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Enforcement Trends and Risk Mitigation for Home Health and Hospice Providers

December 4, 2014

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Recent Headlines

Rising rates of hospice discharge in U.S. raise questions about quality of care

This is the third installment in the "Business of Dying" series .

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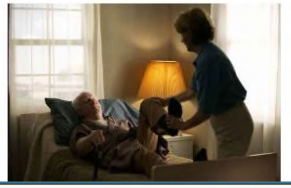

For-profit home health agencies blasted in new analysis

By Steven Ross Johnson | August 4, 2014

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Miami Home Health Agency Owner and Operator Pleads Guilty for Role in Multiple Medicare Fraud Schemes

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Thursday, May 2, 2013

United States Files False Claims Act Lawsuit Against the Largest For-Profit Hospice Chain in the United States

rporation and various wholly owned hospice subsidiaries, including Vitas
ation, alleging false Medicare billings for hospice services, the Justice
or-profit hospice chain in the United States and provides hospice services
do, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kansas,
a, Texas, Virginia and Wisconsin) and the District of Columbia. Chemed,
oto-Rooter Group Inc., a national drain cleaning and plumbing service

.S. Department of Justice
lovember 26, 2014

ASHINGTON—An owner and operator of a Mi
onnection with a long-running $6.2 million Me
lealth LLC (Professional Home Health), and sir
gencies.

ssistant Attorney General Leslie R. Caldwell of
ifredo A. Ferrer of the Southern District of Flo
liami Field Office and Special Agent in Charge
luman Services Office of Inspector General's (H
nnouncement.

rnesto Fernandez, 48, of Miami, pleaded guilty
efore U.S. Magistrate Judge Chris M. McAliley

e the home of her late mother, Evelyn Maples, in Mims, Fla. Maples' family believes Vitas hospice care hastened Maples' death.

How Dying Became A Multibillion-Dollar Industry

By *Ben Hallman*

Development and data reporting by Shane Shifflett.
Additional reporting by Chris Kirkham.
Design by Hilary Fung.

JUNE 19, 2014

Evelyn Maples' last day as a hospice patient wasn't anything like her family imagined when the nurse from Vitas Healthcare first pitched the service two months before.

On the morning of Dec. 31, 2011, Maples' daughter, Kathleen Spry, found

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Agenda

1. Federal Laws and Key Enforcement Players
2. Understanding the Focus of Government Enforcers
3. Recent Regulatory Responses to Risk Areas
4. Risk Mitigation

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Federal Laws and Key Enforcement Players

Federal Laws and Penalties

Defined

- Anti-Kickback Statute
  - Broadly prohibits offering or providing anything of value (remuneration) in return for referrals for goods, services, or items paid for by a federal health care program
  - Imprisonment, fine and civil penalties
- Civil False Claims Act
  - Liability for any person who (1) knowingly presents or causes to be presented a false or fraudulent claim for payment; (2) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; or (3) conspires to commit a violation
  - Attaches to "Reverse" False Claims – knowingly concealing or improperly avoiding or decreasing an obligation to pay the U.S.
    - Affordable Care Act created 60 day overpayment rule
  - $5,500 to $11,000 per claim plus treble damages and attorney fees

Federal Laws and Penalties, con't

Defined

- Stark Law
  - Prohibits a physician from making referrals for designated health services to an entity with which he or she (or an immediate family member) has a financial relationship
  - Up to $15,000 per claim plus 3 times the claims and/or $100,000 per circumvention scheme
- Civil Monetary Penalties
  - Various Social Security Act prohibitions that cover a range of conduct
- Other Criminal Provisions
  - Health Care Fraud
  - Mail and Wire Fraud
  - Obstruction
  - False Statements

Key Enforcement Players

- U.S. Department of Justice (DOJ)
  - United States Attorneys' Office (USAO)
  - Federal Bureau of Investigations (FBI)
- U.S. Department of Health and Human Services (HHS)
  - Office of Inspector General (OIG)
  - Centers for Medicare and Medicaid Services (CMS)
- State Attorneys' General Offices
  - Medicaid Fraud Control Units (MFCUs)
- Program Integrity Contractors
  - Medicare Administrative Contractors (MACs)
  - Recovery Audit Contractors (RACs)
  - Zone Program Integrity Contractors (ZPICs)
  - Medicaid Integrity Contractors (MICs)

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Understanding the Focus of Government Enforcers

