HOME CARE and HOSPICE PROGRAM INTEGRITY: SURVEYING the LANDSCAPE

William A. Dombi, Esq.
National Association for Home Care & Hospice
Center for Health Care Law

COMPLIANCE: FOCUS ON HOME CARE

• ZPICs and RACS looking at home care
  – Homebound status
  – Medical necessity
  – Technical compliance incl. F2F
• High level fraud/False Claims Act investigations
  – E.g., $375M physician-directed fraud allegation
• OIG continues home care efforts
  – New report alleges widespread fraud and abuse
  – Report is weak on facts and methodology, strong on hyperbole
• Medicaid home care new on the agenda
  – Personal care is the main focus
  – Staff credentials including health screening a target
RECENT ENFORCEMENT ACTIVITY

• FIRST, THE SERIOUS STUFF

FBI/DOJ/Medicaid Fraud Units

• Criminal and high level civil fraud
• Usually you know well after they have started
• Warrants to seize documents
• Home care related matters to date include:
  – Fraudulent billings
  – Services not rendered
  – Deep kickback arrangements
  – Potential organized crime
February 28, 2012; U.S. Department of Justice

- **Dallas Doctor Arrested for Alleged Role in Nearly $375 Million Health Care Fraud Scheme**

- A physician, his office manager, and five owners of home health agencies were arrested on charges that they fraudulent billed Medicare for unnecessary services and services not provided. Dr. Jacques Roy allegedly certified or directed the certification of more than 11,000 individual patients during the past five years.

June 6, 2012; U.S. Department of Justice

- **Home Health Agency Owner Pleads Guilty in Connection with Detroit Fraud Scheme**

- The owner of three Detroit-area home health agencies pleaded guilty to charges that he organized a $13 million fraud and money laundering scheme between 2008 and 2011. He was accused of referral kickbacks to patient recruiters, forging beneficiary signatures on care records for services never provided, paying non-licensed individuals who represented themselves to beneficiaries as physicians, and paying various medical professionals to create fictitious patient files.
### June 13, 2012; U.S. Department of Justice

- **Co-Owner of Houston-Area Home Health Care Agency Sentenced To 108 Months in Prison for Role in $5.2 Million Medicare Fraud**
  - The individual pleaded guilty to one count of conspiracy to commit health care fraud, one count of conspiracy to pay illegal kickbacks to patient recruiters, and 16 counts of paying illegal kickbacks. The care provided was alleged to be unnecessary, patients were not homebound, and care records were falsified to support Medicare claims.

### June 15, 2012; U.S. Attorney; Central District of California

- **Rancho Palos Verdes Doctor Agrees to Pay $530,000 to Settle Civil Lawsuit Alleging Home Health Kickback**
  - Doctor and his spouse were alleged to have accepted cash payments and patient referrals in exchange for referring patients to a Medicare-participating home health agency. The lawsuit began as a qui tam action initiated by the receptionist at the home health agency. There were guilty pleas in parallel criminal cases against the home health agency owner and others where charges included the provision of unnecessary care and billing for services not provided.
June 19, 2012; U.S. Department of Justice

- Owner and Employee of Miami Home Health Company Sentenced to Prison in $22 Million Medicare Fraud Scheme
- The owner was sentenced to 108 months in prison and the employee was sentenced to 47 months. Restitution of $14 million and $2 million respectively was also ordered. The individuals had been charged with conspiring with patient recruiters for purposes of billing Medicare for unnecessary care. Bribes and kickbacks were paid to recruiters to falsify prescriptions for care, plans of treatment, and medical certifications.

June 27, 2012; U.S. Attorney; Northern District of Illinois

- Owners of Two Chicago Home Health Care Agencies and Three Doctors among 10 Charged In Alleged Medicare Kickback Schemes
- The charges involve alleged kickbacks to physicians and others for patient referrals. Three physicians allegedly received kickbacks of $324,000, $77,000, and $28,500 beginning in 2006. Three social workers and a nurse were also charged with receiving kickbacks ranging from $1800 to $13,050.
July 11, 2012; U.S. Attorney; Eastern District of Michigan

- **Two Charged for Medicare Fraud Schemes in Detroit Involving $8.8 Million in False Billings**
- The prosecution charges that the two individuals separately engaged in false billings for unnecessary services or not provided along with kickbacks to referral sources.

