HOME HEALTH AND HOSPICE: ENFORCEMENT TRENDS AND COMPLIANCE

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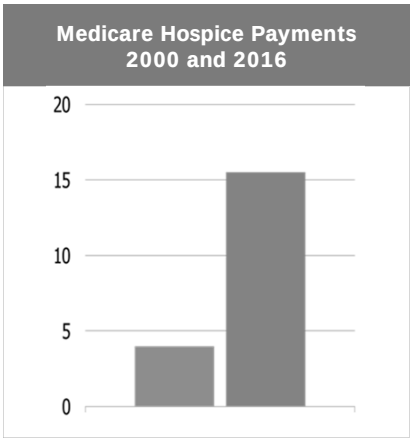
Hospice Audits and Enforcement On Rise

- Medicare and Medicaid are your biggest payor sources
- Government audit activity suggests an industry still rife with poor documentation and technical compliance issues
- Hospice Quality of Care/survey concerns increasingly getting attention
- Whistleblowers continue to bring cases to the government
- Audits result in big $$ recoveries for the government

Increased Hospice Expenditures*



Medicare hospice payments = **$16.8 billion in 2016** (over 4x the 2000 amount)

1.4 million Medicare patients

50% of beneficiaries die on hospice (only 23% in 2000)

4,380 hospices
(up 4.4% in 2016)

*Source: MedPAC March 2018 Report to Congress

OIG July 2018 Report On Hospice

- Reviewing data back to 2005 identified several trends related to hospice services. CMS disputed half of the recommendations but report signals fault lines in hospice services.
- Many hospices providing only routine home care (RHC).
- Availability of continuous home care (CHC) and general inpatient care (GIP).
- Long of length of service (LLOS)
- Staffing and services on weekends and general staff availability
- Missed visits and uncontrolled pain.
- OIG work plan also identified hospice billing related to ambulances, physician services, incentives for SNF or ALF referrals.

Government Players – Who is Looking?

- Medicare & Medicaid Contractors
  - (UPICs, ZPICs, MACs, MICs)
- Department of Justice (DOJ)
  - FBI
  - U.S. Attorney's Office & Main Justice
- HHS Office of Inspector General
- State Attorneys General
  - Medicaid Fraud Control Unit
- State Licensing Boards & Surveyors
- DEA

What's Hot Today in Hospice Program Integrity Reviews?

- Targeted Probe and Educate (TPE) by MACs
- Complaint Surveys
- UPIC audits – pre-pay and post-pay (sometimes with extrapolation)
- OIG Audits
- DOJ investigations and whistleblower litigation
- Opioid epidemic meets hospice

An Audit is Born

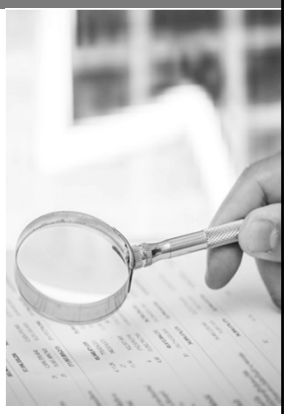
- Initial audits can take several different forms
  - Probes
  - ADR/TMR
  - TPE
  - CERT
  - OIG

Any request for records from a Medicare/Medicaid contractor should be given a consistently high level of attention

TPE Pre-Pay Audits

- ADRs now giving way to MAC's Targeted Probe & Educate (TPE)
  - Replacing all medical reviews (ADRs subsumed)
  - Three rounds of prepayment probe reviews
  - 20 to 40 prepayment claims to start
  - Aberrant data as a trigger
  - Sustained high levels of denials (≥15%) may trigger referral to UPIC/ZPIC
    - Targeted education (one-on-one) phone or video
    - Improve on "education letters" of the past

UPIC Audits



- Pre-pay akin to ADRs – except done by UPIC staff
- Post-pay – quicker reviews, but still scant information on denials
- Probe edits sometimes followed by statistically valid random sample subject to extrapolation
- Some site visits and interviews, including with patients/families
- Payment susp and/or referral to OIG in some cases
- MAC will issue a repayment demand → appeals

OIG Hospice Audits

- Very broad audit scope – compliance with Medicare rules
- Letter informing of upcoming audit
- 100 claim sample and extrapolation!
- On site audit work/focus on controls
- Questionnaires related to controls, including compliance program controls
- Draft audit report
- 30 days to provide input
- Final OIG Audit Report published
- MAC will seek recoupment
- Medicare appeals process available

