New England Home Care & Hospice Conference and Trade Show
May 3, 2023

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WIGGIN
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Agenda

- Home Health and Hospice Survey Process
- Alternative Sanctions
- Appeal Process
- Fraud Enforcement Update

PREPARING FOR SURVEYS: SURVEY TYPES

- Initial Surveys
- Standard Surveys
  - Every 36 months at minimum
  - Review of select numbers of standards (Level 1)
- Extended Survey
  - When any condition level deficiency is found
- Complaint Survey
- Validation Survey

PREPARING FOR SURVEYS: UNDERSTANDING SURVEY PROCESS

- Pre-Survey Preparation → Before the Survey
- Entrance Interview
- Information Gathering
- Information Analysis
- Exit Conference

During the Survey

- Statement of Deficiencies
- Plan of Correction
- Informal Dispute Resolution
- Appeal

After the Survey

Before The Survey

BEFORE THE SURVEY: BE PREPARED

- Create an internal agency survey team
- Identify best clinicians for home visits
- Know DPH and CMS requirements
- Anticipate documents that will be requested and have them ready
- Ensure personnel files are up to date
- Complete survey administrative forms
- Understand top-cited deficiencies
- Train staff on survey expectations
- Consider external mock survey prior to survey window

During The Survey

DURING THE SURVEY

- Greet the surveyors and show them their work area
- Activate the HHA's survey team
- Usually 2-4 surveyors
- Usually 1-5 business days
- Entrance interview
- Pull required reports and requested documents
  - Timely information gathering is key

DURING THE SURVEY: INFORMATION GATHERING

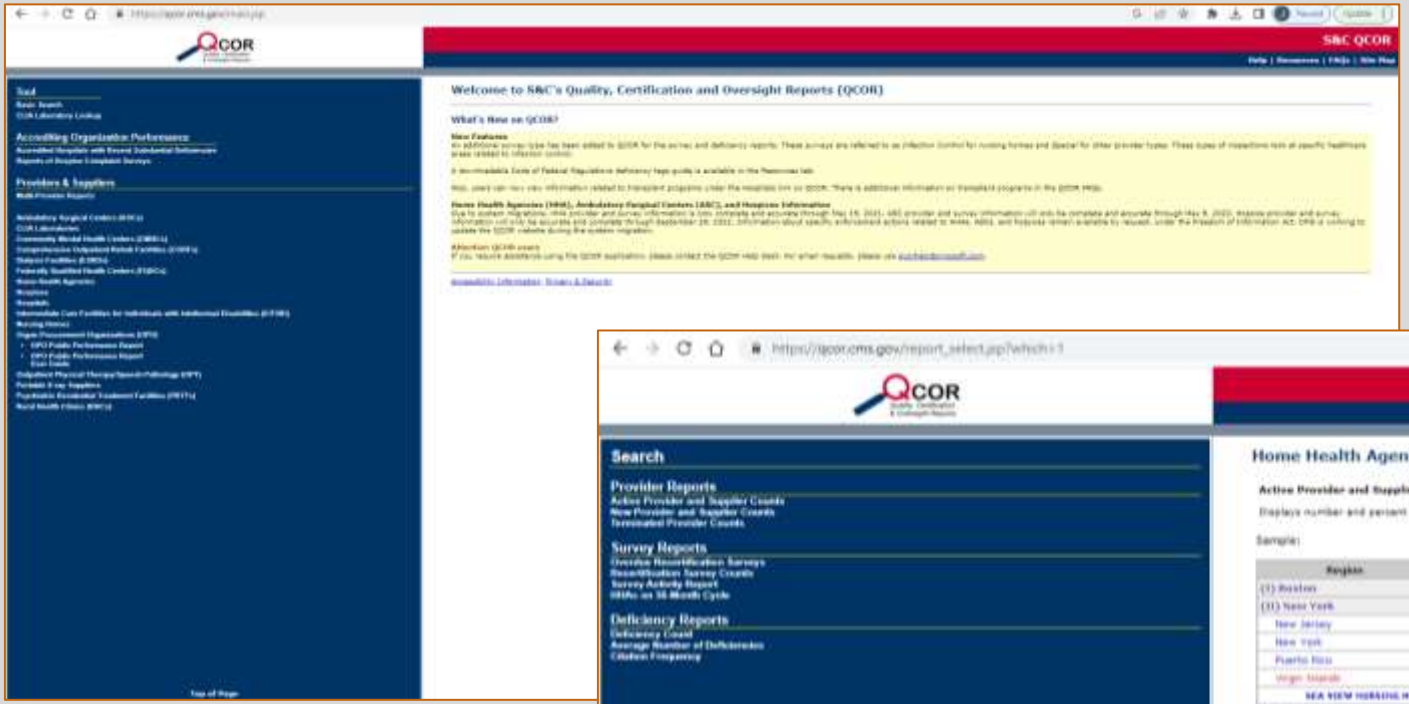
- Clinical records:
  - The number of clinical records without home visits plus the number of clinical records with home visit (based on unduplicated census)
  - Electronic record access
  - Keep duplicates of all copies
- Home Visits:
  - Only with patient's permission
  - Send an additional staff member to escort surveyor
- Staff Interviews:
  - Answer honestly and accurately
  - Post-interview interview

