Enforcement Trends and Compliance: Hospice and Home Health

HCCA Healthcare Enforcement Compliance Institute
October 25, 2016

Agenda

• Overview of Recent Enforcement Trends
• False Claims Act Litigation Developments
• Best Practices for Auditing and Monitoring
• Practical Takeaways

Overview of Recent Enforcement Trends
Many Arms for Enforcement

- Criminal Strike Forces
  - Baton Rouge, Louisiana
  - Brooklyn, New York
  - Chicago, Illinois
  - Dallas, Texas
  - Detroit, Michigan
  - Houston, Texas
  - Los Angeles, California
  - Miami-Dade, Florida
  - Tampa Bay, Florida
- CMS Moratoriums on HHA enrollments
- Data Analysis
  - OIG Data Brief “Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases” (June 2016) OEI-05-16-00031
- False Claims Act Litigation and Settlements

Why the Enforcement Focus on Post-Acute Care?

- Prevention and enforcement against fraudulent providers in the Post Acute space is a priority for the government, particularly due to the significant federal spend in this area.
  - Increase of $1 billion per year for total hospice expenditures, with the average length of stay for beneficiaries continuing to increase.
  - Over 11,000 home health agencies providing services to approximately 3.5 million beneficiaries in 2015, costing the government north of $18.4 billion.
  - Over $10 billion in improper payments estimated in FY 2015
  - Improper hospice admission ends coverage for curative care.
Medical Necessity

- Eligibility
- Level of Care
- Length of Stay/Service
- Documentation to Support Medical Necessity

Recent Medical Necessity Enforcement: Hospice

- Patient Eligibility/Documentation
  - Exercare Hospice and Palliative Care (July 2016)
    - $18 million to resolve False Claims Act allegations that it claimed Medicare reimbursement for hospice care for patients who were not eligible for such care because they were not terminally ill.
    - Medical records allegedly did not support terminal prognosis.
    - Alleged Exercare discouraged physicians from discharging patients who no longer eligible and failed to ensure nurses accurately documented medical necessity.
  - Evercare Hospice and Palliative Care (October 2015)
    - Improper admission of patients who did not meet eligibility requirements—life expectancy of six months or less.
    - Individual Exclusions.
    - Agree to pay $2.2 million to resolve claims it violated the FCA by submitting false claims to Medicare. Serenity and the OIG also entered into a five year Corporate Integrity Agreement to settle the claims.
  - Guardian Hospice of Georgia LLC (October 2015)
    - Agreed to pay $3 million to resolve FCA allegations.
    - Alleged Guardian’s business practices contributed to its submission of false claims, including hiring its own in-house staff and medical directors on the hospice eligibility criteria, setting aggressive targets to recruits and recruit patients, and failing to properly oversee the hospice.
Recent Medical Necessity Enforcement: Hospice

<table>
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<th>Long Lengths of Stay</th>
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<td>Hospice of Arizona and Related Entities (May 2013)</td>
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<td>Agreed to pay $12 million to resolve allegations they violated the FCA. The government alleged that certain practices resulted in the admission of ineligible patients or inflated bills, including adopting procedures that delayed and discouraged staff from discharging patients from hospice when they were no longer appropriate for such services.</td>
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Recent Medical Necessity Enforcement: Hospice

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<th>Level of Care</th>
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<td>Covenant Hospice (June 2015)</td>
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<td>$10 million paid for billing general inpatient care rather than routine home care.</td>
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<td>St Joseph Hospice (September 2015)</td>
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<td>$5.86 million paid for alleged billing of continuous home care hospice, rather than routine home care.</td>
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Recent Medical Necessity Enforcement: Home Health

| Res Care Iowa (February 2015) |
| Agreed to pay $5.63 million to resolve claims it violated the FCA by submitting false home healthcare billings to Medicare and Medicaid. |
| Between 2009-2014, the company failed to obtain required physician certifications of medical necessity, orders for specific types and amounts of services and, after 2011, face-to-face documentation. |
| Careall Companies (November 2014) |
| Agreed to pay $25 million. |
| Allegedly overstated severity of patient medical conditions, billed for medically unnecessary services, and billed for non-homebound patients. |
Recent Medical Necessity Enforcement: Home Health

- **Amedisys (April 2014)**
  - Allegedly 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.
  - Alleged management pressure on nurses and therapists to provide care based on the financial benefits, rather than the needs of patients.
  - Paid $150 million to resolve claims.


