

Compliance Risks Facing Hospice and Home Care Providers

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- **The Current State of Play**
- **A Focus on Hospice**
- **A Focus on Home Care**
- **How to Comply: Identifying Risks & Preventing and Responding to Non-compliance and Fraud, Waste and Abuse**
- **Engaging Management and the Board of Directors in Proactive Efforts**

The Current State of Play: Prosecuting Healthcare Fraud Will Remain a Priority

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▪ 2018 operations “spotlight the far-reaching impact of health care fraud. Such crimes **threaten the vitally important Medicare and Medicaid programs and the beneficiaries they serve.** Though we have made significant progress in our fight against **health care fraud**, our efforts are not complete. **We will continue to work with our partners to protect the health and safety of millions of Americans.**” – HHS Deputy Inspector General Cantrell, June 28, 2018, DOJ Announcement



▪ “Our efforts to root out fraud make our health care system more stable, and our streets more safe... **We will use all available tools to hold people accountable, including criminal penalties and civil penalties.**” – Rod Rosenstein, Deputy Attorney General, March 7, 2018, America’s Health Insurance Plans’ National Health Policy Conference



▪ “In addition to misaligned incentives, Medicare also suffers from **inadequate oversight of fraud and abuse.** And I can tell you that I am **personally committed to improvement in this area.**” – CMS Administrator Seema Verna, October 16, 2018, America’s Health Insurance Plans’ 2018 National Conference

Testimony of Gary Cantrell, Deputy Inspector General for Investigations, Office of Investigations, Office of Inspector General, HHS, 1/17/2018; Press Release, DOJ Office of Public Affairs, 12/14/2016; Press Release, DOJ Office of Public Affairs, 12/21/2017; Press Release, DOJ Office of Public Affairs, 12/21/2018

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Budget of the U.S. Government, Fiscal Year 2019

Improves Program Integrity for Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). The Budget includes legislative proposals and administrative actions to strengthen the integrity and sustainability of Medicare, Medicaid, and CHIP. Combined with additional funding investments, these policies would provide CMS with additional resources and tools to combat fraud, waste, and abuse and to promote high-quality and efficient healthcare.

To Medicare improve supplement payments. In addition, current law allows States to make Medicaid provider payments far in excess of actual service costs. States have used this additional money to leverage Federal reimbursements in excess of their Medicaid matching rate or for other purposes. To avoid this misuse of funds, the Budget also proposes to limit reimbursement to Government providers to no more than the cost of providing services to Medicaid beneficiaries.

Health Care Fraud and Abuse Control: \$5 returned for every \$1 spent

Additional funding for the Health Care Fraud and Abuse Control (HCFAC) program has allowed CMS in recent years to shift forward for implementation of the HCFA’s \$1 billion program. The Budget proposes HCFAC discretionary funding of \$770 million in 2019, which is \$45 million higher than the 2017 enacted level.

<https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf>

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Turning up the Heat: DOJ Continues Fraud Enforcement Efforts

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- **July 2018:** DOJ announces an **enforcement action larger than in 2017:**
 - **601 charged defendants** including 165 doctors, nurses and other licensed medical professionals
 - Across **58 federal districts**
 - **Over \$2 billion** in false claims
 - Included alleged participation in healthcare fraud schemes. Of those charged, 162 defendants were charged for their roles in prescribing and distributing opioids and other narcotics. Thirty state Medicaid Fraud Control Units (MFCUs) participated in the arrests.
- In FY 2018, DOJ obtained over **\$2.5 billion** in settlements from healthcare cases.
- Out of 767 new referrals, investigations and suits initiated in FY 2018—many of which will continue into 2019 and beyond—58% (446 matters) took the form of *qui tam* actions against defendants participating in HHS programs.

