Post-acute providers: Key risk areas and how to minimize them

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Government enforcers continue to focus their efforts on post-acute providers. This article discusses recent government enforcement actions and key risk areas for hospice, home health, and skilled nursing facilities. First, the article summarizes key government enforcers on the federal and state level. Understanding the agency in charge of the investigation, as well as its areas of focus and limitations, will allow compliance professionals to advise management on potential challenges and ramifications for the investigation. Readers who are familiar with healthcare fraud enforcement may want to skip directly to the next section, which discusses recent government enforcement and risk areas. The article concludes with practical advice for compliance professionals in the post-acute care industry drawn from the Department of Justice (DOJ) guidance on corporate compliance programs.

Government enforcers

At the outset of an investigation, it is important to understand the entity conducting the investigation, as well as the agency's focus and objectives. For instance, a demand letter by a Medicare recovery auditor suggests that the provider is facing the threat of recoupment of federal funds paid. An investigation by the DOJ, on the other hand, can result in more serious consequences, including criminal actions. Compliance professionals should keep in mind the limitations and focuses of particular agencies when advising management on potential risks of fraud investigations.

Readers are likely familiar with enforcement actions by the Centers for Medicare & Medicaid Services (CMS), Office of Inspector General (OIG), and DOJ, but other enforcement agencies often enter the fray. For instance, CMS oversees program integrity contractors that perform integrity audits, including provider audits and medical necessity claims reviews and investigations. Although there may be a tendency to view inquiries from these third parties as unimportant, providers do so at their own peril, because these contractors can suspend payment, recoup overpayments, and even refer fraud cases to the OIG.

Program integrity auditors fall roughly into four categories:

- **Unified Program Integrity Contractors (UPICs):** A UPIC's primary goal is to identify fraud.

UPICs have authority to suspend payments, recoup overpayments, and refer providers to the OIG. UPICs are not paid commissions, but CMS does pay performance bonuses. UPIC investigations are the most serious audit or investigation a provider can face by a program integrity contractor.

- **Medicare Recovery Auditors (RAs):** RAs review claims on a post-payment basis and have a three-year lookback period. CMS pays RAs a contingency fee. Actions by RAs typically begin with a demand letter, and providers must be cognizant of the deadlines contained in the letter (usually 30 days).
- **Medicare Administrative Contractors (MACs):** MACs serve as the operational contacts between Medicare and healthcare providers. MACs perform claim-related activities and deal with minor or isolated billing issues. They also perform prepayment reviews and provider education. MAC investigations largely deal with mistakes in billing instead of fraud allegations.
- **Medicaid Integrity Contractors (MICs):** MICs support state Medicaid program integrity efforts. MICs provide technical assistance and training to state Medicaid Program Integrity staff.

Providers should also be aware of investigations by states, the Securities and Exchange Commission, and even Congress. State attorneys' general offices review Medicaid fraud through Medicaid Fraud Control Units.

Now that we have discussed key government enforcers and their focuses, we turn to particular risk areas in the post-acute care industry.

Hospice

The OIG has clearly signaled its intent to focus enforcement efforts on post-acute care and hospice, in particular. In July 2018, the OIG issued a report on vulnerability in the industry.[1] Three key areas emerged: (1) billing for an expensive and unneeded level of care, (2) enrolling ineligible beneficiaries in hospice care, and (3) billing for services not provided. The OIG provided 16 recommendations for CMS, and CMS concurred with six:

- Develop other claims-based information and include it in Hospice Compare (an online tool to compare hospices).
- Work with partners to make available information explaining the hospice benefit.
- Analyze claims data to identify concerning practices.
- Implement Probe and Educate reviews and conduct prepayment reviews for providers with concerning billing.

- Increase oversight of general inpatient care claims.
- Implement a comprehensive prepayment review strategy to address lengthy stays.