Enforcement Environment

Fraud Enforcement is Profitable for the Government

- High rate of return is a driving force behind the continuing increase in health care fraud investigations and prosecutions
- FY 2014 **$2.3 billion** from health care fraud civil FCA settlements and judgments
  - Marks 5 consecutive years > $2 billion in annual health care fraud recoveries
  - **$14.5 billion** total federal health care dollars recovered Jan. 2009 – Sept. 2014
- Average 3-year ROI (FYs 2011-2013) is **$8.10**
- In FY 2013, DOJ opened over 2000 criminal and civil health care fraud investigations
- HHS-OIG - In 2013, investigations led to 849 criminal actions and 458 civil actions against individuals or entities

Enforcement Environment

Fraud Enforcement is Profitable for the Government

- **RACs** returned more than **$3 billion** to the Medicare Trust Funds in FY 2013
  - Home Health: **$6.3 million** overpayments
  - Hospice: **$35,000** overpayments
  - CMS is creating a national RAC solely responsible for home health, hospice and DMEPOS claim reviews

- In 2012, **ZPICs** reviewed 200,000 claims, conducted 3600 beneficiary interviews and 780 onsite inspections
  - ZPIC actions resulted in over **$250 million** in savings to Medicare
  - More than 130 ZPIC investigations were accepted by law enforcement for potential prosecution

Enforcement Environment

Government Investments in Fraud Enforcement Activities

- Investments in state-of-the-art technologies
  - **CMS' Fraud Prevention System:** Employs advanced predictive algorithms and other analytic technologies to analyze billing patterns against every Medicare fee-for-service (Parts A and B) claim prior to payment
- Investments to Increase Collaboration
  - **Health Care Fraud Prevention and Enforcement Action Team (HEAT):** Coordinates the increased tools and resources available across government to help prevent, investigate and prosecute Medicare and Medicaid fraud
  - **Medicare Fraud Strike Force:** Interagency teams of analysts, investigators, and prosecutors from CMS, DOJ, HHS-OIG, FBI state and local law enforcement
  - **Healthcare Fraud Prevention Partnership (HFPP):** Public-Private partnership between federal government, states, private insurers and associations to improve fraud-fighting capabilities across payers

Home Health Enforcement

By the Numbers

- In 2013, 3.5 million Medicare beneficiaries received home health services costing around $18 billion, from more than 12,000 HHAs
- Medicare spending for home health care has doubled since 2001
  - 2001-2012, number of home health episodes rose from 3.9 to 6.7 million
  - 1997-2012, therapy visits increased from 10% to 34% of total home health services
  - Number of HHAs has increased by an average of more than 500 per year since 2002
- According to OIG, since 2010, nearly $1 billion in improper Medicare payments and fraud has been identified relating to the home health benefit

"Fraudulent home-based services are surging across the country"
- Special Agent in Charge Derrick L. Jackson, HHS-OIG Atlanta
November 12, 2014

Home Health Enforcement

HHS-OIG Priorities

- OIG 2015 Work Plan
  - Compliance with PPS requirements, including the documentation required in support of claims paid by Medicare, and determining whether home health claims were paid in accordance with federal laws and regulations
  - Employment of individuals with criminal convictions

- Special Fraud Alert (1995) – susceptible activities of HHAs
  - Paying a physician for plan of care
  - Disguising referral fees as salaries or paying above fair market value
  - Providing hospitals with discharge planners, home care coordinators
  - Subcontracting with Retirement Communities to induce referrals

Home Health Enforcement

RAC Approved Audit Issues for Home Health

RAC (Region)	Approved Issues	Full List Available
Performant Recovery (Region A)	• Skilled nursing length of stay • Outpatient therapy claims above $3,700 threshold • No skilled service	https://www.dcsrac.com/IssuesUnderReview.aspx
CGI Federal (Region B)	• Skilled nursing length of stay • Outpatient therapy claims above $3,700 threshold • No skilled service • Medical necessity and conditions to qualify	https://racb.cgi.com/Issues.aspx
Connolly (Region C)	• Medical necessity and conditions to qualify • RAP claim only • Incorrect billing of PEP claims	http://www.connolly.com/healthcare/pages/ApprovedIssues.aspx
HealthDataInsights (Region D)	• Skilled nursing length of stay • Outpatient therapy claims above $3,700 threshold • Medical necessity and conditions to qualify • Visits during inpatient stay • Services for 5 – 9 visits	https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx

Home Health Enforcement

Other Key Risk Areas

- Medical necessity, and eligibility for home health benefit
  - Medically unnecessary skilled services
  - Services provided to patients who are not homebound
  - Lack of a qualifying service
- Documentation sufficiency and compliance with CMS requirements
- Financial relationships with referral sources
  - To steer beneficiaries to a particular HHA
  - To provide or prescribe unnecessary care
- Marketing practices
  - Interactions with referral sources
  - Interactions with beneficiaries
- Home health aide certification and training

