Developing Your Hospice Compliance Dashboard

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Sessions Objectives

• Review CMS, MAC, RAC, ZPIC, MIC, OIG, and DOJ auditor entities and their recent focus on hospice providers
• Identify compliance issues for hospice providers and how to develop a compliance dashboard to self-assess areas of vulnerability
• Identify how to develop a compliance dashboard to self-assess areas of vulnerability

Healthcare Audit Landscape

• CMS current network of Contractors carrying out program integrity work in Medicare and Medicaid
  – Medicare Administrative Contactor (MAC)
  – Zone Program Integrity Contractors (ZPICs)
  – Recovery Auditors (RAs)
  – Medicaid Integrity Contractors (MICs)
  – Comprehensive Error Rate Testing (CERT) Contractors
  – Payment Error Rate Measurement (PERM) Contractors

CMS resource - Medicare Claim Review Programs (May 2015)
Why?

- Federal government committed to reducing fraud, waste, and abuse across the government
- Combined forces - Health Care Fraud Prevention and Enforcement Action Team (HEAT)
  - U.S. Department of Health & Human Services, Office of Inspector General (HHS OIG), the Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Justice (DOJ)
- Strategy -
  - shifted from a “pay and chase” approach toward fraud prevention

Why?

- The 2010 Affordable Care Act (ACA) contains fraud, waste and abuse provisions to aid the federal government in combating improper payments in Medicare, Medicaid and the Children’s Health Insurance Program ("CHIP").
  - increases participant screening requirements for providers
  - enhances penalties for violations
  - facilitates data sharing among various health programs
  - imposes new requirements for claims
  - expands the authority of the Recovery Audit Contractor (RAC)
  - appropriates additional funding for efforts to combat fraud

The “Pay Day”

- Fiscal Year (FY) 2013 and FY 2014
  - $42 Billion Saved in Medicare and Medicaid
  - For every dollar invested in CMS’ Medicare program integrity efforts saved $12.40 for the Medicare program
The Next New Normal...

Unified Program Integrity Contractor (UPIC)

• CMS is transitioning to a Unified Program Integrity Contractor (UPIC) strategy
• Under this strategy, Medicare and Medicaid program integrity audit and investigation work at the federal level will be consolidated into a single contractor within a defined multi-state area, which will complement audit and investigation efforts by states

UPIC Status

• May 2016
  – $2.5 billion 10 year multiple award IDIQ was awarded to 7 firms in support of the Centers for Medicare and Medicaid Services’ (CMS) audit, oversight and antifraud, waste and abuse efforts
• The 7 awardees include:
  – Tricenturion; StrategicHealthSolutions; Safeguard Services; Noridian Healthcare Solutions; Integriguard; Health Integrity; and AdvanceMed, now part of NCI.
Jurisdiction 1 Area

- The first UPIC first task order was awarded to AdvanceMed for services in the contract vehicle’s Jurisdiction 1 area that encompasses Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky, Iowa, Missouri, Nebraska, and Kansas.

Who is Auditing Hospice?
### Medicare and Medicaid

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<td>Medicare Administrative Contactor (MAC)</td>
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### HHS/ CMS Hospice Audit Issues
- Medical records did not support a terminal illness with a life expectancy of 6 months or less, or did not support patient status generally
- Certification was not provided in a timely manner
- Hospice employees were not properly vetted or licensed
- Documentation supported long-term or custodial care rather than hospice care
- The principal hospice diagnoses on the claims were adult failure to thrive, dementia, and debility

### Other Hospice Audit Issues
- Length of stay
- General inpatient care
  - Utilization
  - Eligibility
- Hospice care in a nursing facility and/or assisted living facility
- Inappropriate billing – False Claims Act violation
Hospice Audit Settlements

• Evercare Hospice and Palliative Care will pay $18 million to resolve False Claims Act allegations that it claimed Medicare reimbursement for hospice care for patients who were not eligible for such care because they were not terminally ill (July 2016)

Hospice Audit Settlements

• Serenity Hospice and Palliative Care, a hospice operating in Phoenix, Ariz., has agreed to pay $2.2 million to resolve civil allegations that it violated the federal False Claims Act by submitting false bills to Medicare for hospice services (Oct 2015)