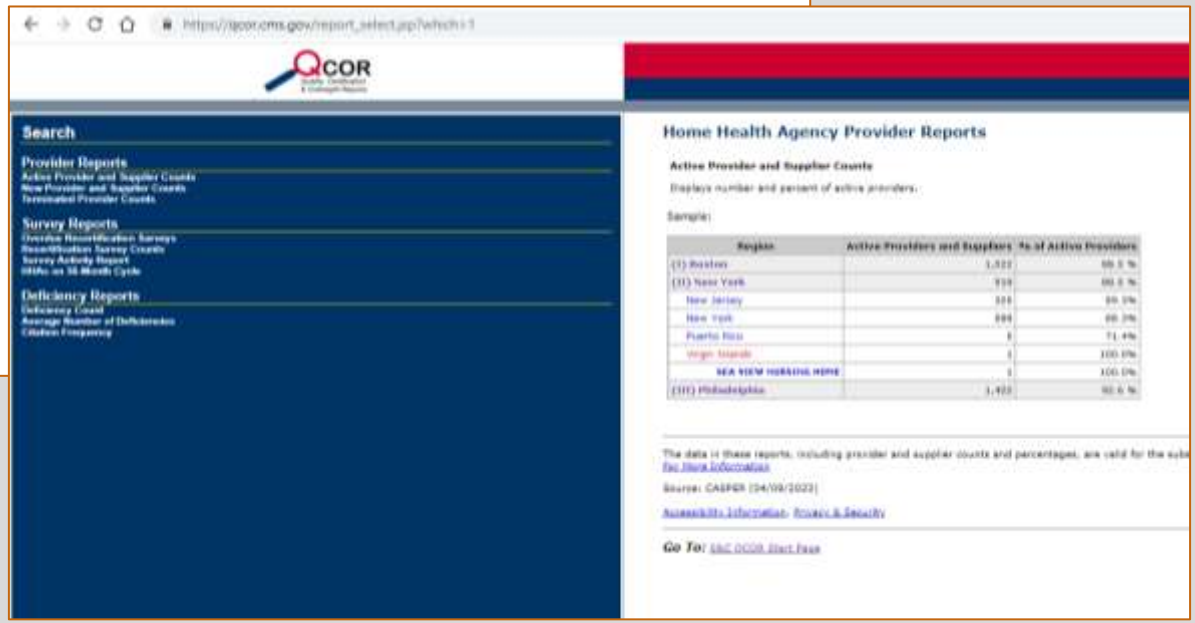
DURING THE SURVEY: INFORMATION ANALYSIS

- Give the surveyors space and be courteous
- Ask questions
- Provide additional documentation as needed
- Be proactive, not passive
- Check to ensure that surveyors have complete information and documentation