July 19, 2012; U.S. Department of Justice

- **Michigan Man Pleads Guilty in Connection with Detroit-Area Medicare Fraud Scheme**
- A $13.8 million fraud scheme included a forged physical therapy assistant degree, falsified medical documentation, and kickbacks to Medicare beneficiaries. The man created patient evaluations, therapy visit notes, and other documentation for patients he did not see or treat.
August 2, 2012; U.S. Department of Justice

- Detroit-Area Adult Day Care Center Owner Pleads Guilty to $10 Million Psychotherapy Fraud Scheme
  - The individual conspired with patient recruiters for purposes of billing Medicare for unnecessary care. Kickbacks and bribes were paid to physicians and patient recruiters in exchange for home health and therapy prescriptions. Patient records were falsified. Medicare was billed $42 million in false claims and paid $27 million. As part of the plea agreement, the individual forfeited to residences and the cash proceeds in several bank accounts.

August 13, 2012; U.S. Attorney; Northern District of Illinois

- 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
  - The individuals are charged with tendering and soliciting kickbacks for patient referrals. The owners of the home health agency allegedly paid cash to outside marketers to secure patient referrals. In some instances, the owners allegedly wrote checks to them, cashed the checks, and used the cash to pay the recruiters.
August 14, 2012; U.S. Department of Justice

- **Owner of Miami Home Health Company Pleads Guilty in $60 Million Health Care Fraud Scheme**
- The owner of a “staffing agency” was paid kickbacks by a Medicare-participating home health agency for referring patients that were billed to Medicare for services purportedly provided by the staffing company. The Medicare agency owners were sentenced to 120, 87, and 87 months in prison in a related case alleging $40 million in false Medicare billings.

**OTHER ENFORCEMENT ACTIVITY**

- Now, the “waste and abuse” otherwise fitting under the categories of noncompliance and errors or omissions
Claims

• MAC, RAC, ZPIC
• MAC
  – Pre-payment review for new providers
  – Pre-payment edits
  – Target providers
    • High volume services
    • High cost
    • RAC, OIG, CERT, GAO identify vulnerability

Claims

• Data analysis to target providers
  - Claims
    – Aberrant patterns outside the norm
      • Statistical deviation
      • Percent increase billing, payment, number visits/services
    – High utilization services/items
    – High cost services/items
Medicare Home Health 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

F2F Oversight

- Face-to-Face physician encounter rule: 42 CFR 424.22
- Enforcement is underway
  - Inconsistent standards with Medicare contractors
    • One MAC denies if one physician does F2F and another signs POC
  - Failure to sign
  - Documentation misses the narrative requirement
  - Narrative insufficient
Therapy Assessments

- 42 CFR 409.44
- 13th and 19th Visit
- Multi-discipline cases allow flexibility
- Miss-timed assessments leaves visits uncounted, e.g. assessment on 14th visit discounts the 14th visit

ZPIC Activity

- Investigations 2007 re: high therapy utilization and outliers
- 2010-11 Broad document request
  - All business agreements
  - Current and past employees, agency works for, schedule
  - List all practice locations
  - List all diagnostic equipment at all locations
  - 1099 for owners, management, directors, Medical Directors
  - Compliance Program Audit Results
  - Some also paired with request for medical records
- Some ZPICs have begun pre-payment HH reviews
RAC Reviews

- Automated without medical records
  - Clear policy always OP
  - Medically unbelievable service
- Complex with medical records
- Limit 3 year look-back; no earlier than 10/1/07
- **RAC just approved to review HH claims for compliance**

