COMPLIANCE: FOCUS ON HOME CARE & HOSPICE

- Growth in oversight activities in home care and hospice
  - Medicare and Medicaid
  - High level fraud/False Claims Act investigations
    - Referrals
    - Wholesale unnecessary care
    - Failure to provide any service
  - Day-to-day compliance oversight
    - Claims
    - Coverage
    - Quality of care
- Multiple oversight bodies
  - Medicare/Medicaid contractors (MAC, RAC, SMRC, ZPIC)
  - Managed Care Organizations
  - OIG
  - FBI, DOJ, Etc.
  - Whistleblowers
PROGRAM FOCUS

- Environmental scan of the nature and extent of oversight
  - Fraud prosecutions
  - Systemic oversight targets
  - Patient referral limitations
  - Claims compliance issues
    - Technical requirements
    - Coverage standards
    - Documentation
    - Quality of care compliance
    - Conditions of Participation/licensure
    - Provider enrollment
- Structural Risk management strategies
- Ethics and Compliance

Recent Prosecutions

- Owner and employee of Miami Home Health company sentenced to prison in $22 million Medicare fraud scheme
- Owners of two Chicago Home Health Care Agencies and three doctors among 10 charged in alleged Medicare kickback schemes
- Two charged for Medicare fraud schemes in Detroit involving $8.8 million in false billings
- Arkansas hospice whistleblower lawsuit with allegation of billing for inpatient care at nursing facilities where only routine care provided and $1.4M overpayment

- Common factors
  - Billing for services not rendered or not necessary
  - Payments to beneficiaries and physicians
  - Patient recruiters used to bribe beneficiaries
Laws that Impact on These Issues

- Coverage / COP / Licensure / Provider Enrollment / HIPAA
- Patient Freedom of Choice, SSA §1802
- Stark II, Phase III, SSA §1877
- Anti-kickback laws, SSA §1128B
- Civil Monetary Penalties, SSA §1128(a)(5)
- False Claims Act, 31 U.S.C. §3730
  - Includes failure to report and refund known overpayments
- State and Federal fraud laws
- Various state referral laws

Home Care Compliance vs. Fraud

- Fraud = Jail, Fines, and Repayments
- Noncompliance = Administrative headaches and Refunding Overpayments

Compliance Areas
- Claims and Conditions for Payment
- Quality of care (CoPs)
- Provider enrollment
Referral Risk Areas: Home Care and Hospice issues

- Hospital discharge planning: patient freedom of choice
- Paid Medical Directors
- Staff compensation for referrals
- Quid pro quo (cross referrals)
- Beneficiary inducements
- ALF service relationships
- Hospice/Nursing facility deals

Referrals: C-Level Screening

- Where are the referrals coming from?
- Has there been any change in referral patterns?
- Is there any financial relationship with any referral source?
- Does the staff compensation method create any risk?
- Do third parties contribute to referrals?
- Do staff have any family or personal relationship with referral sources?
CLAIMS RISK AREAS

- UTILIZATION LEVELS
- AUTHORIZATION OF CARE
- COMPLIANCE/CONSISTENCY WITH APPROVED PLAN OF TREATMENT
- DOCUMENTATION
- TECHNICAL REQUIREMENTS FOR PAYMENT

CLAIMS COMPLIANCE: Oversight Methods

- MACs, ZPICs, SMRC, RACs, States looking
- Hospice and home care targeted
- Audits are data driven based on benchmark aberrancies
- Automated and complex claims reviews
- Technical compliance the first target
- Coverage standards the second stop
- Extrapolation through sampling audits
CLAIMS RISKS: Medicaid

- Personal care services
  - Staff credentials
- Dual-eligibles (Medicare maximization)
- Private duty nursing: pediatric and adults
  - Frequency and duration

Medicaid Hospice Claims 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
- OIG found that Massachusetts Medicaid did not reduce hospice payments to reflect “spend down” patients’ contribution obligation
Medicare Hospice Claims Risk Areas

- Technical compliance
  - Election
  - Attending physician
- Related to terminal illness
  - drugs
- Hospice face-to-face rule
- Terminal illness documentation
- Hospice and the nursing facility resident
- Continuous care
- Inpatient days

Medicare Home Health Oversight Claims Target Areas

- Technical compliance
  - Signed and dated orders
- 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
Claims: C-LEVEL SCREENING

- Has there been any change in utilization patterns, e.g. length of stay?
- What does the claims data tell you about changes in HHRGs, therapy utilization, LUPA volume, outliers volume?
- How is “relatedness” to the hospice terminal diagnosis determined?
- Can you account for the actual hours worked by personal care staff?
- Is your number 2 pencil sharpened and ready for perfection on the technical requirements?
- Are your internal claims compliance systems right for the today risks?
- Is claims documentation consistently done?
- Did you forget about MA Plans?
- Have you checked the exclusions list lately?