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The Other Oversight Entities

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- **Unified Program Integrity Contractor (NE UPIC)**
(the new ZPIC)
- **Probe and Educate**
- **CERT**



- **Audits**
- **Criminal and civil investigations**

State Regulators and Surveyors

- **Licensure surveys**
- **Audit Medicaid Integrity Contractors (MICs)**

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Top Three Risk Areas Affecting All Provider Types

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Financial relationships with referral sources

- Anti-Kickback Statute and Stark Law violations



Medical necessity

- Providing and billing for services that were not medically necessary, including:
 - Services for which the setting, intensity or duration was greater than medically necessary
 - ◆ Long length of stay
 - ◆ Intensity of rehab services and other services



Inadequate documentation

- To demonstrate medical necessity
- To comply with Medicare and state licensure requirements

All of these may be the basis of a False Claims Act case and are ripe for whistleblowers.

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Other High-Risk Areas Affecting All Provider Types

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HIPAA violations

- Protecting electronically stored information from malware and ransomware



Quality of care

- Inadequate care
- Unqualified personnel



Overpayments

- Reverse false claims
- ACA 60-day rule

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Compliance Risks Facing Hospice and Home Care Providers

Key Focus Areas for Enforcement and Settlement Activity

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- Patient eligibility (requires prognosis of six months or less)
 - Red flags for regulators: Long lengths of stay and revocations of hospice
 - Increased use of data analysis to identify outlier providers and patients
- Upcoding: Improperly shifting patients among four categories of care, e.g., general inpatient care
- Failing to timely create and maintain required documentation
 - Certification of face-to-face encounter with physician
 - Written plan of care
 - Records of interdisciplinary team meetings
- Financial relationships with referral sources, including physicians and hospitals
 - Scrutiny of medical director positions
 - Consideration of cash and in-kind benefits
 - Potential liability under AKS

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Hospice Fraud Settlements

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Significant hospice settlements

- **October 2017:** DOJ **\$75MM** settlement with Vitas stemming from an FCA lawsuit filed by former employees. Vitas allegedly billed Medicare for hospice-ineligible patients, **including for continuous care services that were not medically necessary, not actually provided or not performed in accordance with Medicare requirements.** Red-flag conduct (alleged): Employee bonuses for number of patients admitted without regard to eligibility; goals for employees for number of continuous home care days billed.
- **February 2018:** Horizons Hospice, LLC agreed to pay **\$1.24MM** for submitting **false claims** to Medicare and Medicaid for patients who did not qualify for hospice. Red-flag conduct (alleged): Falsifying records to support these claims.
- **May 2018:** Health and Palliative Services of the Treasure Coast, Inc.; The Hospice of Martin and St. Lucie, Inc. and Hospice of the Treasure Coast, Inc. agreed to pay **\$2.5MM** to settle a *qui tam* lawsuit alleging submission of **false claims** to Medicare for hospice patients. Red-flag conduct (alleged): Falsifying doctors' signatures, backdating medical records and misdiagnosing patients as terminally ill.

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The Hospice Case to Watch

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The AseraCare case—major ruling expected on medical necessity under the FCA

- **FCA litigation** against AseraCare, a large for-profit hospice provider, was filed by several former employees (and the government intervened), alleging that the hospice used **high-pressure management and sales techniques** that led to the **admission of patients ineligible** for hospice.
- **Key issue:** The burden the government must meet when alleging that a provider violated the FCA by submitting claims to Medicare for patients who were certified by physicians as hospice-eligible, but whose medical records, the government alleges, do not support eligibility.
 - The government and AseraCare presented contrary expert testimony regarding whether the medical records supported a finding of eligibility.
- **District court issued summary judgment for AseraCare** because **“expressions of opinion, scientific judgments, or statements as to conclusions about which reasonable minds may differ cannot be false”** under the FCA.
- The government appealed to the Eleventh Circuit. No decision has been issued yet.