New OIG Inspection – Complaint Surveys and Quality of Care Trends

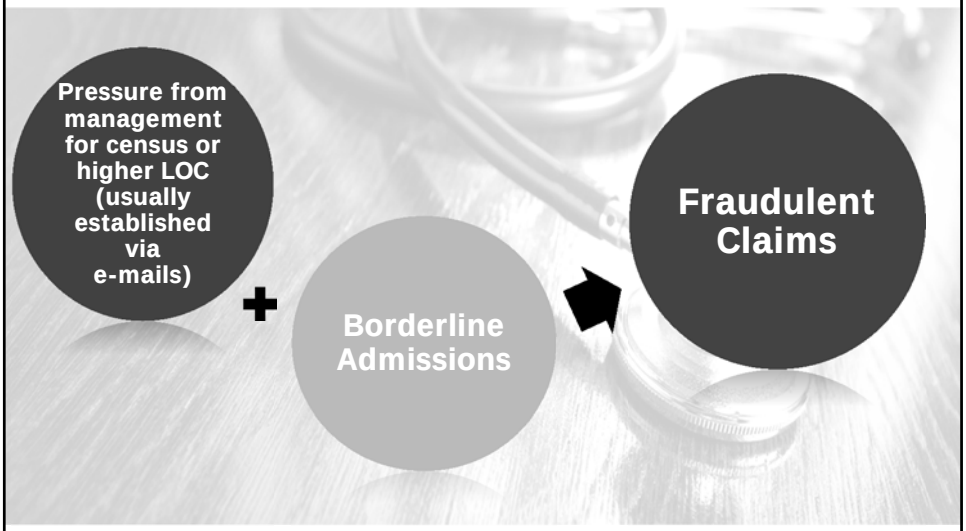
Added to OIG Work Plan in **November 2018** –

Protecting Medicare Hospice Beneficiaries From Harm

Surveys and complaint investigations are critical to oversight of the care hospices provide to beneficiaries. This study is a companion to Trends in Hospice Deficiencies and Complaints (OEI-02-17-00020), in which we determine the extent and nature of hospice deficiencies and complaints and identify trends. For this study, we will use the survey reports to provide more detail about poor-quality care that resulted in harm to beneficiaries. We will describe specific instances of harm to Medicare hospice beneficiaries and identify the vulnerabilities in Medicare's process for preventing and addressing harm.

Expected issue date - 2019

Government's Theory in Most Hospice Fraud Cases



Common Hospice Fraud Allegations

- Admitting or retaining ineligible patients without adequate clinical support
- Billing for higher level of care (GIP/CHC) than appropriate
- Inducements to beneficiaries
- Billing Part D for drugs or Part B for equipment related to terminal illness
- Overly aggressive marketing practices
- Kickbacks to doctors, hospitals, NFs, ALFs

Enforcement Trends: Hospice

- Common risk areas/vulnerabilities
  - Eligibility
  - Levels of Care
    - Routine, Respite, General Inpatient (GIP), Continuous Home Care.
  - Lengths of Care
  - Inappropriate Referrals
  - Paying Hospice Medical Director > FMV
- Audits, Evaluations, & Recommendations
- Settlements and sentences

Recent Hospice Fraud Enforcement

- Chemed Corporation-$75 million False Claims Act settlement and OIG CIA;
- Evercare- $ 18 million False Claims Act settlement and OIG CIA;
- Guardian Hospice-$3 million False Claims Act settlement;
- Treasure Coast Hospice-$2.5 million False Claims Act settlement related to billing;
- Horizons Hospice-$1.2 million False Claims Act settlement for ineligible patients on services.
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Opioid Epidemic and Hospice

- Attending physicians may be less likely to follow hospice patients if asked to write pain Rx
- Getting controlled substances filled at pharmacy – more challenges
  - 5 or 7 day limit or less
  - No faxed orders
  - After hour pick up challenges
- Disposal of unused medications – more challenges
- Comfort kits – more challenges
- Opioid Bill and Hospice – focus on safe disposal of unused meds

Compliance Program Straight Talk

- QAPI and HIPAA compliance do not meet government's compliance program expectations
- Investment in compliance program structure and trained compliance personnel is critical
- Self-audits
- PEPPER report assessment
- Hotline/no retaliation
- Identified overpayments and refunds (60 Day Rule)

60 Day Rule – Medicare and Medicaid

- Key concepts –
  - ACA – 2010 law, regulation Feb 2016
  - "Credible evidence" of a potential overpayment
  - 6 months to investigate, 60 days to refund "identified overpayments"
  - Failure to do so – violation of law and could lead to fraud violation for knowingly failing to refund
  - Mostly self-policed (audits, hotline complaints) but whistleblowers and CMS contractors increasingly weighing in

