

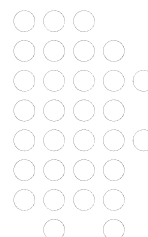
Home Care and Hospice: Compliance Update: 2015

Health Care Compliance Association

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COMPLIANCE: FOCUS ON HOME CARE & HOSPICE

- Growth in oversight activities in home care and hospice
 - Medicare and Medicaid
 - High level fraud/False Claims Act investigations
 - Referrals
 - Wholesale unnecessary care
 - Failure to provide any service
 - Day-to-day compliance oversight
 - Claims
 - Coverage
 - Quality of care
- Multiple oversight bodies
 - Medicare/Medicaid contractors (MAC, RAC, SMRC, ZPIC)
 - Managed Care Organizations
 - OIG
 - FBI, DOJ, Etc.
 - Whistleblowers
- Unique business compliance issues



PROGRAM FOCUS



- **Environmental scan of the nature and extent of oversight**
 - **Fraud prosecutions**
 - **Systemic oversight targets**
 - **Patient referral limitations**
 - **Claims compliance issues**
 - **Technical requirements**
 - **Coverage standards**
 - **Documentation**
 - **Quality of care compliance**
 - **Conditions of Participation/licensure**
 - **Provider enrollment**
 - **Business compliance**
 - **Wage and hour law**
 - **ACA employer mandate**

Recent Prosecutions



- Medicare fraud strike force charges 91 individuals for \$295 million in false billings
- Dallas Doctor arrested for alleged role in nearly \$375 million health care fraud scheme
- Home Health Agency owner pleads guilty in connection with Detroit fraud scheme
- Co-owner of Houston-area Home Health care Agency sentenced to 108 months in prison for role in \$5.2 million Medicare fraud
- Rancho Palos Verdes Doctor agrees to pay \$530,000 to settle civil lawsuit alleging home health kickback scheme

Recent Prosecutions



- Owner and employee of Miami Home Health company sentenced to prison in \$22 million Medicare fraud scheme
- Owners of two Chicago Home Health Care Agencies and three doctors among 10 charged in alleged Medicare kickback schemes
- Two charged for Medicare fraud schemes in Detroit involving \$8.8 million in false billings
- Michigan man pleads guilty in connection with Detroit-area Medicare fraud scheme
- Miami Home Health Care Agency owner pleads guilty in \$42 million Medicare fraud scheme
- Three nurses, including two owners of a home health care agency, and the company among six defendants indicted in alleged conspiracy involving kickbacks for Medicare patients
- Owner of Miami home health company pleads guilty in \$60 million health care fraud scheme

RECENT PROSECUTIONS



- Michigan physician
 - Knowingly certified unqualified patients under Medicare and Medicaid
 - Guilty plea to mail fraud and kickback law violations
 - 5 years probation; 2 years of home confinement; \$200k in fines; \$533k in restitution
 - Civil settlement
 - \$2 million

RECENT PROSECUTIONS



- **Arkansas hospice**
 - Whistleblower lawsuit against owners and the company
 - Allegation of billing for inpatient care at nursing facilities where only routine care provided
 - DoJ concluded that inpatient care not needed
 - Alleged \$1.4M overpayment

RECENT PROSECUTIONS



- **North Texas hospice**
 - OIG investigation
 - Allegation of unallowable hospice care, misrepresentations to physicians on the status of patients' conditions to gain certification, and misrepresentation of Medicare coverage criteria for hospice to ensure patient admission
 - \$500k settlement
 - OIG corporate integrity agreement

PURE FRAUD = PROSECUTION



- **Service not rendered**
- **Widespread ineligible services**
- **Falsified records**
- **Kickbacks for referrals**
- **Bribes**

Laws that Impact on These Issues



- **Coverage / COP / Licensure / Provider Enrollment / HIPAA**
- **Patient Freedom of Choice, SSA §1802**
- **Stark II, Phase III, SSA §1877**
- **Anti-kickback laws, SSA §1128B**
- **Civil Monetary Penalties, SSA §1128(a)(5)**
- **False Claims Act, 31 U.S.C. §3730**
- **State and Federal fraud laws**
- **Various state referral laws**

FALSE CLAIMS ACT



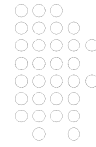
- **Applies to all federal health care claims**
- **Direct and indirect impact on federal expenditures**
- **“Know or have reason to know” standard**
- **Bounty to whistleblowers**
- **Criminal and civil monetary penalties**

FEDERAL ANTI-KICKBACK LAWS



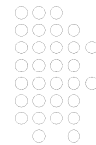
- **Criminal liability**
- **Offer or receipt**
- **Remuneration**
- **Referral of patients or business**
- **Knowing and willful**
- **One purpose test**

FEDERAL ANTI-KICKBACK LAWS



- **Exceptions**
 - **Certain discounts**
 - **Bone Fide Employees**
 - **Safe harbors**

FEDERAL ANTI-KICKBACK LAWS



- **Safe harbors**
 - **Certain investment interests**
 - **Space rental**
 - **Personal services and management contracts**
 - **Referral services**
 - **Discounts**