U.S. v. GGNSC Administrative Services et al., case number 16-13004

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OIG Report on Hospice, July 2018

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OIG issued an extensive, 45-page report detailing many identified vulnerabilities in the hospice program. This report alleged hospices:

- fail to provide needed services to beneficiaries
 - **Hospices provided fewer services than outlined in the plans of care for 31% of claims for hospice beneficiaries residing in nursing facilities.**
- provide poor quality of care
- ineffectively manage symptoms and medications
- fail to provide families and caregivers crucial information to make informed decisions about their care
- inappropriately bill for an expensive level of care when the beneficiary does not need it
 - **Hospices often billed for general inpatient care when the beneficiary needed only routine home care. As a result, these hospices were paid \$672 per day instead of \$151 per day.**
- disproportionately seek beneficiaries who have uncomplicated needs
- fraudulently enroll beneficiaries who are ineligible or bill for services never provided



<https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp>

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OIG Hospice Report Recommendations for CMS

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OIG recommended that CMS:

- Strengthen the survey process to better ensure that hospices provide beneficiaries with needed services and quality care
- Seek statutory authority to establish additional remedies for hospices with poor performance
- Develop and disseminate additional information on hospices to help beneficiaries and their families and caregivers make informed choices about their care
- Educate beneficiaries and their families and caregivers about the hospice benefit
- Promote physician involvement and accountability to ensure that beneficiaries get appropriate care
- Strengthen oversight of hospices to reduce inappropriate billing



<https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp>

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OIG Work Plan

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- Because OIG has identified numerous vulnerabilities and raised concerns about the limited enforcement actions against poorly performing hospices, the OIG intends to:
 - Perform, under contract with state survey agencies, onsite surveys of hospices for certification and in response to complaints
 - Audit records to determine whether registered nurses made required onsite visits to the homes of Medicare beneficiaries who were in hospice care
 - Prepare to 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 (e.g., durable medical equipment, prosthetics, physician services)
- OIG is expected to issue reports on each of the topics above in 2019. OIG also plans to use the state survey report to issue a companion report with more detail about poor-quality care that results in harm to beneficiaries.

Office of Inspector General. Active Work Plan Items, January 2019; available at: <https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp>

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Key Focus Areas for Enforcement and Settlement Activity Home Care

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- Missing eligibility criteria
 - Providing services that were not medically necessary
 - Failing to verify or adequately document a patient's homebound status
 - Billing for personal care without a qualifying skilled service
- Failing to create and timely create required documentation
 - Certification of face-to-face encounter with physician
 - Written plan of care; must be timely created and regularly updated
 - Documentation of skilled services
- Financial relationships with referral sources, including physicians and hospitals, as well as patients
 - Consideration of cash and in-kind benefits
 - Potential liability under the Stark Law and AKS

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Home Care Fraud Settlements

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- **April 2018:** Amedisys Inc. and its affiliates agree to pay **\$150MM** to resolve allegations that, between 2008 and 2010, certain Amedisys offices **billed Medicare** for nursing and therapy services that were **medically unnecessary or provided to patients who were not homebound**, and otherwise **misrepresented patients' conditions** to increase Medicare payments. The settlement also resolves allegations that Amedisys maintained **improper financial relationships with referring physicians**, including an oncology practice in Georgia to which Amedisys provided patient care coordination at below-market prices. As part of the settlement, Amedisys entered into a five-year CIA with the OIG.
- **December 2018:** The owner and operator of two Miami home health agencies **was sentenced to 78 months** in prison and ordered to pay **\$4.65MM in restitution** for her role in a scheme to defraud Medicare. As part of her guilty plea, the woman admitted that from January 2010 through approximately January 2014, she **accepted kickbacks** in return for the referral of Medicare beneficiaries, many of whom did not need or qualify for home health services, to act as patients at the three agencies, and that she performed home healthcare nursing visits and prepared related medical records as if she were a licensed medical professional.

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Major Home Care Case

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The Sixth Circuit Court of Appeals reversed a federal court's dismissal last year of an FCA lawsuit filed against Brookdale Senior Living, the largest senior living provider in the United States and a major home health player, for \$35MM. It was brought forth by a former employee who was hired to review documentation related to the Tennessee-based company's home health care clients.

In a lawsuit filed in 2012, the employee alleged Brookdale and subsidiaries defrauded Medicare of tens of millions of dollars by billing for home health services without obtaining required face-to-face documentation and physician signatures. The company did so to process a backlog of about 7,000 unbilled Medicare claims worth about \$35 MM, the employee alleged.