OIG Oversight Activity

- **OIG 2012 Workplan (Home Care)**
  - States’ Survey and Certification
  - Medicare’s oversight of OASIS data
  - Missing or Incorrect OASIS data
  - Questionable billing characteristics of Home Health Services
  - HH compliance with coverage and coding requirements
  - Medicare contractor oversight of HH
  - HH wage index
  - HHPPS compliance
  - HH trends in revenue and expenses
  - 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 AUDIT • 05-15-2012

Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Healthcare (A-06-09-00063)

• For the period October 1, 2006, through September 30, 2008, we estimated that New Mexico paid Heritage Home Healthcare (Heritage) approximately $4.5 million for personal care services claims that did not always comply with certain Federal and State requirements. Of the 100 claims in our random sample, 36 did not comply with these requirements. The deficiencies included insufficient attendant training, missing prior approval for services, and unsupported units of service claimed.

• We recommended that the State (1) refund to the Federal Government the $4.5 million paid to Heritage for unallowable personal care services and (2) ensure that personal care services providers maintain evidence that they comply with Federal and State requirements. Heritage disagreed with almost all of our findings, and the State disagreed with our recommended refund amount paid to Heritage for improper claims submitted for the audit period.”

OIG AUDIT • 04-20-2012 T

Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services - Manhattan LTHHCP Audit (A-02-10-01002)

• The Department of Health (State agency) did not claim Federal Medicaid reimbursement for some home health services claims submitted by Jewish Home and Hospital Lifecare Community Services - Manhattan LTHHCP (Jewish Home) in accordance with Federal and State requirements. Based on our sample results, we estimate that the State agency improperly claimed $8.2 million in Federal Medicaid reimbursement during our January 1, 2006, through June 30, 2009, audit period.

• Of the 100 claims in our random sample, 61 claims complied with Federal and State requirements, but 39 claims did not. Of the 39 claims, 2 contained more than 1 deficiency. Specifically, for 39 claims, the care plan was not reviewed; for 1 claim, there was no documentation that the service was provided; and for 1 claim, the home health aide did not receive basic training.
OIG AUDIT • 04-16-2012

• St. Luke's Episcopal Church Home Care Program-Juana Diaz Properly Claimed Medicare Reimbursement for Home Health Services (A-02-11-01009)

• “We determined that St. Luke's Episcopal Church Home Care Program-Juana Diaz claimed Medicare reimbursement for home health services during the period January 1, 2009, through June 30, 2010, in accordance with Federal requirements. As a result, we made no recommendations.”

OIG AUDIT • 03-12-12

• Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health (A-06-09-00062)

• “For the period October 1, 2006, through September 30, 2008, we estimated that New Mexico paid Ambercare Home Health (Ambercare) approximately $889,000 (Federal share) for personal care services claims that did not always comply with certain Federal and State requirements. Of the 100 claims in our random sample, 23 did not comply with these requirements. The deficiencies included lapses with attendant training, number of units claimed for attendant services, and prior approval fWe recommended that the State agency (1) refund to the Federal Government the $889,000 paid to Ambercare for unallowable personal care services and (2) ensure that personal care services providers maintain evidence that they comply with Federal and State requirements. Ambercare disagreed with our findings on billing records. The State agency generally agreed with our findings but disagreed with our recommended refund amount paid to Ambercare for improper claims submitted for the audit period.”

• or personal care services provided by a legal guardian.
OIG STUDIES • 08-02-12

• Inappropriate and Questionable Billing by Medicare Home Health Agencies (OEI-04-11-00240)

• FINDINGS

• “In 2010, Medicare inappropriately paid $5 million for home health claims with three specific errors

• CMS has claims processing edits in place to prevent payment for home health claims with services that inappropriately overlap with claims for inpatient hospital stays or skilled nursing facility stays or that are billed for services on dates after beneficiaries’ deaths. However, Medicare inappropriately paid $5 million (out of $19.5 billion total for home health services) in 2010 for home health claims that had at least one of these three errors. The $5 million figure is based solely on our analysis of claims data for these three specific errors. It does not include any additional inappropriate payments that a medical record review

OIG STUDIES • 08-02-12

• Approximately one in every four HHAs had questionable billing

• In 2010, 25 percent (2,594 of 10,341) of HHAs exceeded the threshold that indicated unusually high billing for at least 1 of our 6 measures of questionable billing.