CIVIL MONETARY PENALTIES



- **Range of acts covered as violations**
- **Remuneration to Medicare beneficiary to influence provider selection key action in play**
- **Civil penalty**
 - **\$5000-50,000 each**
 - **Plus, 3 times claim or payment**
- **Exclusion**

STARK II



- **Limitation on physician referral**
- **No intent element**
- **Ownership and compensation arrangements**
- **Civil sanctions and non-coverage**
- **Ten designated services**
- **Includes home health, DME**
- **Applies to Hospice if part of HHA**

STARK II



- **Prohibits most ownership**
 - **Allows physician ownership of certain rural providers**
- **Limits compensation arrangements**
 - **Applies to physician and family**
 - **Exceptions**

STARK II



- **Financial Relationship**
 - **Any relationship between referring physician (or immediate family member) and entity may trigger rule**
 - **May be wholly unrelated to “Designated Health Service” e.g. relationship on private pay services only**
 - **Direct and indirect relationships are included**
 - **Unbroken chain**

STARK II



- **“Referral” includes three physician actions**
 - **“Request by the physician for” an item or service;**
 - **“Ordering of” an item or service; or**
 - **“Certifying or recertifying of need for” item or service payable by Medicare/Medicaid**

Health Reform Revises FCA Liability



- Effective March 23, 2010
- Medicare or Medicaid overpayment must be reported and returned within LATER of
 - 60 days of identity, OR
 - Date corresponding cost report is due
 - Repayment to contractor
 - “Overpayment” - receipt or retention of Medicare/Medicaid funds, that after applicable reconciliation, not entitled to
 - **Note:** State Medicaid rules may have shorter repayment requirement

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Home Care Compliance vs. Fraud



- **Fraud= Jail, Fines, and Repayments**
- **Noncompliance=Administrative headaches and Refunding Overpayments**
- **Compliance Areas**
 - **Claims and Conditions for Payment**
 - **Quality of care (CoPs)**
 - **Provider enrollment**
 - **Business requirements**

Medicaid Home Care Compliance Risk Areas



- **New compliance efforts in Medicaid home care nationwide likely related to growth in spending**
- **ACA requirement for Face to Face**
- **Dual-eligibles (Medicare maximization)**
 - **Pre-payment conditions such as a full Medicare denial**
 - **Post-payment claim by claim review with Medicare claim submissions required**
- **Private duty nursing: pediatric and adults**
 - **Frequency and duration**
- **Personal care services**
- **Hospice**

OIG Oversight Activity



- **OIG Workplan (Medicaid Home Care)**
 - Medicaid home care worker screenings
 - Medicaid home health claims and CoP compliance
 - CMS policies on Medicaid homebound requirements
 - HCBS: oversight of care quality
 - HCBS: vulnerabilities in providing services
 - HCBS: State administrative costs
 - Medicaid Personal Care Services

OIG Oversight Activity, Con't



- Home Health Services—Duplicate Payments by Medicare and Medicaid)
- Hospice Services—Compliance With Reimbursement Requirements
- State Procedures for Identifying and Collecting Third-Party Liability Payments
- State Compliance With the Money Follows the Person Demonstration Program

Medicaid Home Care Target Areas



- **CLAIMS**
- **SERVICES RENDERED**
- **FALSE BILLINGS**
- **STAFF CREDENTIALS**
- **REFERRAL KICKBACKS**

TARGET: CLAIMS



- **UTILIZATION**
- **AUTHORIZATION OF CARE**
- **COMPLIANCE/CONSISTENCY WITH APPROVED PLAN OF TREATMENT**
- **DOCUMENTATION**
- **TECHNICAL REQUIREMENTS**

TARGET: UTILIZATION



- **Data analysis to target provider utilization**
 - **Aberrant patterns outside the norm**
 - **Statistical deviation**
 - **Percent increase billing, payment, number visits/services**
 - **High utilization services/items**
 - **High cost services/items**

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Medicaid F2F Oversight



- **ACA requires F2F on Medicaid home health**
- **CMS yet to promulgate F2F Medicaid rule**
- **States may implement F2F on their own**

Medicaid Personal Care



- **OIG audit focus**
 - North Carolina,
<http://oig.hhs.gov/oas/reports/region4/41004003.pdf> (\$41.71M) Audit (A-04-10-04003, June 2011)
 - Missing documentation
 - Services not in accordance with plan of care
 - No supervisory nursing visits
 - No verification caregiver qualifications
 - No physician order

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Medicaid Personal Care



- Washington State,
<http://oig.hhs.gov/oas/reports/region9/90900030.pdf> Audit (A-09-09-00030, June 2011)
 - No timesheets supporting daily service
 - Billed more hours than on timesheets
 - Training deficiencies