- Qui Tams alleging that AseraCare admitted patients to hospice that were not terminally ill
- District Court (N.D. Ala.) bifurcated trial into 2 phases:
  1. Phase One on the falsity element of Government’s False Claims Act claim
  2. Phase Two on the other elements of the Government’s FCA Claim
     “Falsity cannot be inferred by reference to AseraCare’s general corporate practices unrelated to specific patients. A claim is either false or not without evidence of corporate practices unrelated to that claim.”
- **Phase I Jury Verdict:** On October 15, 2015, the jury largely sided with the government in Phase I of the two part trial and found that 104 of the 121 submitted claims were objectively false.


- **November 2, 2015:** court formally vacated the jury’s verdict, granted AseraCare’s motion for a new trial and reopened summary judgment arguments.
- **March 31, 2016:** the court granted summary judgment in favor of AseraCare, finding that “contradiction based on clinical judgment or opinion alone cannot constitute falsity under the FCA as a matter of law.”

“When two or more medical experts look at the same medical records and reach different conclusions about whether those medical records support the certifying physicians’ COTIs, all that exists is a difference of opinion. This difference of opinion among experts regarding the patients’ hospice eligibility alone is not enough to prove falsity...”


- US Appeal to the Eleventh Circuit
  - Appealing whether the district court erred in granting summary judgment to AseraCare and granting AseraCare a new trial
  - US says district court’s ruling based on a fundamentally flawed view of what it means for a claim to be “false” under the False Claims Act
  - US view:
    - A claim is false if it is not reimbursable by Medicare
    - A hospice claim is only reimbursable by Medicare if provider has sufficient documentation in medical record to support terminal diagnosis
    - Jury properly relied on documentation in medical records to determine if claim is false
    - Evidence of good faith disagreement is relevant to scienter but does not negate falsity.

U.S. ex rel. Wall v. Vista Hospice Care, Inc.

- June 20, 2016, court (N.D. Tex.) granted summary judgment in favor of the hospice
  - Rejected Relator’s attempt to use statistical sampling finding:
    - “the underlying determination of eligibility for hospice is inherently subjective, patient-specific, and dependent on the judgment of involved physicians.”
  - Agreed with AseraCare district court that the opinion of one medical expert alone cannot prove falsity without further evidence of an objective falsehood
Physician Relationships & Anti-Kickback

OIG Special Fraud Alert June 19, 2015

- Physician Compensation May Result in Significant Liability
  - Looking at doctors on the receiving end of the kickback
- The OIG emphasized a shift in government enforcement to actions against individual physicians rather than actions primarily targeting affiliated provider entities.

OIG Special Fraud Alert June 2016

- Improper Arrangements and Conduct Involving Home Health Agencies and Physicians
  - Government is stepping up its enforcement of home health providers and the physicians they do business with
  - Concern that home health companies are paying physicians for referrals
  - Concern that physicians are soliciting payments in return for their referrals
    - In some instances disguised as payments for medical director services
  - OIG concerned that such arrangements compromise medical judgment, result in patient steering, overutilization, and unfair competition
Medical Directors

- Number of Medical Directors
- Fair Market Value of Services Actually Provided
- Evidence of work being done
- Link to Referrals

Marketing Practices

- Payments tied to admissions or census goals raise a red flag
- Employees involved in admissions should not receive census based payments
- Be careful how you talk about census goals

Recent Enforcement: Physician Relationships

- Nurses’ Registry, Vicki House and Estate of Lennie House (July, October 2015)
  - $17 million settlement to resolve allegations of billing for medically unnecessary home health care services and services tainted by kickbacks.
- A Plus (June 2013- February 2015)
  - Home health agency, two owners, and seven physicians and spouses agree to pay over $3 million.
  - Alleged Stark/Anti-Kickback violations based on payments to physicians’ spouses for sham marketing positions to get referrals.
Recent Enforcement: Physician Relationships

- **Good Shepherd Hospice (February 2015)**
  - Agreed to pay $4 million to resolve allegations that the company submitted false claims for hospice patients who were not terminally ill.
  - Among other things, allegedly hired medical directors based on their ability to refer patients, focusing particularly on medical directors with ties to nursing homes, which were seen as an easy source of patient referrals.