• More than one-third (36 percent) of the HHAs with questionable billing exceeded the thresholds for multiple measures of questionable billing. Specifically, 925 HHAs exceeded the thresholds for 2 or more measures, and 6 HHAs exceeded the thresholds for 5 measures.”

• Overall, HHAs with questionable billing were located mostly in Texas, Florida, California, and Michigan.
OIG STUDIES • 03-12-12

- Documentation of Coverage Requirements for Medicare Home Health Claims (OEI-01-08-00390)
- The OIG “medical record review showed that in 2008, 98 percent of beneficiaries met the homebound requirement and needed skilled nursing care or therapy services and that beneficiaries were under the care of a physician. HHAs submitted 22 percent of claims in error because services were not medically necessary or claims were coded inaccurately, resulting in $432 million in improper Medicare payments. Also, HHAs upcoded (i.e., billed at a level higher than warranted) about 10 percent ($278 million) of claims and downcoded (i.e., billed at a level lower than warranted) about 10 percent ($184 million) of claims.”

States’ Survey and Certification of Home Health Agencies: Timeliness, Outcomes, Follow-up, and Medicare Oversight.

- 2012 OIG Work Plan. As part of its 2012 Work Plan, the OIG will:
  - review the timeliness of home health agency standard and complaint surveys conducted by State Survey Agencies and Accreditation Organizations, the outcomes of those surveys, and the nature and follow-up of complaints against HHAs;
  - look at CMS oversight activities designed to monitor the timeliness and effectiveness of HHA surveys.
Medicare’s Oversight of Home Health Agencies’ Patient Outcome and Assessment Data

• **2012 OIG Work Plan.** As part of its 2012 Work Plan, the OIG will review CMS’s oversight of Outcome and Assessment Information Set (OASIS) data submitted by -certified HHAs, including CMS’s process for ensuring that HHAs submit accurate and complete OASIS data.

Missing or Incorrect Patient Outcome and Assessment Data.

• **2012 OIG Work Plan.** As part of its 2012 Work Plan, the OIG will:
  – review HHA OASIS data to identify payments for episodes for which OASIS data were not submitted or for which the billing code on the claim is inconsistent with OASIS data.
Questionable Billing Characteristics of Home Health Services.

- **2012 OIG Work Plan.** As part of its 2012 Work Plan, the OIG will:
  - review claims to identify HHAs that exhibited questionable billing. “Questionable billing” refers to claims that exhibit certain characteristics that may indicate potential fraud; and
  - identify and review HHAs that had a high percentage of claims that meet at least one of the questionable billing characteristics.

Home Health Agency Claims’ Compliance With Coverage and Coding Requirements

- **2012 OIG Work Plan.** As part of its 2012 Work Plan, the OIG will:
  - review Medicare claims submitted by HHAs to determine the extent to which the claims meet Medicare coverage requirements; and
  - assess the accuracy of resource group codes submitted for Medicare home health claims and identify characteristics of miscoding.
Medicare Administrative Contractors’ Oversight of Home Health Agency Claims.

- **2012 OIG Work Plan.** As part of its 2012 Work Plan, the OIG will:
  - review fraud and abuse prevention and services performed by the home health benefit MACs; and
  - review the reduction of payment errors by MACs.

Home Health Prospective Payment System Requirements

- **2012 OIG Work Plan.** As part of its 2012 Work Plan, the OIG will review compliance with various aspects of the home health PPS, including the documentation required in support of the claims paid by Medicare.
Medicaid Home Health Services: Screenings of Health Care Workers

• **2012 OIG Work Plan.** The OIG will review health-screening records of Medicaid home health workers to determine if the workers received compliant screenings.

Medicaid Home Health Services: Agency Claims

• **2012 OIG Work Plan.** The OIG will review home health agency claims to determine whether providers have met all criteria for payment.
Medicaid Home Health Services: Homebound Requirement

• **2012 OIG Workplan.** The OIG will review CMS policies and practices for reviewing Medicaid State Plans related to eligibility for home health services and describe how CMS intends to enforce compliance with appropriate eligibility requirements.