Brookdale petitioned the Supreme Court in November to review a narrow issue of *Escobar* interpretation and the Sixth Circuit's interpretation of the timely certification standard.

No. 18-699, *Brookdale Senior Living Communities, Inc. v. United States ex rel. Prather*
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OIG Work Plan

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- OIG is conducting an audit to identify whether HHA claims with five to ten skilled visits in a payment episode in which the beneficiary was discharged met the conditions for coverage and were adequately supported.
 - OIG expects these to be high-risk claims, as after the fourth home care visit an HHA begins receiving a full 60-day payment based on episode of care, as opposed to the per-visit payments (LUPA), which are paid for visits 1–4.
- OIG has identified improper payments in recent OIG reports consisting primarily of beneficiaries who were not homebound or who did not require skilled services. Therefore, in 2017 OIG began a review of compliance with various aspects of the home health prospective payment system, including medical review of the documentation required in support of the claims paid by Medicare, to determine whether home health claims were paid in accordance with federal requirements.
 - OIG is using data from the Comprehensive Error Rate Testing program to identify trends that can be used to target pre- and post-payment review of claims.
- OIG is auditing Medicare Part A payments to HHAs to determine when certain items, supplies and services furnished to patients covered under Part A were separately billed to Part B.

HHS, Office of Inspector General, Active Work Plan Items. Last accessed 1/27/2019; available at: <https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp>

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New COPs for Home Health Present New Compliance Risks

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Home healthcare agencies must now comply with the new conditions of participation that went into effect in 2018. Compliance is difficult to achieve and hard to monitor.

In particular, it is challenging for HHAs to ensure they:

- Provide transfer summary to facility within two days of a planned transfer or within two business days of becoming aware of an unplanned transfer if the patient is still receiving care in the facility (42 CFR 484.110(a))
- Provide written notice of patient's rights and responsibilities, and transfer and discharge policies to a patient-selected representative within four business days of the initial evaluation visit (42 CFR 484.50(a))
- Communicate revisions to the plan of care due to change in health status to patient, representative (if any), caregiver and physicians issuing orders for plan of care (42 CFR 484.60(c))
- Communicate discharge plan revisions to the patient, representative (if any), caregiver, all physicians issuing orders for the plan of care and to the provider expected to care for the patient after discharge (if any) (42 CFR 484.60(c))

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The Role of a Compliance Program

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- Helping prevent fraud, waste and abuse
- Ensuring compliance with all applicable federal, state, and local requirements
- Performing risk assessments and sharing results with management and staff
- Identifying and responding to potential and actual noncompliance
- Driving a culture of compliance

“[W]hen we make charging decisions, we will . . . take into account whether companies have good compliance programs; whether they cooperate and self-disclose their wrongdoing; and whether they take suitable steps to remediate problems.”

– Remarks of previous Attorney General Jeff Sessions at Ethics & Compliance Initiative Annual Conference (April 24, 2017)

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Hospice and Home Care Presents Unique Oversight Challenges

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- Supervision of largely remote workforce providing care in patient’s homes
- Minimal control over referring and ordering physicians
 - Home Care: Face-to-face certification, timely signed orders, answering clinical phone calls
 - Hospice: Certificate of terminal illness
- Determining and billing the right level of care
 - Home Care: Home safety, number of professional visits, number and frequency of home health aide services
 - Hospice: GIP versus Routine Home Care (recent Probe and Educate on GIP > 7 days)
- Coordination of services between providers to avoid duplication of services and ensure correct billing
 - Home Care: Home health aides versus personal care workers, CHHA versus outpatient therapy
 - Hospice: Pharmacy benefits, hospitalization in non-contracted hospital

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Identifying the Risks: Perform a Risk Assessment

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Risk is the probability or threat of damage, injury or loss that is caused by vulnerabilities and that may be avoided through proactive efforts. It is critical to identify the agency's top risks to prioritize compliance efforts.