60 Day Rule – Medicare and Medicaid

- Take away – Policy and Procedure for 60 Day Rule compliance
  - Who is responsible for what?
  - Accountability
  - Document refunds

Incentive Compensation: Marketing and Admissions

- Bonuses/incentive compensation tied to admissions
  - May be permissible under Anti-Kickback Law for bona fide employees, BUT may misalign proper incentives to provide care for eligible patients
  - Bonuses tied to admissions for clinical or admissions staff – Ill Advised
- Take away – carefully assess incentive compensation for each class of employee and independent contractors

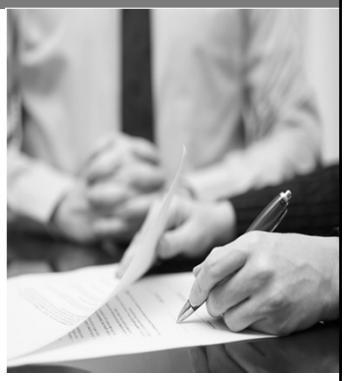
Hospice Physicians / Medical Director Risk Areas

- Selecting medical directors for expected referrals
- Too many "medical directors"/hospice physicians
- Hospice physicians not preparing sufficiently detailed invoices for their work – if refer to hospice
- Hospice physicians not active at IDT
- Hospice physicians not preparing good CTI brief narratives or good attestations on F2F
- Hospice physicians frequently doing reimbursable physician visits (E&M) with poor visit documentation

Documentation, Documentation, Documentation

- EHR –
  - Turn cut/copy and paste feature off?
  - Danger of check boxes and drop downs – lack of detail on the Why hospice?
  - Use text boxes to paint the picture
  - Do they result in technically correct attestations, CTIs, with signatures in correct place, correct attestation language (I "composed", on F2F - I furnished visit findings to certifying physician)
- If note plateau or stability, why still hospice eligible or GIP/CHC eligible?
- Inconsistent objective measures or observations (spoken words)

When the Government Comes Knocking



- Policy and training on what to do
- Speak with agent or not – their choice
- Time & place convenient to them
- Notify supervisor, compliance officer or legal counsel
- Can have attorney present
- Hospice can make attorney available
- Always tell truth!
- Ask for business card information

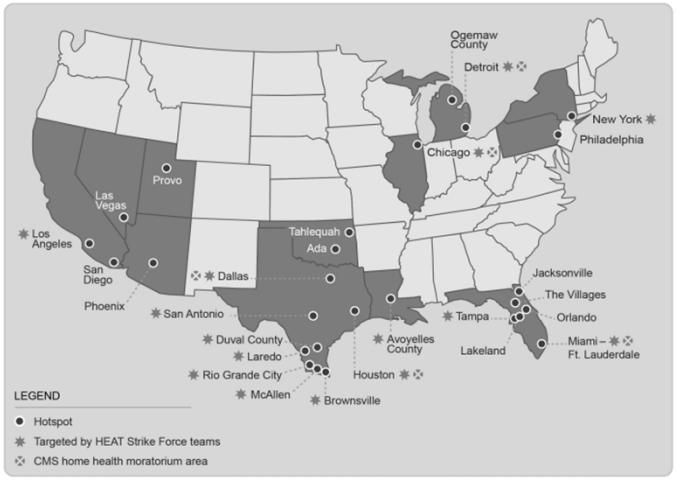
Home Health Fraud-Déjà vu All Over Again.

- Home health services have been a consistent fraud focus since the 1990s.
- Affordable Care Act imposed significant program integrity provisions.
- CMS has regulated the issuance of home health provider numbers in certain geographic areas.
- Several recent criminal prosecutions related to kickbacks and related conduct illustrate that some providers are bad actors tainting the industry.
- Home health is a key ingredient to achieving many health quality benchmarks such as lowering hospital re-admissions.
- New home health regulations impose significant changes to enhance patient participation in health services.
- Increase in civil and administrative enforcement will be costly for the industry and compel innovative compliance measures.
- In 2018, 764 criminal actions, 813 civil enforcement actions, and recoveries over $1.4 billion related to home health fraud.