- **Amedisys, Inc. (April 2014)**
  - Agreed to pay $150 million to settle allegations stemming from 7 qui tams between 2008 and 2010. Included Stark/Anti-Kickback claims based on relationship with Georgia Oncology practice where Amedisys allegedly provided patient care coordination services at below-market rates.

Best Practices for Auditing and Monitoring

Government FRAUD Prevention EFFORTS: REVIEW

- Office of Inspector General (OIG) of the HHS issued Voluntary Compliance Guidance (www.oig.hhs.gov)
  - All provider types: Laboratory, physicians, hospitals, SNF
  - OIG voluntary guidance for Home Health and Hospice
    - Hospice: 64 Fed. Reg. 54031; October 5, 1999
  - Annual OIG Work Plans
  - Increase in Audits; ZPIC; MAC; Pre-Bill...
  - OIG Teams with Department of Justice on Investigations
  - State Audits for Medicaid
  - Involvement from State Offices of Attorney Generals
Mandatory Compliance Requirements

- 2008 HOS CMS Conditions of Participation (CoPs): Cover ethical issues, informed consent, dignity, privacy, resident rights, QAPI, etc. IDG meetings and documentation
- Proposed CoPs for Home Health (October 2014) – pending
- Payment: CPT/Face-to-Face; Attestations; Notice of Election; HH Medical Necessity and Homebound status/POC
- Medicare Administrative Contractors (MACs); Local Coverage Determinations, Eligibility, LOS, Live Discharge
- CMS Regulations, Notices, Transmittals, other
- ICD-10 Coding
- State laws regarding background checks/Medicaid fraud
- OIG Exclusions List
- HIPAA
- Self Disclosure Protocol (revised April 2013)/2016 Regulations

Annual OIG Work Plans: HOSPICE

Cumulative foci:
- 2013-2014 OIG Work Plan (www.oig.hhs.gov/reports)
  - Marketing practices
  - Financial relationships with nursing facilities
    - Mandatory contract language
  - 2014-15: Hospice in Assisted Living Facilities
  - 2015-2016 Hospice general inpatient care
    - Services billed but not received
    - Increase utilization
    - Is level of care appropriate?
  - 2016 Hospice GIP, POC, Revocation, other

Government Oversight FOR home health

- 2013-2014 OIG Work Plan (www.oig.hhs.gov/reports)
  - Face to face encounters
  - 2014-2015 Employment of home health aides (HHA) with criminal convictions
  - OASIS
  - MAC: Claims oversight / ZPICs
  - 2014-2015 Home health PPS requirements
  - State survey and Certification/Quality
  - Trends in expenses and revenues – Cost report analysis
  - 2016: Home Health PPS: documentation; are claims in accordance with laws and regulations
Government focused auditing

- MAC/ZPIC: Claims Oversight & Data Analytics
  - Pre-Bill claims monitoring
  - ZPIC letters requesting clinical records for claims billed and paid:
    - Focus on Hospice: Eligibility, Long Length of Stays, Face to Face, Election of Benefit, Notice of Election, Revocation; Live Discharges, Routine Home Care (RHC), General Inpatient Care (GIP); Continuous Home Care (CHC); other
    - Focus Home Health: Face to Face; therapy evaluation and assessments; medical necessity, home bound status, Plan of Care (POC); other

Corporate Integrity Agreements

- Use CIAs as a learning tool to understand the focus of OIG investigations
- Use CIAs to develop/implement best practices:
  - The seven elements of a compliance program (review next slide) plus:
    - Perform an annual Compliance Program Risk Assessment
    - Provide initial, ongoing governing Board education (see AHLA/OIG/AHA publication for Boards—April 2015)
    - Initiate Management Certifications especially for high risk areas such as marketing, billing staff and clinicians (documentation)
    - System to track Agreements with Referral Sources