Hospice Audit Settlements

• St. Joseph Hospice Entities, which consists of 13 hospice facilities in Mississippi, Louisiana, Texas and Alabama, have agreed to pay the United States $5,867,518 under the False Claims Act to resolve allegations that they submitted false claims for delivery of continuous home care hospice services to patients who were not entitled to receive continuous care hospice level treatment
Issues for a Compliance Dashboard

Compliance with Federal Hospice Regulations

- **Subpart A**
  - Statutory basis
  - Definitions

- **Subpart B**
  - Subpart B - Eligibility, Election and Duration of Benefits
    - (Compliance assessed via MAC, federal, or state-based audit)

- **Subparts C & D (CoPs)**
  - Patient Care
    - Organizational Environment
      - (Compliance assessed during an initial and recertification survey by state or accreditation organization)
Compliance with Federal Hospice Regulations

- **Subpart F**
  - Covered services
  - Requirements for coverage

- **Subpart G**
  - Payment for Hospice Care

- **Subparts F**
  - Coinsurance

Federal Hospice Regulations

Where are the federal regulations?

Title 42 – Public Health
- Chapter IV - Centers for Medicare and Medicaid Services
- Department of Health and Human Services
- Part §418 – **Hospice Care**

Federal Hospice Interpretive Guidelines

State Operations Manual Appendix M – **Guidance to Surveyors: Hospice**
Preparing for a Survey

- Be survey ready at all times!
  - Develop a culture of compliance in your organization
- Surveys are unannounced
- How to prepare:
  - Annual program review with policy and procedure updates
  - Staff and volunteer education on policies and procedures
  - Conduct a mock survey
FY 2017 CMS Data Monitoring

Monitoring will include:
• hospice diagnosis reporting
• length of stay
• live discharge patterns and their relationship to the provision of services and the aggregate cap
• non-hospice spending for Parts A, B and D during a hospice election
• trends of live discharge at or around day 61 of hospice care, and readmissions after a 60 day lapse since live discharge

CMS Quality Reporting

• Hospice Item Set (HIS)
• Hospice Experience of Care Survey (CAHPS)
• 2% penalty to rates if data not submitted

PEPPER Reports

• PEPPER
  – Roadmap to help a provider identify potentially vulnerable or improper payments
  – Assist providers in identifying
• Free comparative report from CMS contractor
• Go to www.PEPPERresources.org
• Click on “PEPPER Distribution ... Get your PEPPER”
Hospice Target Areas – 2016 PEPPER

- Live discharges – not terminally ill
  - CMS claims data analysis
- Live discharges – revocations
  - CMS claims data analysis
- Live discharges – 61-179 days
  - CMS claims data analysis
- Long length of stay
  - CMS claims data analysis
- Claims with single diagnosis coded
  - CMS claims data analysis

Hospice Target Areas – 2016 PEPPER

- CHC in assisted living facility
  - OIG report
- RHC in assisted living facility
  - OIG report
- RHC in nursing facility
  - OIG report
- RHC in skilled nursing facility
  - OIG report
- Episodes with no CHC or GIP
  - CMS claims data analysis

MAC Medical Review

- Additional Documentation Requests (ADRs)
  - Medical Review Additional Development Request (MR ADR) Process CGS Web page
  - Medical Review Additional Development Request (MR ADR) quick resource tool
- Prepayment and postpayment reviews, widespread edits
CGS Current Widespread Edits

Hospice Top Medical Review Denial Reason Codes

- April-June 2016
  1. Information provided does not support a terminal prognosis of six months or less
  2. Physician services were not reasonable and necessary or were administrative in nature
  3. Requested documentation not received/received timely
  4. No documentation to support services as billed
  5. The hospice plan of care does not meet the requirements set forth in the code of federal regulations (§418.56)

Hospice Coverage Regulations

- §418.202 - To be covered, hospice services must meet the following requirements:
  - They must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions.
  - The individual must elect hospice care in accordance with §418.24.
  - A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in §418.56. That plan of care must be established before hospice care is provided.
  - The services provided must be consistent with the plan of care.
  - A certification that the individual is terminally ill must be completed as set forth in §418.22.
Revalidation

- Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information.
- Providers who do not complete timely revalidation are subject to a possible hold on Medicare payment and/or deactivation of Medicare billing privileges.
- Your Medicare Administrative Contractor (MAC) will send a revalidation notice within 2-3 months prior to your revalidation due date.
  - Once notified, your hospice has **60 days to complete the revalidation request** and submit your revalidation application.