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Medicaid Personal Care



- Attendants whose qualifications were not documented, <http://oig.hhs.gov/oei/reports/oei-07-08-00430.pdf> - 10 State review: CA, FL, GA, IL, IA, NE, NY, OH, TN, WV
- NYC, <http://oig.hhs.gov/oas/reports/region2/20701054.pdf> Audit (A-02-07-01054, June 2009)
 - No medical professional exam of beneficiary before service
 - No nursing assessment
 - No nursing supervision
 - No physician's order
- N.Y. State, <http://oig.hhs.gov/oas/reports/region2/20801005.pdf> Audit (A-02-08-01005, Oct. 2010)
 - Same as above for NYC and
 - No in-service training for aide
 - Time with patient not documented

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MEDICARE COMPLIANCE: Claims



- MACs, ZPICs, SMRC, and RACs looking
- Hospice and home health in focus
- Audits are data driven based on benchmark aberrancies
- Automated and complex claims reviews
- Technical compliance the first target
- Coverage standards the second stop

MEDICARE HOSPICE



- 2015 Payment Final Rule:
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices-Items/CMS-1609-F.html>
- CMS Issued the FY2015 proposed rule:
<https://www.federalregister.gov/articles/2014/05/08/2014-10505/medicare-program-fy-2015-hospice-wage-index-and-payment-rate-update-hospice-quality-reporting>
- No new payment model proposed
 - CMS indicates that it wants to evaluate not yet available data from new cost reports and claims submissions; focus on program integrity for now

MEDICARE HOSPICE Final Rule



- Solicited comments on:
 - “terminal illness” definition
 - “related condition” definition
- Hospice cap calculation (speed up)
- Attending MD on election form
- Quality data reporting
- Medicare Part D coordination (codify existing guidance already underway)
 - Prior authorization; hospice or prescriber must document unrelatedness to terminal condition(s)

Medicare Hospice: Legislative Developments



- **IMPACT Act: PL 113-185**
 - Establishes a requirement for CoP surveys at least every 3 years
 - Modifies Annual Cap update formula to pay for increased survey costs
 - Links to annual hospice inflation (MBI) update
 - Result will be slightly increased number hospices over caps in the long term

Medicaid Hospice Risk Areas



- Billing for Medicaid personal care to a Medicare hospice patient
- Medicaid billing for services and items covered under Medicaid hospice benefit
 - Pharmaceuticals
 - Ambulance
- State Medicaid payment reductions that reflect beneficiary contribution obligation
 - <http://www.oig.hhs.gov/oas/reports/region1/11000004.asp>
 - OIG found that Massachusetts Medicaid did not reduce hospice payments to reflect “spend down” patients’ contribution obligation

Medicare Hospice Claims Risk Areas



- Technical compliance
 - Election
 - Attending physician
- Related to terminal illness
- Hospice face-to-face rule
- Terminal illness documentation
- Hospice and the nursing facility resident
- Continuous care
- Inpatient days

MEDICARE HOSPICE: Drug Liability



- Who pays for drugs: Part D or the hospice?
- National coalition addressing CMS policy
- Potential solutions under consideration
- Long term risk to hospices?
- Final rule sets out prior authorization standards for 4 drug categories

Medicare Home Health Oversight Claims Target Areas



- Homebound
 - Absences documented or reported by patient
 - Conflicting documentation
- Medical Necessity
 - Therapy is a big target
 - Improper “improvement” standard
 - Documentation weakness on skilled nature of care
- Coding
 - diagnoses
- Face-to-Face Encounter
- Therapy Assessments

Medicare Home Health: OIG Focus



- Workplans
 - Home health Prospective Payment System requirements
 - Employment of individuals with criminal convictions
 - Home health face-to-face physician encounter requirements
 - Missing or inaccurate OASIS
 - Trends in Revenues and expenses

Confined to the Home



Change Request 8444

- Clarifies that homebound must meet both criteria:

- 1) Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence **OR** - Have a condition such that leaving his or her home is medically contraindicated.

AND

- 2) There must exist a normal inability to leave home; **AND** - Leaving home must require a considerable and taxing effort.

Medicare coverage guidelines



- *Jimmo v Sebelius* settlement
- <http://www.medicareadvocacy.org/wp-content/uploads/2012/12/Jimmo-Settlement-Agreement-00011764.pdf>.
- Focused on illegal “improvement” standard
- CMS is clarifying existing guidelines; provider education will follow
- Permit coverage of skilled maintenance therapy
- Permit coverage of chronic care/terminal patients
- Existing guidelines recognize such coverage but MACs changed the “rules”

Implementation Game Plan



- CMS clarified guidelines with specific prohibition of an improvement standard (w/in 6 months) <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf>
- Training of Medicare contractors and providers (following issuance of guidelines)
- Reopening of select claims denied since 1/11
- Ongoing oversight of claim determinations

PECOS



- ACA and regulation requires all home health certifying and ordering physicians be enrolled in Medicare
- Medicare requires an approved enrollment record in PECOS
 - HHAs only have access to “ordering and referring” file
- Physician name and NPI as they appear in PECOS on the claim
 - Deeming authority interpretation that HHA must independently verify NPI in PECOS
- Edit effective with SOC January 6, 2014
 - Watch for expanded enrollment focus in claims reviews

PECOS



- Full Implementation of Edits Set for January 6, 2014.
- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf>
- See also
- 8441 : Home Health Agency Reporting Requirements for the Certifying Physician and the Physician Who Signs the Plan of Care - Effective July 2014
- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2789CP.pdf>
- 8356: Handling of Incomplete or Invalid Claims once the Phase 2 Ordering and Referring Edits are Implemented
- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2767CP.pdf>

Home Health New Regulatory Compliance Issues



- HPPS 2014 rule
- Face to Face rule
- Therapy Assessment rule
- New Medicare CoP sanctions
- Proposed CoPs

The New Rule



- <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1611-F.html>.