Enforcement Trends: Home Health

- Common risk areas/vulnerabilities
  - Medical Necessity.
  - Homebound Status.
  - Therapy overutilization.
  - Inappropriate Referrals and kickbacks to referral sources.
  - Paying Medical Directors more than Fair Market value for administrative services.
- Alert: Improper Arrangements
- Audits, Evaluations & Recommendations
- Data Brief & Geographic Hotspots
- Settlements & sentences (examples)

Home Health - Geographic HotSpots



Spotlight: Texas Home Health Prosecutions

- Texas is a significant jurisdiction for prosecuting home health fraud and is one of DOJ's health care fraud task force locations.
- HHA payments to marketers and group home owners for Medicare patient information which was used to fraudulently bill for Medicare services.
- HHA owners and administrators convicted of health care fraud for concealing that the owners were excluded from the Medicare program.
- HHA owner, nurse and physician convicted for false certifications for medical necessity for patients never seen by HHA.
- Patient recruiter convicted for selling to HHA patient information used to bill for services not necessary or provided. Recruiter paid physicians, therapy companies, and patients for the info to bill false claims.
- HHA owner and DON convicted of health care fraud for paying to obtain false certifications for medical necessity and for patient information from recruiters.

Other Home Health Enforcement Actions 2019

- Florida Home Health Agency owner and co-conspirator sentenced to 87 and 24 months respectively for $8.6 million fraud scheme involving kickbacks to therapists and therapy services without a license.
- Florida home health patient recruiter convicted in $600,000 kickback scheme in which recruiter was paid over $300,00 to make referrals to the HHA.
- Florida Medical clinic owner convicted of accepting kickbacks from HHA recruiters for the referral of patients to various HHAs.
- Michigan patient recruiter convicted of kickbacks received from HHA for the referral of patients who were not eligible or needed the HHA services.

How does OIG find fraud?

- Whistleblowers/Relators
- DOJ referrals
- OIG Hotline
- Data Analysis
- Internal Referrals (OAS, OEI)
- Referrals from Contractors
- Beneficiaries and families

Enforcement Trends: General Risk Areas

- Billing for services not rendered
- Misrepresentation or upcoding of services
- Medically unnecessary services
- Falsification of medical records and physician authorizations
- False certification of patients as homebound
- Unlawful relationships with patient recruiters and referral sources
- Employing Excluded Individuals
- Poor Documentation of Services
- Kickbacks to patients

Compliance Trends: OIG Fraud Risk Indicator

- OIG's range of administrative options when settling a civil or administrative fraud case: High risk (1) to low risk (5)

1. Exclusion from the Federal Government Healthcare Programs.
2. Heightened scrutiny (unilateral monitoring).
3. Integrity Obligations (Corporate Integrity Agreements (CIA) and Integrity Agreements (IA).
4. No further Action.
5. For Good Faith and cooperative reporting/self-disclosure, release 1128(b)(7) exclusion with no integrity obligations.

- SEE: Criteria for implementing section 1128(b)(7) exclusion authority: April 18, 2016.

Corporate Integrity Agreements (CIAs)

- Medicare/Medicaid Provider entities under investigation for alleged fraud or abuse may enter into a settlement agreement with DHHS OIG.
- In addition to the Settlement Agreement, the OIG may require mandatory compliance with a second agreement — Corporate Integrity Agreement (CIA).
- The Provider agrees to the CIA **and** the OIG agrees *not* to exclude parties to the CIA.

When OIG Settles Without a CIA

- Could be either because
  - Relatively Low Risk warranting no further action by OIG, or
  - High Risk because OIG determined additional oversight needed, but party refused to enter into CIA.
    - For settlements on or after 10/1/18, list of High Risk entities can be found here: https://oig.hhs.gov/compliance/corporate-integrity-agreements/risk.asp

Requirements of CIA

- CIAs based on allegations of false claims billed and paid will require annual clinical record and claims audits by an Independent Review Organization (IRO).
- CIAs based on allegations of violations of Anti-Kickback statute: require annual audits of contracts and "arrangements."
- Reporting Period Annually for 3-5 years
  - CIA may identify sample to be audited.
  - Specific issues such as medical necessity or eligibility, coding.

Negotiating CIAs

- Hospice Review
  - Length of Stay (over 180-210 days).
  - Level of Services (Routine, GIP, CHC, etc.).
  - Initial Eligibility.
- Home Health Claims Review
  - Medical Necessity.
  - Coding & Documentation.

CIA Enforcement

- OIG has the authority to impose civil monetary penalties ---also known as Stipulated Penalties for breaches of the terms of a CIA.
  - Example(s)
- OIG may also consider exclusion if there is a material breach of the CIA/IA.
  - Example(s)

What can you do to stay out of trouble?

- Build a culture of compliance (hotline, no retaliation)
- Hire an Active Compliance Officer
- Train staff continuously
- Monitor referral sources and marketing practices
- Identify risk areas, conduct audits, implement corrective actions
- OIG website: Compliance Resources
- Self-Disclose

OIG's Self-Disclosure Protocol (SDP)

THANK YOU