Quality of Care/Provider Enrollment

- Increased survey frequency emerging
- Immediate jeopardy citations
- Terminations on the rise
- Alternative sanctions imposed in Medicare home health
- Provider enrollment technical perfection
MEDICARE HOME HEALTH: Alternative Sanctions

- Applies to condition level deficiencies
- Sanctions include:
  - Directed corrective action
  - Temporary management
  - Payment suspension
  - Civil monetary penalties
    - $500-$10,000
    - Per diem/per instance
  - Termination
- Informal dispute resolution possible
- CMPs and payment suspension no earlier than 7/1/14,
- Appeal rights w/o penalty suspension

Informal Dispute Resolution: 488.745

- Informal opportunity to resolve disputes
- Available with condition-level deficiencies only
- CMS/state will provide written notification of deficiencies and IDR opportunity
- HHA must request IDR in writing
  - Specify disputed deficiencies
  - w/in 10 days of notice
- IDR does not delay enforcement process
  - CMS to develop timeframes for action
- Left to State/CMS to design IDR
- Effective 7/1/14
Medicare Provider Enrollment

- Ongoing validation reviews
- Change in Information reporting
- Disenrollment and reactivation
- 42 CFR 424.500 et seq.

Risks of Non-Compliance in Provider Enrollment

- Denial of enrollment, 42 C.F.R. §424.530(a)(5)
- Revocation of billing privileges, 42 C.F.R. §424.535(a)(5)
- State enforcement for licensing non-compliance
- Section 14 of 855A Penalties for Falsifying Information
  - Criminal penalties: 4 statutes – fines, jail, 2X unjust gain
  - Civil penalties: 2 statutes – CMP, 3X damages
  - Common law: damages, restitution, recovery unjust profit
Quality and Enrollment: C-Level Screenings

- Are you ready for an unannounced survey today?
- What systems of accountability are in place?
- Is every care plan met?
- What will your patients say about your care?
- How do you respond to patient grievances?
- Are you confident the staff knows when to call the doctor?
- Are all personnel files complete and up to date?

RESET:
A Brief History of Fraud, Abuse and Waste

- Operations Restore Trust (ORT) Pilot 1995
  - Successful recoveries in 5 states
    - 42.3 million
  - 35 Criminal convictions & 18 Civil settlements
  - Recovery from Health Care Fraud and Abuse Program (HIPAA 1996)---
- Fiscal year 2014:
  - HHS/DOJ Annual Report (03/2015) over 3.3 Billion recovered
  - 734 defendants convicted
  - 957 civil matters pending at the end of FY
WHY???

- Why is the Government on watch for fraud, abuse and waste in health care
  - Medicare spends billion of dollars each year on Medicare and Medicaid healthcare services
  - The Government has confirmed many reports of fraud, abuse and waste in provider practices/businesses resulting in settlements for billions of dollars every year...
  - Roadmaps: OIG reports & Work Plans, fraud alert, corporate integrity agreement (CIAs)
  - New regulations dictate new compliance practices
  - See government enforcement actions (Department of Justice)

Why a COMPLIANCE & ETHICS Program?

- Patient Protection & Affordable Care Act (PPACA) also known as ACA 2010
  - Requires all certified Medicare providers ... establish a compliance program that contains.... (Section 6401 (a) (7))
  - Mitigate Risk; CIA negotiations
  - History of OIG voluntary guidance
    - Supplemental 70 Fed. Reg. 4858; January 31, 2005
    - Hospice: 64 Fed. Reg.54031; October 5,1999
  - Clinical lab; ambulance, physician practices; other...
Risk Management:
Elements of an Ethics & Compliance Plan

1. Provider standards/code of conduct and written policies and procedures on risk areas that may subject provider to fraud, waste and abuse (distinguish risk areas for home health vs. hospice)
   - Anti-kickback, billing, claims processing, documentation, face-to-face, certifications, re-certifications, home health OASIS coding, hospice relationships with nursing facilities, new ICD-10 coding requirements for hospice 10/2014 and many others.