Home Health Final Rule: So much more that payment rates



- **HHPPS 2015 Payment Rates**
 - Continued Rate Rebasing
 - Recalibration of Case Mix Weights
 - Major Wage Index Changes
 - Outlier Payment Model
- **Face to Face Physician Encounter**
- **Professional Therapy Assessments**
- **OASIS Submission Standards**
- **Qualification of Speech-Language Pathologists**
- **Standards on the HHA Administration of Insulin Injections**
- **Value Based Purchasing Model**
- **Civil Money Penalty Sanctions for CoP Violations**
- **Changes to Physician Certification/Recertification Requirements**

2015 Medicare Home Health Rates



- Year 2 rebasing payment rates (4 year phase-in)
 - Episode rates: full cut (3.5% of 2010 rates) allowed under ACA
 - LUPA per visit rates: full increase (3.5% of 2010 rates)
 - Non-routine Medical Supplies: 2.82% reduction
- Recalibrated case mix weights
 - Major changes in all 153 case mix weights
 - All variables adjusted
 - Budget neutrality adjustment
- New CBSAs in wage index lead to one-year blended index
- Outlier eligibility remains same despite low spending
- Effective for episodes ending January 1, 2015 or later
- Rates reduced by 2% if no quality data submitted
- 3% rural add-on continues through 2015
- Remember 2% payment sequestration (February 1 and later payments)

Face-to- Face Physician Encounter Changes



- Eliminates physician narrative requirement
- Requires certifying physician to have sufficient records to support certification
 - 01/28/15 CMS issues voluntary 5 page F2F progress note template after CERT determines approx 90% of payment errors due to insufficient documentation:
<http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Electronic-Clinical-Templates/HomeHealthHHElectronicClinicalTemplate.html>

Face-to- Face Physician Encounter Changes



- **Physician narrative requirement rescinded**
 - **Applies to Start of Care episodes beginning January 1, 2015**
- **CMS rejected requests to rescind the rule retroactive to April 2011**
 - **“without fault” waiver of overpayments rejected**
- **CMS acknowledges complaints about confusion and subjective reviews**
- **Defends validity of the rule**

Face-to- Face Physician Narrative



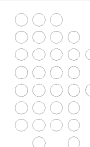
- **Lawsuit Will Continue**
- **NAHC v. Sebelius/Burwell**
 - **1:14-cv-00950 (filed 6-5-14)**
 - » **US District Court for the District of Columbia**
- **Alleges**
 - **excess documentation required in relation to ACA requirements**
 - **failure to provide adequate and clear guidance on acceptable documentation**
 - **Failure to review whole record**
- **Lawsuit will continue to address past claims denials and continuing audits**

Face-to- Face Physician Encounter Changes



- **Certifying physician must have adequate documentation in the file to support certification**
 - **“patient’s medical record,..., must support the certification of eligibility”**
 - **Skilled care need**
 - **Homebound status**
 - **Plan of care**
 - **Under the care of the physician**
 - **Timely face-to-face encounter**
 - **Narrative still required where qualifying skilled service is management and evaluation of the care plan**

Face-to- Face Physician Encounter Changes



- **Physician documentation**
 - **Physician required to provide HHA with such documentation if HH claim audited**
 - **HHA can supply certifying physician with its documentation**
 - **Must show that physician reviewed and signed off on it**
 - **Corroborates physician documents**
 - **CMS expects certification at the start of care or as soon as possible thereafter**
 - **No formal rule standard on exact timing**
 - **Expects prior to end of episode**

Face-to-Face Physician Encounter Changes



- **Physician payment for certification/recertification**
 - **CMS will reject physician claims where HH certification determined to be noncompliant**
 - **No formal rule; will be done through guidance**

SOC and Certification



- **A certification (versus recertification) is considered to be any time that a new Start of Care OASIS is completed to initiate care.**
- **Certification and F2F requirements apply to-**
 - **discharge and admit to HH within 60 day episode (PEP)**
 - **new SOC when episodes are not “continuous” (e.g. inpatient facility over day 60/61)**
 - **Review OASIS consideration document**

Therapy reassessment



- Eliminate 13/19th and every 30 day visit threshold assessments
- Proposed at least every 14 days
- Final rule - at least every 30 days

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Home Health Quality Reporting OASIS



- “Pay for Reporting”
 - 2% reduction in payment if quality reporting requirements are not met
 - OASIS submission and quality episodes
- Proposed
 - To be phased in over three years with goal of 90 %
 - 70% 7/1/15 -6/30/16 ---2017
 - 80 % 7/1/16-6/30/17----2018
 - 90% 7/1/17 -6/30/18 ----2019