The OIG's Work Plans are good sources for compliance professionals to understand areas of focus for the agency. For hospice, OIG initiatives include:

- **Medicare payments made outside the hospice benefit:** In general, a hospice beneficiary waives all rights to Medicare payments for any services that are related to the treatment of the terminal condition for which hospice care was elected. The hospice agency assumes responsibility for medical care related to the beneficiary's terminal illness and related conditions. Medicare continues to pay for covered medical services that are not related to the terminal illness. The OIG will conduct reviews of certain categories of services (including durable medical equipment, prosthetics, orthotics and supplies, and physician services) to determine whether duplicate payments were made.
- **Duplicate drug claims for hospice beneficiaries:** Hospice providers are required to render all services necessary for the palliation and management of a beneficiary's terminal illness and related conditions, including prescription drugs. Medicare Part A pays providers a daily per diem for each individual who elects hospice coverage, and part of the per-diem rate is designed to cover the cost of drugs related to the terminal illness. The OIG will review claims to determine whether prescription claims were inappropriately billed outside the per-diem rate.

A review of recent enforcement action highlights five risk areas: (1) medical necessity, including eligibility for the hospice benefit and the level of care; (2) facility/hospice relationships, including the overlap or appropriateness of services; (3) medical director/physician relationships; (4) worthless services; and (5) documentation. The following recent cases illustrate these issues:

Medical director/Physician relationships

Good Shepherd Hospice – agreed to pay $4 million to resolve allegations that it hired medical directors based on their ability to refer patients. Good Shepherd allegedly targeted medical directors with ties to nursing homes.

Patient eligibility/Documentation

- *Caris Healthcare L.P.* – agreed to pay $8.5 million for admitting patients who were not terminally ill. Caris allegedly continued to bill for hospice care even after it was alerted to the patients' ineligibility and took no meaningful action to determine whether it received improper payments.
- *Health and Palliative Services of the Treasure Coast* – settled False Claims Act (FCA) allegations for $2.5 million for allegedly submitting claims for services that were not eligible for hospice care.

Long lengths of stay

Haven Hospice – settled FCA claims for $5 million to settle allegations that its patients were not eligible for hospice because they did not have a life expectancy of less than six months. Between June 1, 2011, and December 21, 2017, Haven treated at least 63 patients with lengths of stay exceeding three years.

Compliance professionals for hospice providers should verify that procedures are in place to ensure beneficiaries meet Medicare hospice eligibility requirements. Documentation should be adequate and should establish that the patient is eligible for hospice *and* the level of care provided. Long lengths of stay may suggest that patients were not eligible for hospice, and hospice providers with a high proportion of patients with long lengths of stay may be at risk for audits or additional scrutiny. Hospice providers should also ensure that they are not separately billing for services that are already included in a bundled reimbursement rate. We expect CMS to take a more active role in Probe and Educate and prepayment reviews, so providers should be conducting internal audits themselves.

Home Health Agencies (HHAs)

Like hospice, key risk areas include medical necessity, documentation, and improper billing of bundled services. The OIG's home health initiatives for the next fiscal year include:

Review of home health claims for services with 5–10 skilled visits: CMS pays HHAs low utilization payment adjustments if the HHA provides four or fewer visits from a skilled service provider. The OIG will determine whether home health claims with 5–10 skilled visits in a payment episode were appropriate and adequately supported by documentation.

Hospitals' compliance with Medicare's transfer policy with the resumption of home health services and the use of condition codes: Normally, Medicare pays a hospital that discharges a beneficiary the full amount for the corresponding DRG. In contrast, a hospital that transfers a beneficiary to another facility or to home health services is paid a graduated per-diem rate. When transferring a patient to home health services, the hospital can apply specific condition codes to the claim and receive the full DRG payment. The hospital is responsible for coding the bill according to its discharge plan for the patient or adjusting the claim if it finds out that the patient received post-acute care after the discharge. The OIG will determine whether Medicare appropriately paid hospitals' inpatient claims subject to the post-acute care transfer policy when patients resumed home health services after discharge or hospitals applied condition codes to claims to receive a full DRG payment.

