the payment equation.
Home Health Prospective Payment System (HH PPS)

- The number of therapy visits projected on the OASIS assessment at the start of the episode, entered in OASIS

- Additional therapy visits may change the score in the service domain of the HIPPS code (affecting payment)
Home Health Prospective Payment System (HH PPS)

- Outlier payments
  - Mechanism for provider to recover excessive costs for services
  - Effective January 1, 2010 no more than 10% of an entity’s HH PPS payments
HOSPICE

Must have both

Terminal illnesses

and

Life expectancy of 6 months or less
Hospice Services

- **Eligibility:**
  - The patient must be entitled to Part A of Medicare; and
  - Must be certified as being terminally ill
    - clinical findings that supports a life expectancy of 6 months or less

- **Election Periods**
  - An initial 90-day period;
  - A subsequent 90-day period;
  - An unlimited number of subsequent 60-day periods
Hospice Services

- Physician services provided by Hospice-employed physicians and nurse practitioners or other physicians arranged by the Hospice
- Nursing Care
- Medical Equipment
- Medical Supplies
- Drugs for symptom control and pain relief
- Hospice aide and homemaker services
- Physical Therapy
Hospice Services

- Occupational Therapy
- Speech-language pathology services
- Social worker services
- Dietary counseling
- Spiritual counseling
- Grief and loss counseling for the individual and his or her family
- Short-term inpatient care for pain control and symptom management, and for respite care
Hospice

- Care in an emergency room, hospital, or other inpatient facility; outpatient services; ambulance transportation

  - Hospice

  - or

  - Unrelated to the terminal illness
Hospice Levels of Care

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care
Hospice Levels of Care

- Routine home care – where patient lives
- Continuous home care - where patient lives
- Inpatient respite care – in a facility
- General inpatient care – in a facility
## Levels of Care
### 2013 Payment Rates

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Home Care</td>
<td>$153.45</td>
</tr>
<tr>
<td>Continuous Home Care</td>
<td>$895.56</td>
</tr>
<tr>
<td>Inpatient Respite Care</td>
<td>$158.72</td>
</tr>
<tr>
<td>General Inpatient Care</td>
<td>$682.59</td>
</tr>
</tbody>
</table>
Payment Rates 2013 → 2014

- Routine Home Care: $153.45 → $156.21
- Continuous Home Care: $895.56 → $911.68
- Inpatient Respite Care: $158.72 → $161.58
- General Inpatient Care: $682.59 → $694.88
Continuous Home Care

- Periods of crisis
- Maintain the beneficiary at home
- Beneficiary requires the higher level of “continuous care”
  - least 8 hours in a 24-hr period
    • (midnight to midnight)
  - achieve palliation/manage acute medical symptom
  - care does not need to be “continuous”
    • must total 8 hours or more of care within the 24-hr period
  - predominantly nursing care by RN, LPN, LVN
    • at least 50% - vs. HHA, aide services
General Inpatient care

- Acute symptoms cannot be safely managed at home/residential setting
- Skilled nursing facility, a hospital, or a hospice inpatient unit
- Return “home” once symptoms are under control under the routine level of care
Jimmo v. Sebelius Aettlement Agreement

- No expansion of coverage

- Provides clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the existing Medicare policy.

- Revisions do not alter or supersede any other applicable coverage requirements beyond those involving the need for skilled care, such as Medicare’s overall requirement that covered services must to be reasonable and necessary to diagnose or treat the beneficiary’s condition.
CMS manual revisions clarify that coverage of skilled nursing and skilled therapy services in the skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) settings "...does not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the beneficiary’s need for skilled care." Skilled care may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/jimmo_fact_sheet2_022014_final.pdf
Medicare has never supported the imposition of an “Improvement Standard” rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient’s condition.