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Home Health Quality Reporting OASIS



- **Final rule:**
 - **70% the first year**
 - **CMS to monitor during July 1, 2014 –June 30, 2015 reporting time frame**
 - **Provide a “hypothetical performance” report to each HHAs**
 - **Determine 2nd year and beyond threshold**

Home Health Quality Reporting OASIS



- **CMS defines a “Quality assessment” several ways**
 - **SOC /ROC with a matching EOC (transfer, discharge or death)**
 - **SOC/ROC in the last 60 days of reporting period**
 - **EOC in the first 60 days of the reporting period**
 - **SOC/ROC followed by one or more follow-up assessments the last of which is in the last 60 days**
 - **EOC episode that is precede by a one or more recertification episode last of which occurs in the first 60 days of the reporting period**
 - **SOC/ROC one visit episode**
- **Non quality assessments : SOC/ROC, EOC that do not meet the above conditions**
- **Follow-up Assessments are neutral**

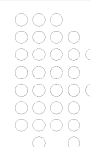
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Home Health Quality Reporting OASIS



$$QA0 = \frac{(\# \text{ of Quality Assessments})}{(\# \text{ of Quality Assessments} + \# \text{ of NonQuality Assessments})} * 100$$

Home Health Quality Reporting HHCAPHS



- Continued monthly HHCAPHS data collection and reporting for 4 quarters.
- The data collection period for CY 2015 APU includes the second quarter 2013 through the first quarter 2014 (the months of April 2013 through March 2014).
- The data collection period for the CY 2016 APU includes the second quarter 2014 through the first quarter 2015 (the months of April 2014 through March 2015)
- The data collection period for the CY 2017 APU includes the second quarter 2015 through the first quarter 2016 (the months of April 2015 through March 2016)

ICD-10-CM



- ICD-10- CM compliance 10/1/2015 (M0090 – Date assessment completed)
- CMS to release the ICD–10–CM HH PPS Grouper on April 1, 2015
- The final translation list will be posted to the Home Health section of the CMS Web site.
- A draft ICD–10–CM HH PPS Grouper will be released on or before January 1, 2015 to vendors that have registered as beta-testers.

Insulin coverage



- Additional diagnosis that supports inability to self inject
 - Provides a list of diagnoses
 - Requested comments related to comprehensiveness
- Presumptive; require complete review of the medical record
- **CMS responses:** Did not propose to use the list of codes as the sole means of establishing coverage eligibility for insulin injection. Rather, we identified these conditions as a means for providers and contractors to identify patients who may not be able to self-inject insulin.
 - We have not proposed a policy that limits coverage to a list of conditions that would indicate why a home health beneficiary is unable to self-inject.
 - Risk area: insulin pens

Quality of care: Medicare HH CoPs



- Increased survey frequency emerging
- Immediate jeopardy citations
- Terminations on the rise
- Alternative sanctions imposed

Speech Language Pathology: CoP revision



- **Qualifications**
 - **Master or doctoral degree and (a) Is licensed as a speech-language pathologist by the State in which the individual furnishes such services; or (b) In the case of an individual who furnishes services in a State which does not license speech-language pathologists:**
 - 1) **Has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience);**
 - 2) **Performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech language pathology or a related field; and**
 - 3) **Successfully completed a national examination in speech-language pathology approved by the Secretary.**

MEDICARE HOME HEALTH: Alternative Sanctions



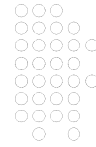
- Applies to condition level deficiencies
- Sanctions include:
 - Directed corrective action
 - Temporary management
 - Payment suspension
 - Civil monetary penalties
 - \$500-\$10,000
 - Per diem/per instance
 - Termination
- Informal dispute resolution possible
- CMPs and payment suspension no earlier than 7/1/14,
- Appeal rights w/o penalty suspension

The New Survey and Sanctions Rule



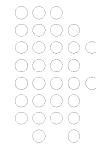
- 77 Fed. Reg. 67068 (November 8, 2012)
- Codifies HHA survey process
- Establishes intermediate sanctions
 - Civil money penalties and payment suspensions effective 7-1-14
 - Other sanction effective 7-1-13
- Establishes Informal Dispute Resolution process
 - Effective 7-1-14

Definitions



- **42 CFR 488.705**
 - **Survey types**
 - **Standard, abbreviated standard, extended, partial extended, and complaint**
 - **Deficiencies**
 - **Condition-level deficiency, deficiency, noncompliance, standard-level deficiency, substandard care, and substantial compliance**

Survey Process: 488.710-735



- Follows statutory standards
- Standard survey
- Partial Extended survey
- Extended survey
- Unannounced survey
- Frequency and content
- Surveyor qualifications

Informal Dispute Resolution: 488.745



- Informal opportunity to resolve disputes
- Available with condition-level deficiencies only
- CMS/state will provide written notification of deficiencies and IDR opportunity
- HHA must request IDR in writing
 - Specify disputed deficiencies
 - w/in 10 days of notice
- IDR does not delay enforcement process
 - CMS to develop timeframes for action
- Left to State/CMS to design IDR
- Effective 7/1/14

Alternative Sanctions: 488.800 et seq.