CORE ELEMENTS OF A COMPLIANCE PROGRAM

Identify Best Practices for each element:
1. Policy/Procedure/Written Code
2. Compliance Officer/Committee/Governing Board
3. Training/Education
4. Communications/Anonymous
5. Auditing Monitoring ---- internal & external monitoring; Quality Monitoring
6. Disciplinary Measures
7. Disclosure/Timely Investigations and Reporting
PEPPER REPORTS: DEFINED

- PEPPER Reports (information taken from CMS training materials at www.cms.gov):
  - Program for Evaluating Payment Patterns Electronic Report (PEPPER)
    - These reports summarize Medicare claims data statistics for a home health or hospice agency in target areas that may be at risk for improper Medicare payments
    - PEPPER data provides a comparison of a home health or hospice's Medicare claims data statistics with aggregate Medicare data for the nation, MAC jurisdiction and state.

The History of PEPPER

- PEPPER was initially developed in 2003 for short-term acute care hospitals
- Now PEPPER is used for long-term care, acute care PPS hospitals, inpatient psychiatric facilities, critical access hospitals, inpatient rehabilitation facilities, partial hospitalization programs, hospices, skilled nursing facilities and home health

Why CMS provides PEPPER REPORTS

- CMS is charged with protecting the Medicare Trust Fund from fraud, abuse and waste
- PEPPER reporting supports CMS' Program Integrity activities
- PEPPER can be utilized as an educational tool to assist providers in assessing their risk for improper Medicare payments:
  - Go to www.pepperresources.org
PEPPER DATA

- If outliers are revealed by PEPPER data, review claims, and documentation in medical record; consider patient population, external factors,
- Develop best practices regardless of whether something is an outlier
- PEPPER Data is not publically available; TMF Health Quality Institute does not provide PEPPER data to MACs or Recovery Auditors but the MACs provide access to database with PEPPER statistics for their region-so it is available to the MACs

Hospice Specific Audits

- Design Audits Specific to Hospice Issues
  - Admission and Recertification
  - Relevant Claim Period
  - Long Length of Stay
    - Entire length of stay for stays greater than 240 days to review medical necessity

Kickbacks

- Agreements with referral sources must be in writing and signed by both parties for a term of at least one year
- Agreement must cover all services to be provided
- Aggregate compensation must be set in advance, be consistent with fair market value, and not take into account the volume or value of referrals
- Maintain and regularly review time logs
- Only hire number of medical directors reasonably necessary to meet the legitimate regulatory and business needs of provider
- Routinely monitor physician/provider relationships
- Review Fair Market Value periodically for longer agreements or agreements with auto-renewal terms
### Kickbacks

- OIG recommends as best practice maintaining a database of all agreements with actual referral sources to track:
  - Terms
  - Fair Market Value
  - Legal and Compliance Review
  - Business need
  - Compliance with terms of agreement
    - Timely and accurate payments
    - Services or products delivered
  - Remember that anything of value can constitute remuneration
    - Forgiven payments or late payments without interest or fees
    - Not fulfilling a term of the contract, e.g., not attending meetings.

### Practical Takeaways

- Documentation of eligibility and medical necessity is key
  - Hospice – Terminally ill with prognosis of life expectancy less than six months if illness follows its normal course.
  - Home Health – Homebound
- Regularly review provider/physician agreements for compliance
- FMV
- Services Provided/Time sheets
- Anti-kickback compliance
- Audit for overpayments
- Review your Pepper reports
- Review the OIG Workplan for OIG Initiatives and areas of enforcement
- Review settlements and recent CIAs

### QUESTIONS
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| **Laura Ellis**  
Senior Counsel  
Office of Inspector General  
U.S. Department of Health & Human Services  
Laura.Ellis@oig.hhs.gov | **Sara Mclean**  
Assistant Director  
Commercial Litigation Branch  
Fraud Section, U.S. Dept. of Justice  
Sara.McLean@usdoj.gov |
| **Kathleen Hessler**  
Dir. Compliance & Risk  
Simione Healthcare Consultants  
khessler@simione.com | **Wade Miller**  
Partner  
Alston & Bird LLP  
wade.miller@Alston.com |