Revalidation

- Due dates are posted to the data.cms.gov website through a **"Revalidation Due Date Look Up Tool"**. The list will display all currently enrolled providers and will have either a Due date or a "TBD" listed.
- Due dates are:
  - posted up to 6 months before the revalidation due date
  - Due Dates are updated every 60 days at the beginning of the month

Revalidation

- CMS may require a hospice entity to disclose “full and complete information” confirming the identity of each person with an “ownership and control interest” in the entity.
- That includes an officer or member of a hospice’s board of directors, even if the entity is a non-profit. In addition to the names of all board members, this could also include Social Security numbers and dates of birth for each board member.
Compliance with State

- Hospice licensure regulations
- Medicaid Hospice Benefit regulations
  - Mirror Medicare Hospice Benefit regulations

Hospice MIC Audits

- There are three types of MICs: Review MICs; Audit MICs; and Education MICs
  - Review MICs conduct data mining analysis and risk assessments of Medicaid claims data
  - Audit MICs conduct post-payment audits of Medicaid providers and identify overpayments.
    - The audit ensures that claims are paid in compliance with Medicaid rules and regulations and that claims paid are medically necessary
    - Education MICs educate providers and others on matters regarding payment integrity and quality of care issues
Hospice Audit Issues

- Medical records did not support a terminal illness with a life expectancy of 6 months or less, or did not support patient status generally
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Office of Inspector General (OIG)

- Mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries
- It is the largest inspector general’s office in the Federal Government, with approximately 1,600 dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs
Report on Hospice General Inpatient Care...

• Among the findings published March 31, 2016 the OIG found that “hospices billed one-third of GIP stays inappropriately, costing Medicare $268 million in 2012.

• Hospices commonly billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms.

OIG Recommendations

• Increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries

• Ensure that a physician is involved in the decision to use GIP

• Conduct prepayment reviews for lengthy GIP stays

• Increase surveyor efforts to ensure that hospices meet care planning requirements

• Establish additional enforcement remedies for poor hospice performance

• Follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care.

What should a hospice do?

• Level of care eligibility
  – Process and procedure for determining eligibility for the GIP level of care
  – DOCUMENT the reasons that GIP is appropriate for each patient
  – Evaluate continued eligibility for GIP EVERY DAY

• Physician involvement in GIP decision making
  – Physician orders for a change in level of care?
  – Industry best practice
What should a hospice do?

- **Review GIP length of stay regularly**
  - Review use of GIP and length of stay regularly, even monthly
  - Conduct internal chart reviews for LOS more than 2-3 days
- **Care planning**
  - Review care plan scope and frequency for the GIP stay
  - Confirm that all required members of the IDT participate in GIP plan of care development
- **Part D and hospice**
  - Vigilance for medication coverage, especially in contract GIP facilities
  - Keep accurate and detailed pharmacy records to document payment for medications

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Report on Hospice General Inpatient Care...

- Click here for a copy of the report: [http://oig.hhs.gov/oei/reports/oei-02-10-00491.pdf](http://oig.hhs.gov/oei/reports/oei-02-10-00491.pdf)
- Listen to Related Podcast [http://go.usa.gov/csvgj](http://go.usa.gov/csvgj)

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OIG List of Excluded Individuals/Entities (LEIE)

- List of Excluded Individuals/Entities (LEIE) provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs
- The effect of exclusion is that no payment will be made by any Federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity
Who Should Providers Screen for Exclusion?

- Providers should screen employees and contractors to ensure they have not been excluded from a Federal health care program (including volunteers)
- Providers should screen physicians and other practitioners who order items and services that the provider renders
- Providers will want to check that board members are not excluded

How Often Should Exclusion Checks Be Done?

