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What Hospice Owners and Operators Need to Know About Voluntary Disclosure

Anyone who has participated as a hospice provider in the Medicare and Medicaid programs over the past several years has witnessed dramatic changes in the way government regulates that participation. Chief among these changes has been the scrutiny applied by state and federal regulators to provider payments, especially when the possibility exists that the payments were erroneously or improperly obtained. Conduct or overpayment scenarios that may have in the past given rise to an obligation to disclose and repay any excess payments may, in today's health care climate, result in severe government sanctions, including exclusion from the federal and state health care programs, large fines, civil, and even criminal liability.

Given the current emphasis on combating fraud, waste and abuse in federal health care programs, it may be surprising that a formal, federal-level program establishing guidelines for reporting one's conduct and excess payments is a very recent development in health care. In fact, it was not until 1995 that, as part of the Clinton Administration's "Operation Restore Trust," the HHS Office of Inspector General ("OIG") developed a formal process whereby Medicare providers could voluntarily disclose to the government conduct that gave rise to an overpayment or other liability. Equally surprising is that for the first 2 years of the OIG's voluntary disclosure program, only 11 health care providers applied to participate in the program and, of these, just 7 were accepted by the OIG into the voluntary disclosure program.

In October 1998, the OIG revamped its voluntary disclosure program. Since that time, approximately 120 providers have disclosed to the OIG, enabling the federal government to recover over $42 million for the Medicare Trust Fund. The primary purpose of the OIG's voluntary disclosure program is to provide guidance to health care providers that decide to voluntarily disclose irregularities in their dealings with Federal health care programs. Providers who wish to disclose the existence of overpayments or other conduct that could conceivably expose them to exclusion from the health care programs or civil or criminal liability have a greater freedom to do so under the OIG's current disclosure program. Unlike its predecessor, the OIG's new program requires no applications, is not limited to any particular type of provider, and may not be precluded when the disclosing provider is already under investigation by state or federal government.

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Despite increased flexibility in the OIG's current voluntary disclosure protocol, it leaves several important questions unanswered. Additionally, the information required by the OIG is extensive and questions may arise about whether disclosure of such information will result in a waiver of the attorney-client privilege. As a result, the decision whether to disclose conduct or overpayments to the government is a complicated one, and should not be undertaken without the advice of counsel experienced in such matters.

Perhaps the most important question unanswered by the OIG's disclosure protocol is the disclosure itself. Hospice providers should be aware that the OIG's self-disclosure protocol does not definitively tell them where or to whom the disclosure should be made. On this point, the OIG states only that the Protocol is intended to facilitate the resolution of matters that, in the provider's reasonable assessment, are potentially violative of Federal criminal, civil or administrative laws. On the other hand, matters or conduct involving overpayments or errors that do not suggest violations of law should be brought to the attention of the entity or contractor that processes claims and makes payments on behalf of the Federal health care program (Medicare, Medicaid, VA, Champus, etc.). Even if a hospice or other provider believes that no federal law has been violated and thus makes disclosure to its fiscal intermediary or carrier, the contractor has the discretion to refer the disclosure to the OIG if it is concerned about the integrity of the provider.

In situations where a hospice provider believes that its conduct does not violate Federal civil, criminal or administrative law but also believes that they inadvertently or erroneously received excess reimbursement, the Centers for Medicare and Medicaid Services (formerly known as HCFA) has published a memorandum providing guidance. A CMS form directs the provider to disclose its name, address, provider number, check number, a contact person with telephone number, and the amount of the repayment. For each claim, the provider must disclose the patient name, HIC number, Medicare claim number, claim amount refunded, and, most significantly, a "Reason Code" for repayment. CMS lists 17 "reason codes" as bases for the repayment, including "duplicate payment," "billed in error," and "services not rendered." After the form is received, the fiscal contractor will send a letter to the disclosing provider indicating receipt of the voluntary refund check, but also stating that the amount of the repayment may be insufficient to discharge the debt and that the debt may not be fully extinguished.

Should the hospice believe that its conduct violates federal law, it may disclose

this conduct to the OIG. The substantive requirements for disclosure under the OIG's protocol are too numerous to be fully discussed here, but the hospice provider should be aware it is required to fully describe the matter being disclosed, including the type of claim, transaction or other conduct giving rise to the disclosed matter. The provider must also disclose the reasons why it believes a violation of Federal law may have occurred. The provider will be required to certify that to the best of its knowledge, the disclosure is truthful and is based on a good faith effort to bring the matter to the government's attention so that it can be resolved. Finally, the disclosing provider must submit a report, based on its own internal investigation, identifying the conduct involved, individuals involved in the conduct, and an estimate of the financial impact of the conduct on the federal health care program(s) involved. The OIG, of course, will investigate the information disclosed by the provider and verify the matters listed there. The OIG will not accept payments from providers until its investigation has been completed.

Hospice providers should be aware that the decision to voluntarily disclose (wherever that disclosure is made) might involve both incentives and risks. One incentive to disclose is contained in the Federal Criminal Sentencing Guidelines, which allows for a reduction in the provider's "culpability score" and a reduction in any criminal fines. The civil False Claims Act also provides for a reduction in civil damages if disclosure is made within certain time limits. Voluntary disclosure may also allow the provider to exercise a degree of control of the timing and scope of a government investigation and may prevent the successful prosecution of a *qui tam* "whistleblower" lawsuit. A risk from disclosure is that the federal government is not bound by the disclosing provider's findings. Another risk is that employees having knowledge of the matter may secretly file a "whistleblower" lawsuit. As discussed earlier, another area of risk is the assertion or waiver of such legal privileges as the attorney-client privilege. Hospice providers can attest to the fact that the Medicare and Medicaid programs are some of the most complex government programs ever enacted. The government's "war" on fraud, abuse and waste in health care programs continues to be a top priority of the federal government and shows no signs of slowing down. Depending on the conduct involved, civil or criminal liability may result from the provider's conduct. For these reasons, the decision about whether to disclose to the government and where the disclosure should be made should only be made after careful investigation, consideration and the advice of legal counsel experienced in disclosure and payment issues."