Home Health Enforcement

Action Taken

- **Amedisys, Inc.**
  - April 23, 2014 – Agreed to pay $150 million to settle allegations stemming from 7 *qui tams* that between 2008 and 2010, Amedisys:
    - Billed Medicare for nursing and therapy services that were not medically necessary, and for services to patients who were not homebound
    - Misrepresented patients' conditions to increase Medicare payments
    - Management pressured nurses and therapists to provide care based on the financial benefits to Amedisys rather than the needs of patients
    - Maintained an improper financial relationships with a private oncology practice in Georgia where by Amedisys employees provided patient care coordination services to the oncology practice at below-market prices

Home Health Enforcement

Action Taken

- **CareAll Management, LLC (Tennessee)**
  - November 2014 – Agreed to pay $25 million
  - *Qui tam* alleged that between 2006 and 2013, CareAll submitted claims overstating the severity of patients' conditions and billed for services that were not medically necessary and rendered to patients who were not homebound
  - CareAll contended issues in the case stemmed from issues with "paperwork technicalities" and home health visits that were not properly documented
  - CareAll's second settlement of FCA allegations within the past two years
    - In 2012, CareAll paid $9.4 million for allegedly submitting false cost reports to Medicare
  - HHS-OIG imposed an enhanced and extended CIA

Home Health Enforcement

Actions Taken Involving Patient Recruiters, Kickbacks and Inducements

- August 2013 – owner and director of nursing of a Louisiana HHA sentenced to 15 years and 5 years, respectively and ordered to forfeit $9.2 million, pay $17.1 in restitution
  - Kickbacks to patient recruiters to obtain Medicare beneficiary information
  - Nurses, including nursing director, falsified qualification documents to make it appear beneficiaries qualified for home health services
  - Kickbacks to physicians to sign fraudulent referrals and certifications for home health services that were not medically necessary

- August 2013 – owner of a network of Michigan health care companies and 8 others were sentenced to over 7 years imprisonment, $1.1M in civil FCA settlements and 40 years in total exclusions
  - Kickbacks for referring patients for home health and other services
  - Illegal payments were made disguised as bonuses, mileage reimbursements, and payments for medical director and consulting services that were never performed

Home Health Enforcement

Medicaid Action Taken

- February 20, 2014 – More than 20 people, including operators of home care agencies and nurse staffing agencies, office workers, and personal care assistants, were arrested
  - Multi-year effort by federal and local law enforcement agencies to target widespread fraud in the District of Columbia Medicaid program
- Allegations include:
  - Receipt of $75 M in DC and Maryland Medicaid funds by an owner of 3 agencies who was excluded after her nursing license was revoked
  - Kickbacks to beneficiaries to exaggerate symptoms in order to receive home care and sign biweekly timesheets falsely stating they received services
  - Selling counterfeit Home Health Care Aide Certificates

Hospice Enforcement

By the Numbers

- Medicare expenditures totaled about $15.1 billion
  - More than 400% increase in spending since 2000
- Average length of stay increased to 88 days
- Between 2000 and 2012 hospice length of stay at the 90th percentile grew substantially, increasing from 141 days to 246 days
- 68% of Medicare decedents who used hospice had a non-cancer diagnosis, up from 48% in 2000

Hospice Enforcement

HHS-OIG Priorities

- OIG 2015 Work Plan
  - Hospices in assisted living facilities
    - Extent to which hospices service beneficiaries in ALFs
    - Length of stay, levels of care received, common terminal illnesses
  - Hospice general inpatient care
    - Appropriateness of GIP care claims and the content of election statements for hospice beneficiaries who receive GIP
    - Concern that this level of hospice care is being misused
- Special Fraud Alert (1998) - suspect activities between hospices and nursing facilities
  - Offering free goods (or below fair market value) to induce referrals
  - Inappropriate room and board payments
  - Hospice paying for “additional” services that Medicaid consider to be included in room and board
  - Swapping arrangements between hospice and nursing facility

Hospice Enforcement

RAC Approved Audit Issues for Hospice

RAC (Region)	Approved Issues	Full List Available
Performant Recovery (Region A)	• Excessive length of stay	https://www.dcsrac.com/IssuesUnderReview.aspx
Connolly (Region C)	• Core-based statistical areas • Medicare coverage requirement review	http://www.connolly.com/healthcare/pages/ApprovedIssues.aspx
HealthDataInsights (Region D)	• Hospice related Part B services • Date of death • Excessive units of physician services • Face-to-face evaluations	https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx

Hospice Enforcement

Other Key Risk Areas

- Levels and locations of care
- Medical necessity eligibility and appropriateness for benefit
  - Admissions
  - Long lengths of stay
  - Stability and failure to discharge clinically ineligible patients
- Documentation
  - Adequacy of physician attestations, clinical documentation, financial records, and other documents that support claims for reimbursement
  - Timeliness and completeness of physician referrals, plans of care, hospice certifications and face-to-face evaluations
- Marketing practices
  - Payments tied to admissions and census goals
  - Kickbacks to referral sources

Hospice Enforcement

Actions Taken

- Levels and locations of care
  - December 2011 – A hospice paid $2.7 million to resolve allegations that it submitted claims for general inpatient care when only routine care was needed
  - February 2012 – A hospice paid $25 million to resolve allegations that it submitted claims for services that were medically unnecessary and billed Medicare for continuous or crisis care services when the patients were not experiencing a crisis
- Medical eligibility and appropriateness for hospice benefit
  - June 2012 – A hospice paid $6.1 million to resolve allegations that it submitted claims for ineligible patients who did not have a terminal prognosis of six months or less
  - February 2013 – A non-profit hospice closed and declared bankruptcy following a government audit focused on patient eligibility
  - March 2013 – A hospice paid $12 million to resolve allegations that it submitted claims for ineligible patients and that it adopted business practices and procedures to delay or discourage discharge of ineligible patients

Hospice Enforcement

Actions Taken

- Documentation
  - May 2014 – The owner of a hospice was sentenced to 14 years in prison and ordered to pay $32.4 million for a Medicare fraud scheme that included submitting claims for ineligible patients, submitting claims for patients who never received the level of hospice services billed, routinely altering patient records, rewriting documentation to make patient appear sicker than they were, and falsifying documentation for high-cost, intensive hospice care

- Marketing
  - March 2014 – The parent company for a hospice provider paid $3.9 million to resolve allegations that it submitted claims for ineligible patients and induced employees and staff to admit ineligible patients

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Recent Regulatory Responses to Risk Areas

Recent Regulatory Responses

Home Health

- CY 2015 Home Health PPS Final Rule
  - Changes to face-to-face encounter documentation requirements
  - Therapy reassessment visits

- Proposed changes to the Home Health Conditions of Participation
  - Comments due January 7, 2015

- Intermediate Sanctions for HHAs
  - 2013 Home Health PPS finalized regulations authorizing CMS to impose intermediate sanctions on HHAs found to be out of compliance as part of the survey and certification process

Recent Regulatory Responses

Hospice

- Changes to allowed principal diagnoses
  - As of October 1, 2014, “debility” and “adult failure to thrive” are no longer accepted principal diagnoses

- IMPACT Act
  - Mandated surveys for Medicare-certified providers
  - Medical reviews for hospices with long length of stay patients

- Part D - Coordination and coverage of certain classes of drugs
- Definition of terminal illness and relatedness

Newer Enforcement Tools

Increased Focus on Prevention

- Enhanced Medicare Provider Screening and Enrollment Requirements
  - Greater scrutiny for providers deemed to pose a higher risk of fraud or abuse
    - Newly enrolling HHAs
      - High risk: Fingerprint-based criminal background checks for all individuals with a 5% or greater ownership interest
    - Currently enrolled HHAs and all hospice providers
      - Moderate risk: subject to unscheduled site visits

- Temporary Moratoria on Enrollment of Providers
  - Current moratoria on new HHAs in Chicago, Ft. Lauderdale, Miami, Detroit, Dallas, Houston

Newer Enforcement Tools

Increased Focus on Prevention

- Suspension of Medicare and Medicaid Payments
  - If there is "reliable information" that an overpayment exists, or pending investigation of a "credible allegation of fraud"
  - Credible allegation of fraud is an extremely low standard
    - "indicia of reliability"
    - Allegations can come from any source (e.g., hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, law enforcement investigations)
  - As of September 2013, CMS had 297 providers under active payment suspension, with 105 of these having been approved in 2013
  - For Medicaid, states are required to suspend payments to Medicaid providers where a credible allegation of fraud exists that has been "verified" by the state

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Risk Mitigation

Compliance Program Activities

- Develop and Implement an effective corporate compliance program
- Ensuring Effectiveness
  - An effective compliance program is dynamic and evolves
  - One size does not fit all – an effective program is tailored to a provider's structure and operation
  - Track guidance for government views as to what is necessary
    - HHS-OIG Compliance Program Guidance
    - Federal Sentencing Guidelines
    - Recent CIAs
  - Know your fraud and abuse risk areas – they change