2. Effective Oversight by provider compliance office
   - Establish a Board Resolution
   - Appoint Company Compliance Officer
   - Establish effective Compliance Committee and meet regularly
   - Compliance Officer should report to CEO or other high level management
   - Compliance Officer should report to Board on regular basis.
Elements: Ethics & Compliance Plan

3. Effective communications for reporting suspected allegations of violations
   • Establish company hotline for optional anonymous reporting
     • Other methods of reporting: email, mail

4. Effective training and education throughout the provider organization on hire and annually
   • Specialized training for high risk areas
     • Hospice high risk areas
     • Home health high risk areas

Elements: Ethics & Compliance Plan

5. Monitoring and Auditing Activities to include internal and external monitoring activities.
   • Conduct systematic self audits of clinical documentation, pre-bill reviews
   • Review contracts
   • Review OIG work plans, fraud alerts,
   • Analyze CIAs to determine provider audit plan focus

6. Enforcement through disciplinary action

7. Effective policies that ensure prompt investigations, reporting and corrective actions; Annual assessment of plan.
No Compliance Program?  
Do not despair!

- Take inventory of compliance measures you already have in place.

Assess Agency Compliance Measures

- Assess agency programs/processes already in place:
  - Clinical policies and procedures
    - Written manuals or computer accessible?
    - Current and up-to-date?
    - Accessible to all clinical staff?
    - Reviewed/revised annually?
  - Billing and Claims submission policies/processes
    - Written manuals or computer accessible
    - Pre-billing checks
    - Special training and education for billing personnel: on-hire and annually?
Assess Ethics & Compliance Measures

- Effective Quality Assessment and Performance Improvement (QAPI) Committee?
  - Dashboard? Agency management team put together for what your agency wants to measure.
  - Analysis of data? Action plans? Ongoing auditing and monitoring?
- Electronic Medical Records
  - Compliance measures in place to capture regulatory requirements?
    Clinical people working w/vendor?
- Human Resource Function
  - Written progressive disciplinary procedures all levels management?
- Bioethics/ethics committee? Compliance Committee

Ethics vs. The Law: Ethics Defined

- The word ethics comes from the Greek word ethos which means “custom” or “character”
- Principle of “right” or “wrong” conduct
- A set of rules or conduct governing a profession or business: **ABA Model Rules of Professional Conduct for lawyers; ANA Code of Ethics for Nurses; AMA; CPAs, Corporate Standards or Code of Conduct; Other**
- Set of social or religious norms and a way of life
Who Decides?

- Ethical principles or judgments are closely related to moral judgments or principles
- Based on values of individual, community, company or society
- Values may vary in individuals... cultures....communities...countries

Laws are often based on a group of people's ethical values

Values Defined

- A principle, quality or standard considered desirable and important
- Many types of values:
  - Social: i.e. social programs, security...
  - Religious: charity, sanctity of life...
  - Legal: order, justice, equality, freedom
  - Economic: frugality, financial security...
  - Cultural: sanctity of land, caring for elderly
  - Environmental: clean air, carpooling, other
VALUES … continued

- Corporation/Agency/Providers: quality, leadership, teamwork
- Self Determination: autonomy, respect, responsibility, right to consent/refuse medical/health care
- Aid-in-Dying, Other...

HEALTHCARE ETHICAL PRINCIPLES

- Principles in Healthcare delivery
  - Respect for Autonomy
  - Non-maleficence: do no harm
  - Beneficence: do good, duty to help
  - Distribution of Justice
Corporate/Business Ethics

- Compliance Programs require a healthcare entity to have a written Code of Conduct (Standards of Ethics)
- What does this mean:
  - It is about “doing the right” and knowing the right thing to do… and doing it....
  - Avoid appearances of impropriety
  - Disclose conflicts of interest
  - Maintain company proprietary information
  - Maintain patient/customer/client confidentiality
  - Crediting balances/claims adjustments for overpayments
  - Maintaining licenses/certification
  - Patient /Client rights/respect
  - Do no harm/guarding against patient abuse and neglect
  - Appropriate referrals

Ethical versus legal

- Difficult issues:
  - What is ethical may be illegal
  - What is legal may be unethical
- Less complicated issues:
  - Legal and ethical
  - Illegal and unethical
- Examples in our society...
Does doing the right thing...???

... mean more regulation? Why? Why not?

- Who is subject to more regulations?
  - Medicare certified providers & State Medicaid Programs
- What government oversight and enforcement?
  - CMS COPs, OIG compliance mandates & monitoring; investigations & enforcement actions; MACs, RACs, ZPICs, state laws & Medicaid fraud units (AG offices); DOJ
- Where is the effect being seen?
  - All regions across the United States
- When is this happening?
  - Now—past, present & future

Educate the Health Care Governing Board

- Private or Public: The government is looking to provider governing Boards for effective oversight of healthcare providers ---and to monitor company quality and compliance:
  - See “Practical Guidance for Health Care Governing Boards on Compliance Oversight” —attached to materials
  - See also: “A toolkit for Health Care Board:
  - See also www.oig/hhs/gov for additional resources and guidance for compliance related issues
Assess, Audit, Measure & Monitor...and Do It Again

- **DO THIS**  **TO AVOID**  **THIS**