- Condition-level deficiencies only
 - Repeat standard-level deficiencies may trigger condition-level finding
- CMS developing detailed guidance on sanction process in SOM
 - Progressive action approach
- Sanction determinations made by CMS RO
 - Survey recommendations
 - State agency recommendations
- No CMP funds can be used to finance survey activities
 - Avoids “bounty hunter” risk

General Provisions: 488.810



- Sanctions imposed only for condition-level deficiencies
- Accrediting Organizations report condition-level findings to CMS RO
 - Sanctions lead CMS and SA to take over oversight and enforcement
- Branch deficiencies counted against parent
- Subunit deficiencies do not apply to parent
- All deficiencies require a Plan of Correction
 - CMS approval required
- Written notification of intent to impose sanction
- Appeal rights under 42 CFR Part 498
 - Penalties accrue during appeal, but collection delayed

Sanction Factors: 488.815



- Choice reflects “the impact on patient care and the seriousness of the HHA’s patterns on noncompliance
- Whether deficiencies pose immediate jeopardy to patient health and safety
- The nature, incidence, degree, manner, and duration of the deficiencies
- The presence of repeat deficiencies; compliance history in general and specific to cited deficiencies
- Whether deficiencies directly relate to patient care
- Whether the HHA is part of a larger organization with documented problems
- Whether the deficiencies indicate system wide failure

Available Sanctions: 488.820



- **Civil Money Penalties (CMP)***
- **Suspension of payment on new admissions***
 - **Payment denial, not payment hold**
- **Temporary management***
- **Directed plan of correction****
- **Directed in-service training****

- *** required by statute**
- **** required by regulation**

Civil Money Penalties: 488.845



- **Per instance CMPs: \$1000-\$10,000**
- **Per day CMPs: \$500-\$10,000; three tiers**
- **Factors considered**
 - **488.5 factors**
 - **Size of the HHA**
 - **Accurate and credible resources such as PECOS, cost reports, claims information providing information on operations and resources of HHA**
 - **Evidence of built-in, self-regulating quality assessment and performance improvement system**
- **Discretion to increase or decrease CMP at revisit**

Civil Money Penalties: 488.845



- **Penalty start**
 - **Per-day: day of the survey that identified noncompliance**
- **Penalty ends: date of correction of all deficiencies/date of termination**
 - **Correction=revisit survey finding date**

Civil Money Penalties: 488.845



- **Appeal Rights: 42 CFR Part 498**
- **CMPs held pending outcome, but still accruing during appeal**
 - **Payment due 15 days after final administrative decision**
- **Written request for hearing w/in 60 days of notice**
- **Waiving right to appeal reduces CMP 35%**
 - **Payment due w/in 15 days of waiver request receipt**
- **IDR option**
 - **Request w/in 10 days of notice of penalty**
- **CMP may be offset against Medicare or Medicaid payments**

PROPOSED HH CoPS



- Proposed rule
- Federal Register 10/9/2014
- 60 day comment period (12/8)
- CMS reviews and eventually published a final rule
 - Up to three years
- <http://www.gpo.gov/fdsys/pkg/FR-2014-10-09/pdf/2014-23895.pdf>

PROPOSED HH COPS



- History
 - Proposed rule issued 1997-never finalized
 - Expected to issue another proposed rule in 2006
 - Delayed due to competing priorities at CMS

PROPOSED HH CoPs –Changes



Structural changes

- Renumbering
 - Three sections: A - General Provisions 484.1-484.2; B - Patient Care; 484.40- 484.80 C- Organizational Environment
 - 484. 100 – 484. 115
- Several standards combined or incorporated into new CoPs
 e.g. Current standard for 484.14(g) “Coordination of patient services” combined with 484.18 “Acceptance of patients Plan of care and Medical supervision” to create 484.60 care planning, coordination of services, and quality of care
- Two new CoPs
 - 484.65 Quality Assessment and performance improvement (QAPI)
 - 484.70 Infection Control

PROPOSED HH CoPS – Changes



- Many of the requirements remain
- Expands patient rights
- Add a discharge and transfer summary requirement and time frames
- Emphasis on integration and interdisciplinary care planning
- Where standards are written in broad and vague terms, more specificity regarding what is required.
- Increase in Governing body involvement/accountability

PROPOSED HH CoPS –Changes



- **Eliminated**
 - **60 day summary to physician**
- **Group of professionals (PAC)**
- **Quarterly record review**

PROPOSED HH COPS- Principles



High quality home health care:

- **Patient centered**
- **Outcome oriented**
- **Data driven**

PROPOSED HH CoPS -Principles



- **Develop a more continuous, integrated care process across all aspects of home health services, based on a patient-centered assessment, care planning, service delivery, and quality assessment and performance improvement.**
- **Use a patient-centered, interdisciplinary approach that recognizes the contributions of various skilled professionals and their interactions with each other to meet the patient's needs. Stress quality improvements by incorporating an outcome-oriented, data-driven quality assessment and performance improvement program specific to each HHA.**

PROPOSED HH CoPS -Principles



- **Eliminate the focus on administrative process requirements that lack adequate consensus or evidence that they are predictive of either achieving clinically relevant outcomes for patients or preventing harmful outcomes for patients.**
- **Safeguard patient rights.**

PROPOSED HH CoPS -Patient Rights



484.50 Condition of Participation: Patient Rights

The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights.

