HCCA
hcca-info.org

Compliance TODAY

A PUBLICATION OF THE HEALTH CARE COMPLIANCE ASSOCIATION

JUNE 2018

Healthcare fraud enforcement in federal programs

an interview with
Amy Berne

> I believe you will continue to see nursing home cases and kickback cases a priority, but the Office is also focusing on providers who prescribe and pharmacies that distribute opioids...

See page 18

ARTICLES

50 **Improving outcomes of Compliance Program Effectiveness audits**
by Tonya Teschendorf
The Top 5 issues that Part C and Part D Plan sponsors must know to prevent audit deficiencies and have a successful outcome for one of the most rigorous audits that CMS conducts.

56 **Federal guidance for hospice providers: A year in review**
by Bill Musick
Key takeaways for hospice organizations gleaned from the OIG Work Plan, DOJ settlements for fraud and abuse, corporate integrity agreements, PEPPER, and other reports.

60 [CEU] **Compliance with attestation requirements: Tips for FDR**
by Bethany A. Corbin
Nine action tips that Medicare and Part D Plan sponsors can use to improve oversight of their first-tier, downstream, and related entities.

67 **Healthcare system "rulebook"**
by Miriam R. Miller
Much like the rules for the game of SCRABBLE®, healthcare systems must establish a set of policies and procedures to cover the questions and day-to-day issues that arise.

70 **Compliance risk and the legalization of marijuana**
by Dan Coney
Although some states have legalized the medical and/or recreational use of the drug, the federal regulations are still enforced and pose a compliance risk for healthcare providers.

73 [CEU] **The ethics of taking and giving gifts**
by Paul P. Jesep
Your gifts and entertainment policy should go above and beyond what the law requires to avoid conflicts of interest and possible scandal.

Compliance TODAY

Compliance Today (CT) (ISSN 1523-8466) is published by the Health Care Compliance Association (HCCA), 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. Subscription rate is $295 a year for nonmembers. Periodicals postage-paid at Minneapolis, MN 55435. Postmaster: Send address changes to Compliance Today, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435.

VOLUME 20, ISSUE 6

by Bill Musick, BS, MBA, CHC, CHCP

Federal guidance for hospice providers: A year in review

» Hospices must keep abreast of activity by multiple federal agencies.
» Drop the notion that there's such thing as an "acceptable" error rate.
» Hospices should examine the relationship between the compliance officer and the board.
» Risk areas include clinical documentation, physician arrangements, and employee oversight.
» Communication with contracted organizations is increasingly important.

Bill Musick *(bmusick@integriti3d.com) is Principal of Integriti3D in Lafayette, CA.*

Forewarned is forearmed. Federal agencies share a number of reports and information that allow hospices to better understand trends in compliance activity and to anticipate future areas of focus. In a recent webinar for HCCA, I reviewed the guidance and activities from federal agencies during 2017 that might be of interest to home health and hospice providers.[1] In this article, I plan to summarize the key takeaways for hospice organizations without going through the sordid details of individual fraud and abuse cases, CIAs, and all the applicable OIG Work Plan items.

Musick

Regulatory resources

Historically, hospices might await the annual release of the HHS OIG Work Plan to ascertain new areas of focus and anticipate future regulatory or investigative actions. In 2017, the OIG replaced its annual report with a website[2] that has three sections: Recently Added, Active Work Plans Items, and Archived Items, and these are updated on a monthly basis. So, hospices now have 12 times a year to check on OIG Work Plan changes. But the Work Plan itself is only one of many sources of guidance and activity that help hospices discern the future of government compliance efforts. The OIG also publishes regularly scheduled reports as well as ad hoc reports on topics of interest.

The OIG issues a strategic plan every five years (the current plan covers 2014 to 2018),[3] an annual Compendium of Unimplemented Recommendations (Compendium),[4] and semi-annual Reports to Congress.[5] The OIG also publishes annual reports on the top management challenges facing HHS[6] and Medicaid Fraud Units.[7] Each of these helps to show the evolution of the OIG's focus over time. For example, the Compendium has carried an item on "Implementing a Hospital Transfer Payment Policy for Early Discharge to Hospice" since 2013. In the 2018 Bipartisan Budget Act, signed into law in February, that policy will become effective for hospice beginning in FY 2019.

