MEDICARE PROGRAM LOSES MILLIONS (BILLIONS?) AS A RESULT OF NON-RECOVERED OVERPAYMENTS TO HEALTHCARE PROVIDERS

By
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INTRODUCTION

I have served hospices in a consulting, accounting, and auditing capacity since 1986 (home health agencies since 1978). Of all the types of healthcare providers, hospice services represent one of the most morally appealing services, "providing those patients approaching the end of life with those services intended to provide the maximum quality of life possible as well as to assist those left behind with that spiritual and bereavement counseling to better enable them to continue in life". Of course, this is my definition as I personally see the goal of hospice. I have assisted many hospices, and home health agencies, over the years when they experienced Medicare program overpayments. Accordingly, I am experienced with providers that have secured Medicare repayment plans, entered into Bankruptcy protection, exited from Bankruptcy protection, and those that have failed. My concern is that the industry is and will continue to receive negative publicity as long as some hospices fail and leave behind an unpaid Medicare program obligation. These concerns focus on the dual responsibility of both the hospice providers and the Medicare program to effect appropriate, but not excessive, efforts to reduce the prevalence of such occurrences into the future. It is my concern for preservation of the hospice benefit and the many high-quality providers meeting the needs of hospice patients that have given rise to the following comments regarding Medicare program losses from unrecoverable overpayments to healthcare providers generally and hospice providers specifically. The comments provided are mine alone and should not be associated with any other individual or organization (excluding any reference to published materials).

Nothing contained herein is intended in any way to contradict my belief that the hospice benefit and coverage rules should be updated to reflect the substantial change in the population served from that in place at the time the hospice benefit was created. More and longer term patients, more non-cancer patients, and increased numbers of dementia and Alzheimer patients are being served. The six-month criteria should be increased and CAP amounts recalibrated to reflect the costs associated with the targeted populations intended to be benefactors of hospice services. At the same time, it is essential that providers fully recognize that with certification in Medicare they are entering into a contract that has attendant responsibilities, including financial responsibilities that must be enforced.

OVERPAYMENTS TO HEALTHCARE PROVIDERS (HOSPICE FOCUS)

Generally, liabilities owed by providers to the Medicare program for overpayments are non-recourse liabilities, meaning that the owners of the Medicare provider are not personally obligated to repay any liability that exceeds the available assets of the Medicare provider. Accordingly, healthcare providers that discontinue providing services due to financial conditions are obligated to pay any outstanding liabilities to the Medicare program; however, when funds are not available to liquidate the liability the Medicare program generally does not have or has not exercised the ability to look to the owners, Board members, or other management personnel for any remaining unpaid obligation due the Medicare program.

Recently Sojourn Care, a hospice located in Tulsa, Oklahoma, received significant attention when it closed its doors owing the Medicare program a reported amount in excess of $27 million as a result of payments in excess of the Medicare aggregate payment limitation ("CAP"). It was also reported that the owners of Sojourn Care are managing another hospice, and that this hospice, RoseRock Healthcare, admitted some, but not all of the former Sojourn Care patients. It is my understanding that almost all of the former hospice patients were placed, if not with RoseRock, with another area hospice provider.

Is This Situation Unique?

The Sojourn Care obligation to the Medicare program is not an isolated situation (10.2% of all hospice providers exceeded the Medicare CAP in 2008 according to the MedPAC Report to Congress in March 2011; an aggregate overpayment in excess of $190 million for the year. The overpayment in the two preceding years exceeded $200 million in each year). In fact, unpaid obligations to Medicare go back to the beginning of the program. Most notable examples are the extensive obligations as a result of payments to hospices in excess of the CAP and the extensive obligations by home health agencies during the cost reimbursement era and during the two years of the Interim Payment System ("IPS"). During this two year period (1997-1999) approximately one-third of all Medicare certified home health agencies went out of business, many of which owed obligations to the Medicare program that have never been collected. It is noteworthy that Surety Bonds were mandated for home health agencies as a result of the Balanced Budget Act of 1997. Surely, the Medicare program, administered by the U.S. Centers for Medicare and Medicaid Services, has estimated the loss experienced by the Medicare program as a result of the failures of home health agencies, hospices, and other providers over the years. It is important that the Medicare program adequately reimburse healthcare providers for the valuable services that are provided to Medicare program beneficiaries consistent with Medicare coverage requirements. It is also important that valuable Medicare program resources not be lost as a result of excess payments that are not recoverable. Such loss impacts the ability to appropriately reimburse providers for the covered services they do provide.

Hospice Provider's Argument

Many hospices around the country are currently receiving payments from the Medicare program in excess of the CAP. These are amounts that will be subject to recovery by the Medicare program. These hospices argue that as more and more non-cancer patients were served the average life expectancy of the patients lengthened, thereby causing much of the overpayment problem. They also argue that the unlimited number of election periods encourage hospices to accept patients with longer life expectancies. Once patients were admitted the hospices often refuse to terminate services to patients already admitted to the hospice program.

Of course, the length of service to hospice patients, who are supposed to have a life expectancy of six months or less, is the primary contributor to the overpayment by the Medicare program. Everyone understands that accurately predicting life expectancy is not always possible. However, given that many hospice patients have very short life expectancies, those hospices with extremely high average lengths of stay (the average of the short and long periods of care through death) obviously need to focus on their admission process including the assessment of life expectancy. The Medicare program hospice benefit, while in need of reconsideration, is what it is and the Medicare program cannot be blamed for the hospice provider's inability to assess life expectancy and other factors which results in the overpayment from the Medicare program. However, the Medicare program can be blamed for those practices which have allowed hospices to continue to receive overpayments beyond the point where such payments should have been altered as well as for not implementing prospective policies to minimize such overpayments.