Home and Community Based Services: Federal and State Oversight of Quality of Care

• **2012 OIG Workplan.** The OIG will review CMS and State oversight of HCBS waiver services to ensure quality of care.
Medicaid Personal Care Services

- **2012 OIG Workplan.** The OIG will review Medicaid payments for PCS to determine whether States have properly claimed the Federal Financial Participation.

Medicaid Home Care Risk Areas

- New compliance efforts in Medicaid home care nationwide likely related to growth in spending
- 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
Medicaid Personal Care

• OIG audit focus
  – North Carolina,
    • Missing documentation
    • Services not in accordance with plan of care
    • No supervisory nursing visits
    • No verification caregiver qualifications
    • No physician order

– Washington State,
  • No timesheets supporting daily service
  • Billed more hours than on timesheets
  • Training deficiencies
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
  - No medical professional exam of beneficiary before service
  - No nursing assessment
  - No nursing supervision
  - No physician's order
  - Same as above for NYC and
    - No in-service training for aide
    - Time with patient not documented

Medicaid Personal Care

- Iowa State Audit
  - CDAC services-$200,000 overpayment
  - Provider took over care for hospital that stopped furnishing CDAC services
  - Technical documentation denials
    - Client name
    - Caregiver name
    - Time/date/year
    - CDAC Agreement not in file
    - Additional services furnished (billed by time)
  - Sampling and extrapolation
Provider Enrollment Compliance

- Program Integrity Focus
  - Report changes of information timely (HHA and hospice)
    - Changes of ownership or control: 30 days
    - Changes of information: 90 days
    - Revocation of Medicare billing privileges for failure to report address change after CHOW filed, Health Connect at Home, CR2371 (ALJ, May 18, 2011) [http://www.hhs.gov/dab/decisions/civildecisions/cr2371.pdf](http://www.hhs.gov/dab/decisions/civildecisions/cr2371.pdf)
  - Can’t buy HHA and “move” it across state as part of CHOW Caretenders Visiting Services of Columbus, LLC, (ALJ, Jan. 19, 2011) [http://www.hhs.gov/dab/decisions/civildecisions/cr2311.pdf](http://www.hhs.gov/dab/decisions/civildecisions/cr2311.pdf)

Referral Sources

- Stark law
  - Medical Directors
    - How many do you have?
    - What are you paying each of them to do?
    - Payment rate?
    - Employee or contractor?
  - Technical compliance includes
    - Written agreement
    - FMV
    - Records of time and work performed
OIG Advisory Opinion 11-06

- Use of Electronic Referral Systems
  - E-referral system may violate antikickback law where hospital gives paying e-referral entities first opportunity to acquire “first come, first chosen” referrals
    - Non participants get later notices of potential referral than e-referral participants

- NAHC investigation concludes that current e-referral systems are wholly unlike system reviewed by OIG
  - Systems may be abused by referral sources

OIG ADVISORY OPINIONS

- Fall monitors for HH patients- OK since Congressional intent to support telehealth in HHPPS
OIG Activity

- Free gifts to beneficiaries
  - OIG Advisory Opinions
    - Pre-op visits, OIG Advisory Opinion No. 06-01 – No
    - Pre-op videos, OIG Advisory Opinion No. 07-16 – Yes
  - Why were the pre-op videos acceptable to the OIG?
    - No clinical personnel
    - Information available for free on Internet
    - Patient not view as valuable service resulting in better surgical outcome
    - No pre-op initiation patient-therapist relationship causing patient to choose agency

Hospice Claims: Target Areas

- Hospice election
  - Benefit waiver
  - Timeliness in relation to Start of Care
  - Competency/Surrogate Authority
- Terminal illness
  - Clinical support
  - Compliant process, i.e. attending physician/medical director certification
- Level of care
  - Focus on increases of continuous care days and appropriateness of inpatient days
- Unbundling of services/non-terminal illness related care
- Face-to-Face Encounter
  - Timing and documentation
HOSPICE ELECTION