The OIG also issues topical reports on an ad hoc basis, usually related to completed items from the annual Work Plan.

The OIG also provides access to corporate integrity agreements (CIAs),[8] which have been negotiated with agencies that have made compliance settlements. The requirements imposed by a CIA are often viewed as indicators of practices that, if modelled, would place an agency in a better position if they are ever the subject of a government investigation.

The Department of Justice (DOJ) releases information on cases related to fraud and abuse.[9] CMS benchmarks hospices on measures that it considers to be potential indicators of fraud and abuse in its Program for Evaluating Payment Patterns Electronic Reports (PEPPER reports).[10] The Government Accounting Office (GAO) also reviews the implementation of its compliance guidelines across federal agencies, and in 2017 recommended that CMS increase fraud-awareness training for its own employees.[11]

Hospice-specific guidance

So, what can hospices take away from these sources for 2018?

The OIG Work Plan

The currently active OIG Work Plan has seven items related to hospice, three of which were added in 2017, and these relate to general concerns about vulnerabilities in the definition of the Medicare Hospice Benefit and compliance with current Medicare requirements. DOJ reports on recent investigations help fill in the concerns that the OIG has with current regulations and compliance therewith. The reports that will come out from these three new items should be watched carefully.

Three of the active OIG Work Plan items for hospice deal with the potential for duplicate payments:

- in Part D drug payments,
- in Part B claims submitted by hospice vendors, and
- with physician billing for chronic care management (CCM).

This points to an increasing need to communicate clearly with referral sources and vendors when hospice should be the sole payer for services. Although it is the partnering entity that is potentially doing the duplicate billing, it's the hospice that will face recoupment.

The final item relates to the requirement that an RN make an in-home visit every two weeks to ensure that inter-disciplinary team services are meeting the patient's needs. Like background checks and health screening issues raised over the past several years, lapses in these "technical" processes are being increasingly viewed as "not providing quality care."

Other OIG reports

The Compendium was revised in 2017 to include only its Top 25 recommendations. In addition to the Hospital Transfer Payment Policy already noted above, it includes one other hospice item, which concerns the potential for financial incentives to provide care in assisted living facilities, especially for patients with cognitive diseases. We might also see this addressed as part of the active Work Plan items on general hospice vulnerabilities and violations.

In the Health Care Fraud and Abuse Control Program Annual Report for 2016,[12] issued jointly by the OIG and DOJ in 2017, four hospices are showcased as "successful" investigations. The allegations included paying recruiters, paying cash kickbacks to the hospice medical directors for signing Certificates of Terminal Illness for patients that were not appropriate for hospice, documentation that did not support eligibility, and discouraging physicians from recommending that patients be discharged from hospice service. Owners, physicians, and an admission

manager in these cases were fined and/or sentenced to prison terms.

According to the Medicaid Fraud Control Units FY2016 Annual Report,[7] hospices accounted for two criminal convictions and 13 civil settlements. This amounts to only 1% of total convictions; however, 113 investigations remained open. For all types of providers and individuals, 74% were related to fraud, and 26% were categorized as abuse or neglect. Of the fraud cases, 16% were related to drug diversion.

The top challenges in the HHS Top Management and Performance Challenges[6] include "improper payments and fraud in home-based settings." A sidebar focuses on reducing Medicare payments for home health in certain geographic "hot spots," but recall that the active Work Plan has three items that could be part of this focus.

Several new hospice CIAs were released in 2017.[8] Key takeaways include:

- The OIG requires a compliance program structure where the compliance officer reports directly to the CEO, has full access to the board, and the board provides input into the compliance officer's performance review; and
- Two recent hospice CIAs dropped a previous standard for Independent Review Organizations that set a 5% error rate as the tipping point for further review. The newer CIAs do not provide for any "acceptable" error rate, and dictate that all billing errors must be repaid within 60 days, with the potential for extrapolation of the sample error rate to the entire population of claims.