Standards

- (a) Notice of right
- (b) Exercise rights
- (c) Rights of the patient
- (d) Transfer and discharge
- (e) Investigation of complaints
- (f) Accessibility

HH CoPS – Patient Rights (con't)



- a) Notice of rights
 - 1) Written and verbal notice in a language understandable to the patient and accessible to patients with disabilities
 - 2) Provide contact information for the HHA Administrator
 - 3) OASIS privacy notices
 - 4) patient/representative signature
- b) Exercise of rights
 - Related to honoring court decisions on competency and recognizing role of appointed representative

HH CoPS- Patient Rights (con't)



c) Standard: Rights of the patient 12 rights under this standard

- 1) Property and person treated respect
- 2) Be free of abuse, injuries, neglect and misappropriation of property
- 3) Complaints regarding treatment or care, etc.
- 4) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to,
 - (i) Completion of the comprehensive assessment
 - (ii) Care furnished based on the comprehensive assessment
 - (iii) Establishing and revising the plan of care, including receiving a copy of it
 - (iv) The disciplines that will furnish the care
 - (v) The frequency of visits
 - (vi) Expected outcomes of care, including patient identified goals, and anticipated risk and benefits
 - (vii) Any factors that could impact treatment effectiveness

PROPOSED HHCoPs- Patient Rights



- 5) Receive all services outlined in the POC
- 6) Addresses confidential record and HIPAA references
- 7) Be advised to the extent which payment for HH service are expected..... financial liability
The charges for services that may not be covered by Medicare, Medicaid.... The charges the individual may have to pay before care is initiated; and any changes in the information
The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) ----- ABN
- 8) Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204.(HHCCN and NOMNC)

PROPOSED HHCoPs- Patient Rights



9) Hot line

10) Be advised of the names, addresses, and telephone numbers of pertinent, Federally-funded and State funded, State and local consumer information, consumer protection, and advocacy agencies.

11) Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HHA or an outside entity.

(12) Be informed of the right to access auxiliary aids and language services as described in paragraph (f) of this section, and how to access these services.

PROPOSED HHCoPs- Patient Rights



d) Standard –Transfer and discharge

The patient and representative (if any), have a right to be informed of the HHA's policies for admission, transfer, and discharge in advance of care being furnished. The HHA may only transfer or discharge the patient from the HHA if:

- 1) acuity requires another level of care
- 2) no payment
- 3) goals met
- 4) patient refuses care or elects transfer/discharge
- 5) cause – disruptive, abusive, uncooperative behavior;
 - i) advise patient, physician etc. of the plan to d/tr
 - ii) efforts to resolve problems prior to d/tr
 - iii) provide patient with contact information for other agencies/providers
 - iv) document efforts made to resolve issues
- 6) death
- 7) HHA ceases to operate

PROPOSED HHCoPs- Patient Rights



- **(e) Standard: Investigation of complaints**
 - Investigate, document actions to resolve and actions to prevent
Allegations reported by patients /representatives of mistreatment, neglect, or verbal, mental, psychosocial, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA.
 - Staff to report to agency and authorities allegations of mistreatment, neglect, or verbal, mental, psychosocial, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA.

PROPOSED HHCoPs- Patient Rights



f) Standard: Accessibility

Information must be provided to patients in plain language and in a manner that is accessible and timely to—

- 1) patients with disabilities
 - web site
 - aids
 - compliance with ADA
- 2) LEP
 - language services
 - oral and written translations

HH CoPS – QAPI



Preamble

- “Through the survey process, we intend to assess whether HHAs have all of the components of a QAPI program in place. Surveyors would expect HHAs to demonstrate, with the objective data from the OASIS data set and other sources available to the HHA, that improvements had taken place with respect to actual care outcomes, processes of care, patient satisfaction levels and/or other quality indicators. Additionally, surveyors would expect the HHA to demonstrate that all disciplines are involved in its QAPI program,.....”
- We believe that physician involvement in efforts to improve the outcome of patient care is vital and, as previously noted, we have addressed this issue by proposing the physician involvement requirement at proposed § 484.60, “Care planning, coordination of services, and quality of care.” We have also addressed this issue by requiring all HHA skilled professionals, which would include physicians employed by or under contract with the HHA, to participate in the HHA’s QAPI program (see proposed § 484.75).