Medicare payments for unallowable overlapping home health claims and Part B claims: Medicare's prospective payment system pays HHAs for home services and covers all of their costs for furnishing services to Medicare beneficiaries. Payment is made to the

HHA's fee, even if the service is provided by another entity. The OIG will review Medicare payments to HHAs to determine whether duplicate claims were submitted. Generally, certain items, supplies, and services furnished to inpatients are covered under Part A and should not be separately billable to Part B.

Medicare payments for chronic care management: Chronic care management (CCM) is defined as the non–face-to-face services provided to Medicare beneficiaries who have multiple (two or more) significant chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CCM cannot be billed during the same service period as transitional care management, home health care supervision/hospice care, or certain end-stage renal disease services. The OIG will determine whether payments for CCM services were paid in accordance with Medicare requirements.

Recent enforcement actions highlight the following risk areas for home health providers: (1) medical necessity, including medically unnecessary skilled services or services provided to patients who are not homebound; (2) documentation sufficiency, including face-to-face requirements and plans of care; (3) financial relationships with referral sources; (4) marketing practices; (5) home health aide certification and training; (6) patient safety and quality of care; and (7) therapy threshold manipulation. The following recent cases illustrate these issues:

Documentation

Anointed Care Services/Edith Manzano: Edith Manzano was convicted of three fraud counts related to allegations that she falsified documentation to suggest that patients satisfied Medicare's requirements for admission.

Medical necessity

Timely Home Health: Two doctors and three nurses were sentenced to prison terms for their role in an $11.3 million fraud scheme to bill Medicare for medically unnecessary home health services.

Financial relationship with referral source/medical necessity

Amedisys Inc. agreed to pay $150 million to settle allegations stemming from seven whistleblower cases between 2008 and 2010. The government alleged that the company billed Medicare for services that were not medically necessary, maintained improper financial relationships with referral sources, and pressured staff to provide care based on financial benefits to the company rather than on the needs of patients.

Marketing

Healthquest Inc. paid kickbacks to its marketers from December 2013 to May 2017 to induce them to refer patients to Healthquest. Healthquest and its owners agreed to pay $1.5 million to settle the case.

Therapy manipulation

Southern SNF Management Inc. agreed to a $10 million settlement over allegations that it implemented a company-wide policy of assigning residents to an unsupported "ultra high" therapy level. The assignments were made to inflate reimbursements without regard to the medical condition of residents.

Documentation and medical necessity are key focuses for enforcement. Home health agencies should ensure that documentation supports the level of care, especially if the agency is billing for services above 5–10 visits. Like hospice providers, home health providers should ensure that they are not improperly billing Medicare or Medicaid for payments that are already bundled in another entity's payments. Financial relationships with referral sources should also be carefully reviewed to ensure compliance with federal and state anti-kickback laws.

Skilled nursing facilities (SNFs) and nursing homes

Perhaps the most important risk area for SNFs in the upcoming year is compliance with the new Patient-Driven Payment Model (PDPM). Beginning October 1, 2019, SNFs will be paid a per-diem rate that focuses on patient outcomes instead of services provided. Under the existing model, therapy minutes play a role in determining compensation. Although the PDPM requires that SNFs report the therapy minutes provided, therapy minutes no longer determine payment. Instead, payment will now be based on five patient characteristics. SNFs should ensure staff are educated on this new payment methodology to ensure appropriate billing. In particular, SNFs should be careful to understand the relevant patient characteristics to ensure that they are not overbilling for their services.

Additionally, the OIG's Work Plan identified the following focus areas for SNFs and nursing homes:

- **Skilled nursing facilities' unreported incidents of potential abuse and neglect:** Ongoing OIG reviews indicate the potential for unreported instances of abuse and neglect. The OIG will assess the incidence of abuse and neglect of Medicare beneficiaries receiving treatment in SNFs and determine whether these incidences were properly reported and investigated in accordance with applicable federal and state requirements.
- **Medicare Part B payments for ambulance services subject to Part A skilled nursing facility consolidated billing requirements:** Medicare Part A prospective payments to SNFs include most of the services that outside suppliers provide to SNF residents.