- Utilize the OIG and any state agency work plans
- Consider the complexity of existing requirements, or the issuance of any new regulations
- Consider the length of time since an area was reviewed
- Evaluate whether there have been recent compliance issues identified in the area
- What other risks this area may face: staffing shortages or competency, system limitations, high turnover, lack of training, etc.
- Interview key staff at different levels
- Leverage exit interviews
- Lead response to external audits and carefully study results
- Review at least biannually, but recommend quarterly



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Creating a Compliance Work Plan

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The risk assessment drives the work plan and it is a “living” document

- Auditing and monitoring activities
 - Routine activities such as policy reviews and monitoring available data (key metrics)
 - Regular auditing (probes and larger samples)
 - Education and training activities related to routine compliance topics and in response to audit and monitoring findings
- Ongoing collaboration with stakeholders
 - Share audit calendar and findings
 - Develop and help the business implement corrective action plans
 - Monitor progress on corrective action plan; re-audit as necessary
- Hold compliance and business accountable through Compliance Committee and other forums
- Update as new issues emerge
- Regularly report to senior management and the Board on risk rankings, audit results, status of corrective action plans, current metrics and Work Plan progress

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Sample Work Plan

Element #	Activity Type	Entity	Collaboration	Activity	Genesis	Regular Activity / 2019 Item	Status	Comments
6	Audit	Home Care	Quality	Focused Review of Care Time for Outlier Patients	Govt Activity	2019 Item	Pending	
6	Audit	Home Care	Quality, IT	Medicare Notices and Consents	Govt Activity	2019 Item	Pending	
6	Audit	Hospice	Quality	General Inpatient Care Billing and Documentation	Govt Activity	2019 Item	Pending	
6	Audit	Hospice	Quality	Ongoing Eligibility and Long Stay Cases (> 180 Days)	Govt Activity	2019 Item	Pending	

Other sections to consider adding to the work plan include:

- Sample size
- Responsible person
- Quarter to be completed
- High-priority indicator
- When to bring in outside resources

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Ongoing Monitoring

Hospice

- Length of stay > 180 days
- Live discharges
- Continuous versus GIP
- GIP admission > 5 days
- Gifts to referral sources
- Part D coordination
- Length of stay for patients in SNFs/ALFs
- PEPPER report metrics*

Home Health

- LUPAs
- Long length of stay
- Low-skilled care utilization
- High therapy utilization
- Timely start of care
- Timely discharge OASIS
- Gifts to referral sources
- PEPPER report metrics*

*Program for Evaluating Payment Patterns Electronic Report—summarizes your Medicare claim data statistics and compares them with aggregate data of other agencies in the nation, your MAC jurisdiction and the state.
<https://pepper.cbpepper.org/Training-Resources/Home-Health-Agencies/PEPPER-Review>

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Identify Noncompliance and Remediate

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Suspected or identified noncompliance should be promptly investigated. If noncompliance is substantiated, implement prompt corrective action.



- Hold staff accountable
 - Training; memo to personnel file; termination
- Hold management accountable
 - Track and monitor effectiveness of a corrective action; training
- Promptly quantify any overpayment and refund
 - “Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government” (False Claims Act - 31 U.S.C. 3729)
 - “Report and return any overpayment within 60 days after identification (or the date any corresponding cost report is due), whichever is later” (Section 1128J(d) of the Social Security Act)
 - “Overpayment” is defined as any funds that a person receives or retains from Medicare or Medicaid to which the person, after any applicable reconciliation, is not entitled (Section 1128J(d) of the Social Security Act)
- Potential disclosures to different agencies
 - OIG, CMS, DOJ, MAC
- Consider reporting findings of an investigation to the reporter, when appropriate

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Responding to External Audits

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- Government audits can come from many places
 - OIG, state Medicaid agencies, state Medicaid fraud agencies, CMS contractors, state health departments
- How to prepare and adequately respond
 - Note due date, size, volume and amount; request extension if needed
 - Consult with relevant program manager to understand facts, operations and possible defenses
 - Review related regulations; be aware of industry positions on audit issue(s)
- Track results and consider ongoing Work Plan items
 - Track audits, responses and outcomes
 - Information can be used to determine whether future corrective actions, routine monitoring and internal auditing are needed