Department of Justice

The DOJ announced its largest settlement of a False Claims Act with a hospice in 2017.[13] Chemed, the parent of VITAS Healthcare, resolved allegations for $75 million. Other hospice settlements in 2017 ranged from $2 million to $60 million. Key issues in these cases included:

- documentation that did not support hospice eligibility or appropriateness of elevated levels of care,
- kickbacks for referrals,
- diagnoses that were not medically justified,
- destruction of documents to conceal activities,
- improper certifications of terminal illness, and
- several cases where individual employees or contractors diverted opioids.

PEPPER reports

CMS issues Program for Evaluating Payment Patterns Electronic Reports to all providers to allow agencies to benchmark themselves on indicators that CMS considers potential indicators of fraud. For hospice, these include:

- Live discharge revocations
- Long lengths of stay
- Levels of care provided in assisted living facilities and nursing facilities
- Single diagnosis coding
- No utilization of inpatient or continuous levels of care

The most surprising fact revealed from the PEPPER contractor report in 2017 was that only 59% of hospices had opened their PEPPER report as of December 2017.

Summary

Hospices should be aware of an increasing number and frequency of government activities related to compliance. Other key takeaways from recent government guidance include:

- Drop any thinking that there's an "acceptable" error rate.
- Assess your compliance program structure in terms of reporting relationship and performance evaluation process for the compliance officer.

- Self-assess for the following hospice risk areas identified in recent government publications:
  - Basic hospice eligibility, appropriateness of levels of care, Notice of Election accuracy, Certificate of Terminal Illness accuracy, and RN supervision visits
  - Physician arrangements, physician documentation that addresses Local Coverage Determinations and is congruent with other clinical notes
  - Individual employee credentialing and supervision, visit verification, oversight of potential abuse/neglect, potential drug diversion, and new conscience and religious freedom regulations
- Avoid the potential of duplicate billing with standardized, clear communication with clinical and health plan partners: physicians billing for CCM and transitional care management services, Part D Plans, vendors of any type who routinely bill Medicare or Medicaid directly for services, and beginning in FY 2019, hospitals transferring patients to hospice.
- It never hurts to revisit the "old standard," that is, the original OIG Compliance Program Guidance for Hospice,[14] issued in 1999. Much (if not all) of it is still very relevant today.

1. HCCA Web Conference: OIG Work Plan and Other Key Guidance: Review of 2017 and Looking into 2018- Home Health and Hospice. January 24, 2018. Slides available at http://bit.ly/2vGfC4Z
2. HHS OIG Annual Work Plan. Available at http://1.usa.gov/1g9X7oi
3. HHS OIG Strategic Plan 2014 – 2018. Available at http://bit.ly/2qSlpj7
4. HHS OIG: Compendium of Unimplemented Recommendations, May 2017. Available at http://bit.ly/2Jftdlq
5. HHS OIG: Semi-Annual Report to Congress, April 1, 2017 - September 30, 2017. Available at http://bit.ly/2K9rb7K
6. HHS OIG: Top Management and Performance Challenges Facing HHS, 2017. Available at http://bit.ly/2K6pnMO
7. HHS OIG: Medicaid Fraud Control Units Fiscal Year 2016 Annual Report. Available at http://bit.ly/2HlgaCD
8. HHS OIG: Corporate Integrity Agreement Documents. Available at http://bit.ly/2HkQuWEp
9. Department of Justice: Justice News site. Available at: www.justice.gov
10. PEPPER Resources website. Available at www.pepperresources.org
11. GAO: Report to Congressional Addressees: Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework. December 2017. Available at http://bit.ly/2HmGmNa
12. HHS/DOJ: Health Care Fraud and Abuse Control Program Annual Report for 2016. Available at http://bit.ly/2F7FwOh
13. Maggie Flynn: "[Updated] $75 Million FCA Settlement is Largest-Ever for a Hospice" *Home Health Care News*; November 14, 2017. Available at http://bit.ly/2vJsvei
14. HHS OIG: Publication of the OIG Compliance Program, Guidance for Hospices. Available at http://1.usa.gov/1NHmLyg