- While there is no statutory or regulatory requirement to check the LEIE, OIG recommends that providers screen their employees and contractors for exclusion prior to employment or engagement and on a monthly basis to minimize risk

Penalties

- An excluded person that submits a claim for payment to a Federal health care program, or causes such a claim to be submitted, may be subject to civil monetary penalties (CMP) of $10,000 for each claimed item or service furnished during the period that the person was excluded
- The person may also be subject to an assessment of up to three times the amount claimed for each item or service
- Other criminal statutes may also apply to such violations
Health Insurance Portability and Accountability Act (HIPAA)

- Privacy Rule
- Security Rule
- Enforcement Rule
- Breach Notification
- Omnibus Rule

OCR webpage: HIPAA for Professionals

HIPPA/HITECH Breaches

- Reporting requirement for fewer than 500 individuals:
  - Provide OCR/HHS with notice annually
  - All notifications of breaches occurring in a calendar year:
  - Submit within 60 days of the end of the calendar year in which the breaches occurred
  - Submit Notice of a Breach Affecting Fewer than 500 Individuals
Security Risk Assessment Requirement

- The Health Insurance Portability and Accountability Act (HIPAA) Security Rule requires that covered entities conduct a risk assessment of their healthcare organization to ensure it is compliant with HIPAA’s administrative, physical, and technical safeguards.
- A risk assessment also helps reveal areas where your organization’s protected health information (PHI and EPHI) could be at risk.

Assess Your Risk

- A security risk assessment (SRA) tool is available from HHS/OCR to help guide health care providers in small to medium sized offices conduct risk assessments of their organizations.
- Risk assessment purpose:
  - Can uncover potential weaknesses in security policies, processes and systems.
  - Help providers address vulnerabilities, potentially preventing health data breaches or other adverse security events.
  - A vigorous risk assessment process supports improved security of patient health data.

Security Risk Assessment Tool

- The SRA tool’s website contains a User Guide and Tutorial video to help providers begin using the tool. Videos on risk analysis and contingency planning are available at the website to provide further context.
- The tool is available for both Windows operating systems and iOS iPads. Download the Windows version at http://www.HealthIT.gov/security-risk-assessment. The iOS iPad version is available from the Apple App Store (search under “HHS SRA tool”).
Enforcement Activity

- Increased focus on audits, investigations, and corrective action plans
  - Phase II audits in progress
- Financial costs are large – potential fines, expense of corrective action plan, damage to agency reputation
- OCR will pursue civil monetary penalties for egregious behavior
- Ongoing review of rule implementation with revised guidance issued as indicated

Non-discrimination Final Rule

- Effective Date: July 18, 2016
- Implements Section 1557 of the Affordable Care Act (ACA). Which prohibits certain entities that administer health programs and activities from excluding an individual from participation, denying program benefits, or discriminating based on race, color, national origin, sex, age or disability
- While Section 1557 has been in effect since the ACA’s enactment, these regulations mark the first time HHS has issued implementing guidance

Providers Are Required To...

- Covered entities must post a notice regarding their non-discrimination policies by October 16, 2016
- Covered entities must provide the notice in English and include taglines in the top 15 languages spoken by individuals with LEP within the state
- Covered entities that employ at least 15 people must adopt a grievance procedure that incorporates appropriate due process standards and provides prompt and equitable resolution of grievances under Section 1557
Providers Are Required To...

• Covered entities must take remedial action as required by the HHS OCR Director if they are found to have discriminated on any basis prohibited by Section 1557

Other Compliance Dashboard Issues

OSHA Compliance

• OSHA Injury and Illness Summaries
• OSHA reminds employers of their obligation to post a copy of OSHA’s Form 300A, which summarizes job-related injuries and illnesses logged during 2015. The summary must be displayed in a common area where notices to employees are usually posted each year between February 1 and April 30. Visit OSHA’s Recordkeeping Rule webpage for more information on recordkeeping requirements.
Department of Labor

• Providers must:
  – Ensure that employment posters are updated and posted for 2012
  – Visible in key employee areas
  – Access the DOL’s eLaws FirstStep Poster Advisor to determine which poster updates you will need

• Link to Department of Labor:
  http://www.dol.gov/elaws/posters.htm

Questions

NHPCO members enjoy unlimited access to Regulatory Assistance
Feel free to email questions to regulatory@nhpco.org

Regulatory and Compliance Team at NHPCO

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Email us at: regulatory@nhpco.org
NHPCO Regulatory Resources

• NHPCO website
  – Regulatory – check Hot Topics for latest issues
  – Compliance guides, tip sheets, wage index rate charts and
detailed regulatory/compliance information

• Regulatory technical assistance
  – Contact regulatory@nhpco.org