Outside suppliers (including ambulance suppliers) must bill and receive payment from the SNF, not Medicare.

- **Potential abuse and neglect of Medicare beneficiaries:** Prior OIG reviews have shown that there are problems with the quality of care and the reporting and investigation of potential abuse or neglect at group homes, nursing homes, and skilled nursing facilities. The OIG will analyze treating medical facilities' diagnoses to determine the prevalence of abuse/neglect of Medicare beneficiaries.

SNFs and nursing homes should be wary of the following risk areas that have emerged in recent enforcement actions: (1) medical necessity, (2) quality of care, (3) employee screening, (4) vendor relationships, (5) billing and cost reporting, (6) recordkeeping and documentation, and (7) relationships with hospice providers that suggest compensation for referrals. Below is a list of examples:

Improper coding/substandard services

- *Preferred Care Inc.* agreed to pay $540,000 to resolve allegations that it improperly inflated coding for skilled nursing services and provided substandard or worthless services to Medicare beneficiaries.
- *Signature HealthCARE LLC* agreed to pay $30 million to resolve allegations that it submitted rehabilitation therapy services that were not reasonable, necessary, and skilled.

Improper kickbacks

Reliant Rehabilitation Holdings LLC settled claims for $6.1 million over allegations that it paid kickbacks to SNFs and physicians as a way of promoting Reliant's rehab business.

Patient neglect and abuse are at the forefront of enforcement, so SNFs and nursing homes should ensure procedures are in place to prevent neglect or abuse. According to CMS, the primary reasons for improper payments were insufficient or missing certification/recertification statements.[2] SNFs should be mindful of the new payment methodology effective October 1, 2019, and ensure staff are trained on appropriate billing and documentation guidelines. As with all healthcare providers, referral relationships should be reviewed to ensure compliance with federal and state anti-kickback prohibitions.

Conclusion – Proactive audits and effective compliance programs

Medical necessity, quality of care, and appropriate documentation are key risk areas across the industry. Providers should be aware that, at least in the hospice space, CMS is looking to conduct more proactive prepayment and Probe and Educate reviews to root out issues on the front end. Providers may be able to get out in front of payment issues through proactive audits.

Indeed, CMS expects providers to conduct proactive audits on their claims, but providers must keep in mind that the False Claims Act was amended in 2009 to require providers to return overpayments for Medicare and Medicaid within 60 days.[3] Compliance professionals who supervise audits must remember that, if an overpayment is identified and quantified in the audit, the 60-day clock to return the overpayment begins. Compliance professionals should also review other payer's requirements.

Compliance professionals should also assess the effectiveness of their compliance program. An effective compliance program not only reduces the risk of legal issues, it will help mitigate any liability if an investigation occurs. All compliance professionals should review the DOJ's guidelines on effective compliance programs.[4] Government enforcers may look favorably on a compliance program if: (1) audit findings and remediation progress are regularly reported to management and the board; (2) policies and procedures have been designed in consultation with business units to ensure that they are practical; (3) training is tailored for high-risk employees in areas where misconduct can occur; and (4) risk assessments and policies and procedures are updated regularly. The DOJ's compliance guide not only provides clear benchmarks, it may give compliance professionals the ammunition they need to implement meaningful change.

Takeaways

- Enforcement actions are initiated by government agencies and third-party contractors. Understanding these entities will help compliance professionals advise management on potential risks.
- Medical necessity continues to be a key focus area. Providers must ensure that documentation supports benefit eligibility and the level of care.
- Enforcers are closely looking at quality of care and patient neglect. Policies and procedures should be implemented to ensure applicable standards are met.
- Government enforcers expect proactive audits, but audits may trigger the 60-day window to return identified and quantified overpayments for Medicare and Medicaid.
- In addition to proactive audits, compliance professionals should review DOJ compliance guidelines to ensure that their program meets these suggested parameters and areas of focus.