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Engaging Management

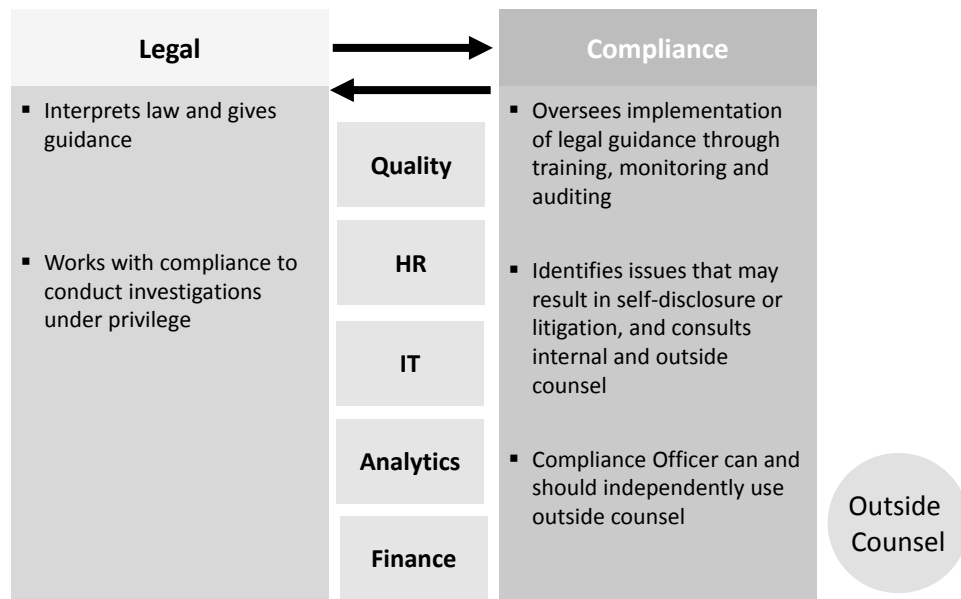
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- Regularly report in Operational and Compliance forums
 - Ask to be present at Operational meetings and trainings to regularly report on risk areas, hotline logs, audit results, and progress on corrective actions.
 - Collaborate with Quality for PAC and similar meetings, and invite them to participate in Compliance meetings.
- Why should management want to listen?
 - Officers have a fiduciary duty and may be subject to criminal prosecution and civil sanctions for corporate wrong doing, including monetary penalties and/or exclusion from federal healthcare programs, according to the “Yates Memo” (September 2015).
 - Proven costs of non-compliance.
 - Proactive efforts to address compliance produce efficiencies.
- Ways to improve culture
 - Ask for senior management support in messaging culture of compliance.
 - Participation in Compliance Awareness
 - Messages in Code of Conduct, Orientation and Annual Training
 - Break down silos and myths (ex. “compliance as police”).

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Ongoing Collaboration Between Legal and Compliance: How to Break Down Silos and Better Collaborate with Management

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Striking the Right Balance With the Board

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- Who should inform the Board about compliance concerns?
 - The Board has general oversight over the compliance program. The Compliance Officer should report independently and directly to the Board.
- Why should the Board want to listen?
 - Board members have a fiduciary duty and may be subject to criminal prosecution and civil sanctions for corporate wrongdoing, including monetary penalties and/or exclusion from federal healthcare programs, according to the “Yates Memo” (September 2015).
- When should the compliance officer report to the Board?
 - It depends. The type and size of the organization will impact how often the Board meets. The Compliance Officer should report, at a minimum, once per year, but at least twice a year is recommended.
- What should the compliance officer tell the Board about?
 - Time will be limited. Deliver a well-written report, together with a brief oral presentation, noting:
 - Key compliance risks and related auditing and monitoring
 - Trends demonstrated by auditing or monitoring
 - Substantial self-disclosures and/or refunds

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Questions?

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