Compliance Program Activities

Auditing and Monitoring

- Audit and monitor high risk areas
  - Develop and adhere to a work plan that sets forth a schedule and scope of internal reviews
  - Consider periodic external reviews by independent third parties
  - Identify and refund overpayments within 60 days

- Evaluate your data to identify trends and investigate outliers
  - Review PEPPER reports
  - Other Home Health metrics: lengths of stay, vague diagnosis codes, therapy utilization patterns, readmission patterns
  - Other hospice metrics: live discharges, lengths of stay > 180 days, primary diagnosis
  - Hospice cap overpayment trends

Compliance Program Activities

Auditing and Monitoring

- Consider engaging legal counsel to conduct or direct auditing activities you want protected by privilege
  - Compliance effectiveness review
  - Targeted internal investigations
- Utilize legal counsel to monitor and manage financial relationships
- Ensure background and exclusion/debarment checks are regularly conducted
  - Not only employees, but also independent contractors and vendors
  - Check both HHS-OIG LEIE database and GSA's SAM database (www.sam.gov)
  - Also state Medicaid excluded provider lists

Compliance Program Activities

Training and Education

- Designate a specific individual to be responsible for tracking and understanding regulatory changes and disseminating information to appropriate staff
- Importance of documentation training for home health and hospice staff
  - Certification of plans of care
  - Certification of terminal illness
  - Face-to-face visits
- Focused training for marketing staff on interactions with referral sources and beneficiaries
- HHS-OIG HEAT Provider Compliance Training Initiative resources

Other Risk Mitigation Actions

- Track and log compliance questions, complaints and issues raised through the compliance program, steps taken to follow up, how issues were resolved, including corrective and preventative actions
- Implement systems to ensure timely certifications, F2F visits, therapy reassessment visits
  - EHRs can have features built-in to flag patients with upcoming requirements
  - Schedule IDGs sufficiently in advance to help monitor key timing requirements
- Have means to identify disgruntled employee or contractor
  - Publicize compliance hotline to contractors, vendors
  - Conduct and document exit interviews, reviewed by compliance officer
- Monitor payor and contractor audits for patterns for signs of systemic issues
  - Multiple audits of same/similar issues, multiple RAC or ZPIC audits

Government Overtures

- Vary in type and intensity
  - Contractor audits and additional documentation requests
  - Administrative subpoenas
  - OIG subpoenas
  - Civil Investigative Demands
  - Grand Jury subpoenas
  - Search warrant
- What to expect:
  - Unannounced requests
  - Clinical documentation demands
  - Rigorous data analysis
  - Potential for conflicting interpretation of Medicare guidelines

Responding to Government Overtures

- Be sure the organization knows how to respond to all types of government inquiries
  - Who is in charge of responding to written requests?
  - Who is in charge of tracking responses to government requests?
  - Who should the front desk contact if an agent arrives?
  - What to do when an agent is on the premises?
  - What to do if an agent approaches the employee outside of work?
  - Next steps?

Questions?

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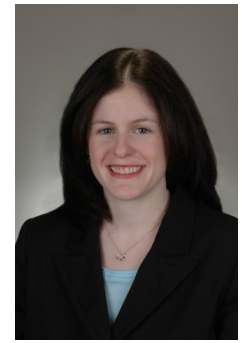

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Epstein Becker Green Resources

- **Health Care and Life Sciences Client Alert:** Hospice and Home Health Update: Recent Legislative and Regulatory Efforts Continue to Change the Regulatory Landscape for Hospice and Home Health Providers

  http://www.ebglaw.com/publications/hospice-and-home-health-update-recent-legislative-and-regulatory-efforts-continue-to-change-the-regulatory-landscape-for-hospice-and-home-health-providers/

- **Health Care and Life Sciences Alert:** Medicare's Proposed Home Health Rule for 2015: CMS Suggests Only Limited Relief to the Face-to-Face Encounter Documentation Requirements but Continued Compliance Burdens on Home Health Agencies

  http://www.ebglaw.com/publications/medicares-proposed-home-health-rule-for-2015-cms-suggests-only-limited-relief-to-the-face-to-face-encounter-documentation-requirements-but-continued-compliance-burdens-on-home-health-agencies/

- **The Advisory Board Company's *Daily Briefing*:** How Hospices Can Prepare for Increased Federal Audits Under the IMPACT Act

  http://www.ebglaw.com/publications/emily-bajcsi-jason-christ-interviewed-in-how-hospices-can-prepare-for-increased-federal-audits-under-the-impact-act/

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Thank you.