Proposed HH CoPS – Home Health Aides



- Requirements retained
- Structural changes
 - Clarification and reorganization
 - Incorporates personal qualifications currently in 484.4
 - Separates Instructors and organizations into two standards
 - Separates competency evaluation and In-service training into two standards

Proposed HH CoPS – Home Health Aides



Changes:

- A nurse aide training and competency evaluation program that is approved by the state as meeting the requirements of § 483.151 through § 483.154 (State review and approval of nurse aide training and competency evaluation programs) and is currently listed in good standing on the state nurse aide registry;
- Communication skills under contents of training include the aide's ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff.
 - Evaluated through direct observation
- Documentation requirement for training and competency evaluation
- Conduct aide training on a mannequin, and to conduct a competency evaluation on a "pseudo-patient." However, the pseudo-patient for the competency evaluation would have to be an individual, such as another aide or volunteer, whose age is representative of the primary population served by the HHA.
- New skill requirement related to recognizing and reporting changes in skin condition, including pressure ulcers.

Proposed HH CoPS Home Health Aide



Changes (con't)

- The home health aide would be assigned to a specific patient by the RN or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist)
- If a patient is receiving skilled care, the home health aide supervisor (RN or therapist) must make an onsite visit to the patient's home no less frequently than every 14 days, without the aide
- Annual onsite supervisory visits with the aide
- Emphasis on home health aides as part of the interdisciplinary team
- Outlines specific areas that need to be evaluated during all supervisory on visit

Medicare Provider Enrollment



- Ongoing validation reviews
- Change in Information reporting
- Disenrollment and reactivation
- 42 CFR 424.500 et seq.

Medicare Provider Enrollment Compliance



- Provider enrollment and state licensing compliance
 - Operational, 42 C.F.R. §424.502
 - Qualified physical practice location
 - Open to public to provide hospice
 - Prepared to submit valid Medicare claims
 - Properly staffed, equipped, and stocked to furnish hospice services
 - Applies to initial enrollment and change of ownership
- Form 855A

Risks of Non-Compliance



- Denial of enrollment, 42 C.F.R. §424.530(a)(5)
- Revocation of billing privileges, 42 C.F.R. §424.535(a)(5)
- State enforcement for licensing non-compliance
- Section 14 of 855A Penalties for Falsifying Information
 - Criminal penalties: 4 statutes – fines, jail, 2X unjust gain
 - Civil penalties: 2 statutes – CMP, 3X damages
 - Common law: damages, restitution, recovery unjust profit

Provider Enrollment



- Required disclosures
 - Organizations with ownership or managing control (§5)
 - Ownership
 - 5% or more
 - Direct or indirect
 - Managing control
 - Exercises operational or managerial control over Provider
 - OR
 - Conducts day-to-day operations of Provider
 - Not need ownership interest in Provider

Provider Enrollment



- **Individuals with ownership or managing control (§6)**
 - **Ownership**
 - 5% or more
 - Direct or indirect
 - **Managing control**
 - Officers and directors (corporation only)
 - **Partners, with any interest**
 - **Managing employees**
 - Administrator, DON, Medical Director
 - Delegates?
 - Includes non-W2 personnel

Provider Enrollment



- **Timely and accurately report changes of ownership or control**
 - **Sale of assets**
 - **5% or more direct or indirect ownership**
 - **Control**
 - **Organization**
 - **Individuals: officers, directors, partners**
 - **Within 30 days of change**

Provider Enrollment



- **Timely and accurately report changes of information**
 - Change to any information listed on 855A
 - Address, branch, billing services
 - Within 90 days of change
 - Includes managing employees per 42 C.F.R. §424.540(a)(2)
- **Sale of stock**
 - Not CHOW per 42 C.F.R. §489.18
 - Heightened Intermediary + CMS scrutiny
 - Fraud Demo – CMS interpreted as 30-day notification
- **Section 15 Certification Statement – 855A,**
<http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf>

Business Compliance Issues



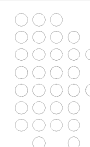
- **ACA Employer Mandate**
- **Fair Labor Standards Act: minimum wage and overtime**

ACA Employer Mandate: Home Care Impact



- **Many, but not all HHAs have comprehensive health insurance**
 - \$3000 per non-insured penalty a risk
- **Most Medicaid home care providers do not have health insurance for employees**
 - \$2000 per FTE penalty a risk
- **Private pay home care companies rarely have employee health insurance**
 - \$2000 per FTE penalty a virtual certainty

Private Pay Home Care: Companionship Services FLSA Exemption and more!



- **DoL rule effectively eliminates minimum wage and overtime exemption (in litigation)**
 - Eliminates exemption for 3rd party employment
 - Changes definition of companionship services
 - Excludes 3rd party employers from live-in exemption
 - Medicaid and disability rights advocates opposition
- **Increased litigation on W&H issues**
 - Validity of claimed FLSA exemption status
 - “hours worked”
 - Break time rights

CONCLUSION



- **Home Care and Hospice is diverse**
- **Range of legal/regulatory issues is endless**
 - **Significant regulatory energy directed towards home care and hospice**
 - **Compliance issues/concerns**
- **Center of innovation in care is home care; change triggers action**

Thank You!

Questions?