• Issues
  – Completed prior to the start of hospice care
  – Compliant waiver of benefits notice
  – Evidence of individual’s competency
  – Documentation of surrogate’s authority
    • Health Power of Attorney (state law compliant)
    • Where no POA, state law standards met

TERMAL ILLNESS

• Compliance with hospice LCDs
• Supporting documentation
• Non-cancer diagnoses get extra attention
• Technical compliance crucial in terms of proper physicians involved, consistency with interdisciplinary team findings, timing, and signing/dating
Level of Care

- Inpatient care
  - Audits focus on nursing facility patients
  - Unstated suspicion of some hospices providing inpatient days to the max to maximize revenue share between NF and hospice
  - As always, it is documentation that makes or breaks it

- Continuous care
  - Audits focus on nursing facility patients
  - Gaming is suspected
  - Need to show skilled care needs with precise documentation

F2F Oversight

- Face-to-Face physician encounter: 42 CFR 418.22

- Enforcement is underway (still very limited)
  - Failure to sign F2F certification
  - Narrative absent
  - Narrative insufficient
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](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

OIG Activity/Studies

- Hospice patients in nursing facilities
  - These reports have created an environment of suspicion around hospice care in nursing facilities
- New study on hospice marketing practices with NFs
OIG ACTIVITY/Studies

  - 31% fewer services than on Plan of Care
  - 31% of hospice beneficiaries reside in nursing facilities
  - $2.59B in 2006
  - 91% routine care days
  - 4.2 visits per week of nursing, aide, and medical social services
  - Aide services higher for for-profit hospices
  - Volunteer services lower for for-profit hospices

OIG Activity/Studies

- Respite care
  - Limited use of respite care
  - Some patients received care in excess of the 5 day limitation
  - Some nursing facility inpatients received respite care
- General Inpatient Care
- 2012 OIG study underway
- Appropriateness of claims
- Concurrent Part D drugs
OIG Activity/Fraud Alert

F Hospice and nursing homes (1998)


– Excessive room and board payments
– Payment for add-ons
– Cross referrals
– Subcontracting nursing pre hospice
– Performance of facility duties

OIG Activity/Advisory Opinions

– Services are furnished by volunteers and are primarily intangible or psychic (free pre-hospice services)

– Donations from health system foundation

– Payments from hospice to nursing facility for added cost of drugs to dual-eligible patient
Investigation by DOJ

- Terminal illness certification
- Up-coding the care category (routine vs. continuous vs. inpatient)
- Can this be criminal conduct or fraud???

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

- 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

• 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
  – $5000k settlement
  – OIG corporate integrity agreement
RECENT PROSECUTIONS

• Oregon hospice
  – Self disclosure of noncompliance
  – Failure to secure proper written certification of terminal illness prior to billing
  – $1,830,322 repayment

RECENT PROSECUTIONS

• Alabama hospice
  – Multi-state company operation
  – Whistleblower lawsuit (2)
  – Allegation of admitting ineligible patients
  – $24.7 M settlement
  – OIG Corporate Integrity Agreement
    • 5 years
    • Sampling of claims for eligibility
    • Marketing activities subject to review
RECENT PROSECUTIONS

• Delaware hospice
  – Employee indicted for mail fraud
  – Allegation that employee ordered large amounts of electronics for the hospice, but removed equipment and used it for his own personal gain
  – $200k worth of equipment

NAHC Program Integrity Proposals

• Implement a targeted, temporary moratorium on new home health agencies
• Require credentialing of home health agency executives
• Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care
• Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan
• Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment, prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors
Program Integrity Proposals

• Establish targeted systemic payment safeguards focused on abusive utilization of home health services
• Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries
• Require criminal background checks on home health agency owners, significant financial investors, and management
• Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight
• Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of program standards

CONCLUSION

• There is true fraud
• Noncompliance exists
• Errors are easy to make given the complexities of Medicare and Medicaid
• Industry image is made of fraud, errors, and negligent noncompliance
• Criminals require different measures than
• Time to redouble compliance efforts