The CAP Was Not a Secret

Of equal importance is that hospice providers knew the rules regarding payments when they voluntarily enrolled in the Medicare program. There is no excuse for not recognizing that excessive payments were being received or for admitting patients that did not meet the required six-month or less anticipated life expectancy. Perhaps part of the responsibility resides with the physicians that certified to the life expectancy; however, more important is the loss being experienced by the Medicare program when the long-term solvency of the Medicare program is at issue and random reductions to Medicare providers are being made without regard to the reasonableness of such payment reductions. Any monies saved by the Medicare program enhance the financial viability of the program and assist in preserving the integrity of Medicare payments to providers into the future.

Comments Regarding Medicare CAP Overpayments

The following represent my opinion regarding actions which could possibly minimize the instances when such Medicare program losses would occur and those that would lower the risk of overpayment reoccurrence. It is my belief that these are options which could be considered. They are not intended to represent dependency on one another; however, the application of any or all of these recommendations could impact Medicare losses in the past as well as in the future. The hospice benefit is an extremely valuable Medicare benefit and hospice providers do not deserve, as an industry, the negative publicity that it occasionally receives. Those subject to criticism are not just the provider at the subject of the current matter but also the Medicare program and those that administer the program as well. The government and those administering the benefit provided the ability for such overpayments to occur and losses sustained, and accordingly are equally responsible for the lost Medicare monies.

(1) The Medicare program currently allows Medicare providers to request a repayment plan on outstanding liabilities to the Medicare program. The provider has a very short-period of time (30-days) to submit such a plan. The period of time permitted to prepare such a repayment plan should be increased to allow more focus, and quality of the submission, regarding how such overpayment would be made. Likewise the repayment plan acceptance criteria should be enhanced to better ensure that repayment plans are accepted by the Medicare program when such criteria is met and repayment appears to be possible. It makes no sense to approve repayment plans when there is no ability to meet the terms of the repayment plan. Payments on the repayment plan should be handled as withholdings from Medicare payments in accordance with the accepted plan.

(2) Total repayment obligations that are included in repayment plans for any provider should be limited (currently many hospices have multiple repayment plans outstanding covering several years). The limitation should be set based on an amount that could be recoverable by the Medicare program in case the financial circumstances of the provider do not improve (for example maybe three months of Medicare revenue).
(3) When a healthcare provider requests a repayment plan it is generally obvious that traditional lenders will not consider a loan inasmuch as the Medicare program is a lender of last resort (interest rates are extremely high compared to rates charged by traditional lenders). Accordingly, at the time of approving such a repayment plan the Medicare program should look to personal guaranties by the owner for at least part of the obligation and/or secure a security position on the assets of the provider.
(4) All providers that cease providing services when an outstanding obligation to the Medicare program exists should be subjected to some form of financial review to ensure that assets are not, nor have they been, extracted for the personal benefit of those controlling or managing the provider. Such inappropriate asset extraction could trigger personal liability on the part of those responsible for the personal use or extraction of assets.
(5) The survey, accreditation process should be increased in the areas of financial review. Perhaps a financial survey, accreditation should be added separate and distinct from the current process in place.
(6) Owners of a provider that ceases operations with an outstanding balance to the Medicare program should not be permitted to participate in the ownership and/or management of another Medicare or Medicaid provider or supplier unless such outstanding obligation from the failed provider is repaid.
(7) If patient served by a failed provider with an outstanding liability are admitted to another provider where the predecessor owners are involved in an ownership or management capacity (employed or contracted) the Medicare reimbursement for those patients should be applied to repayment of the outstanding liability of the predecessor provider.
(8) Payments to hospices that have an outstanding repayment plan for patient services could be ceased, or partially ceased, on a patient-by-patient basis when the CAP amount for that respective patient is reached to minimize the risk of increasing the overpayment obligation. At the end of the year the Medicare program could pay the hospice for additional billings if the CAP is not reached in the aggregate for that year.
(9) Although not pleasing to healthcare providers, perhaps requiring Surety Bonds as a condition of Medicare participation for all providers makes financial sense given the potential of Medicare overpayments being made to those providers. Surety bond requirements that were placed on certain healthcare providers were a problem in the past.

Other purchasers (insurance carriers included) of healthcare services would not be amenable to contracting with insolvent service providers and would aggressively pursue providers for any overpayments made to those providers. They definitely would not convert overpayments into a loan to them. Recently, the U.S. Centers for Medicare and Medicaid Services ("CMS") issued proposed rules regarding reporting and returning overpayments to the Medicare program within 60 days of identification of the overpayment or any corresponding cost report due date, if applicable.

In the proposed rule, overpayments are defined as "any funds that a person receives or retains under title XVIII to which the person, after applicable reconciliation, is not entitled under such title." The examples provided include. "Medicare payment in excess of the allowable amount for an identified covered service". Repayment is made under existing voluntary refund processes in place. Hospice

providers are required to submit information from their records on an annual basis that would assist them in the determination of whether an overpayment has been received even though official Medicare notification occurs substantially later. It is uncertain whether the proposed rules require voluntary notification of a CAP liability at the time that the hospice submission (admissions during the relevant CAP period) occurs?

As with anyone substantially involved with healthcare financial matters, I am extremely concerned regarding the difficulty of healthcare providers to meet all of the regulatory requirements associated with the provision of healthcare services generally and participation in the Medicare program specifically. The extensive regulatory requirements increase the cost of healthcare services and pose financial difficulties for many providers. However, the losses sustained by the Medicare program as a result of overpayment losses represent losses that can be substantially reduced or eliminated in a cost beneficial manner.