Thus, such coverage depends not on the beneficiary’s restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves.
QUESTIONS

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General Inpatient care

- Illinois Passages Hospice founder charged with healthcare fraud - February 21, 2014

- “Red flags went up” when monthly payouts for in-patient hospice care jumped from $4,400 from 2006 to 2008, to more than $946,000 in 2011
Fired nurse says hospice falsified records

“SAN DIEGO — A federal lawsuit made public this week against San Diego Hospice alleged that the organization actively worked to circumvent Medicare reimbursement guidelines and make patients appear sicker than they really were.”

(Cont’d)
“The suit, filed under the Federal False Claims Act by a former San Diego Hospice nurse, comes as the hospice works in bankruptcy court to liquidate its assets.

It plans to transfer most of its 430 current patients and employees to Scripps Health, which stepped forward at the hospice’s request to soften the collapse of what was the region’s largest provider of end-of-life care.”

Update by By Paul Sisson U-T San Diego June 18, 2013 — “The federal government finally spoke up Monday in the San Diego Hospice bankruptcy case, saying it is owed $112 million for “false claims for payment” in 2009 and 2010.”
California Doctor Sentenced for Role in Medicare Scam
December 17, 2012, in Los Angeles, Calif.

Dr. Kenneth Thaler of Westminster, CA
- 12 months in prison and ordered to pay approximately $11 million in restitution to the Medicare program

Admitted homeless patients to the Tustin Hospital and Medical Center after they had been driven from “Skid Row” in downtown Los Angeles as part of a Medicare fraud scheme.

Thaler admitted approximately 60 patients per month, including some who did not require hospitalization.

The patients were recruited by marketers who were being paid kickbacks by recruiters such as Estill Mitts to refer homeless Medicare and Medi-Cal beneficiaries for in-patient hospital stays.
VITAS

• Biggest U.S. Hospice Co Defrauded Medicare, Feds Charge - May 7, 2013

• Complaint filed in the District Court for the western district of Missouri that since 2001 Vitas has defrauded Medicare two ways:
  
  • It has accepted for hospice care patients not eligible to receive it, billing Medicare for their treatment
  
  • It has charged Medicare for "crisis care" given to patients who didn't need it and/or never got it

Jane

- 66 year old lives alone
- Complaint: joystick does not work
- Visits doctors’ offices 2-3 x week by van
- Shoulder injury 20 years ago
- Goes outside her apartment to smoke
- Has Medicaid in-home support
Roy

- Roy is getting skin breakdown and can’t get an air mattress

- HICAP asked for my help with this

- Note that he recently returned home from an inpatient hospice
Some practices which are suspected kickbacks

- hospice offering free goods or goods at below fair market value to induce a nursing home to refer patients to the hospice.

- hospice paying “room and board” payments to the nursing home in amounts in excess of what the nursing home would have received directly from Medicaid had the patient not been enrolled in hospice.

- hospice paying amounts to the nursing home for “additional” services that Medicaid considers to be included in its room and board payment to the hospice.
(cont’d) Some practices which are suspected kickbacks

- hospice pays above fair market value for “additional” non-core services which Medicaid does not consider to be included in its room and board payment to the nursing home.

- hospice referring its patients to a nursing home to induce the nursing home to refer its patients to the hospice.

- hospice providing free (or below fair market value) care to nursing home patients, for whom the nursing home is receiving Medicare payment under the skilled nursing facility benefit, with the expectation that after the patient exhausts the skilled nursing facility benefit, the patient will receive hospice services from that hospice.

- hospice providing staff at its expense to the nursing home to perform duties that otherwise would be performed by the nursing home.
Some practices which are suspected kickbacks

- All residents of an assisted living facility have the same HHA or hospice

- All residents of a 40+ bed assisted living facility talk about
  - “Their nurse”
  - “Going to their nurse’s office”
Other Red Flags

- Being transferred back and forth between
  - Home health → hospice
  - Home health → Home Health
Resources

- Medicare Claims Processing Manual Chapter 10 - Home Health Agency Billing:

- Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims
QUESTIONS

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Thank you all!!

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