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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.