DURING THE SURVEY: Exit Conference

- Last day of the survey
- Purpose: To inform the HHA staff of the observations and preliminary findings of the survey, and provide an opportunity for the interchange of information, especially if there are differences of opinion.
- The surveyors are supposed to avoid using data tag numbers when referring to findings, but are supposed to inform the HHA if there are any areas for which further possible deficiency citations may be made offsite after further analysis with team members or the survey supervisor.
- If the provider presents information to negate any of the findings, surveyors should indicate their willingness to reevaluate the findings before leaving the facility.
- **START IMPLEMENTING CORRECTIVE ACTIONS THAT DAY!**


QCOR
S&C QCOR
Welcome to S&C's Quality, Certification and Oversight Reports (QCOR)
What's New on QCOR?


https://qcor.cms.gov/report_select.jsp?whichr=1
QCOR
Search
Provider Reports
Active Provider and Supplier Counts
New Provider and Supplier Counts
Terminated Provider Counts
Survey Reports
Overdue Recertification Surveys
Recertification Survey Counts
Survey Activity Report
HHAs on 36-Month Cycle
Deficiency Reports
Deficiency Count
Average Number of Deficiencies
Citation Frequency
Home Health Agency Provider Reports
Active Provider and Supplier Counts
Displays number and percent of active providers.
Sample:
Region
Active Providers and Suppliers
% of Active Providers
(I) Boston
1,322
99.5 %
(II) New York
939
99.8 %
New Jersey
333
99.0%
New York
594
99.3%
Puerto Rico
8
71.4%
Virgin Islands
1
100.0%
SEA VIEW NURSING HOME
1
100.0%
(III) Philadelphia
1,403
92.6 %
The data in these reports, including provider and supplier counts and percentages, are valid for the subs
For More Information
Source: CASPER (04/09/2023)
Accessibility Information, Privacy & Security
Go To: S&C QCOR Start Page

TOP DEFICIENCIES- HOME HEALTH (FY 2021 National)

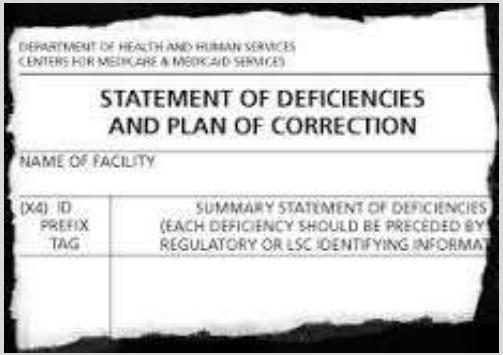
Tag	Tag Description	# Citations (Active Providers=11698)	% Providers Cited	% Surveys Cited (Total Number of Surveys=3994)
G0574	Plan of care must include the following	447	3.0%	11.2%
G0536	A review of all current medications	291	1.9%	7.3%
G0572	Plan of care	263	1.7%	6.6%
G0682	Infection Prevention	242	1.4%	6.1%
G0684	Infection control	197	1.1%	4.9%

2022 TOP DEFICIENCIES - HOSPICE

Tag	Tag Description	# Citations (Active Providers=6913)	% Providers Cited	% Surveys Cited (Total Number of Surveys=1765)
L0545	Content Of Plan Of Care	110	1.5%	6.2%
L0530	Content Of Comprehensive Assessment	107	1.5%	6.1%
L0579	Prevention	97	1.2%	5.5%
L0543	Plan Of Care	96	1.3%	5.4%
L0555	Coordination Of Services	73	1.0%	4.1%

After The Survey

AFTER THE SURVEY: STATEMENT OF DEFICIENCIES


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

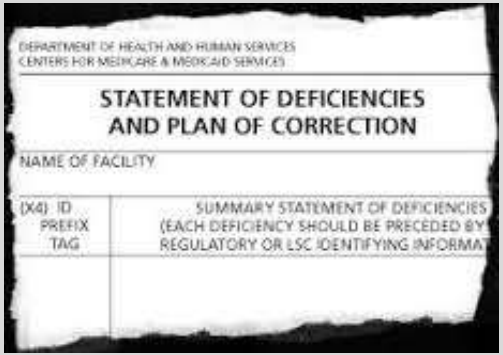
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF FACILITY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA

- Form CMS-2567
- No later than 10 working days after the exit conference
- Standard deficiencies
- Condition level findings
  - *"[W]here the deficiencies are of such character as to substantially limit the [agency's] . . . capacity to furnish adequate care or . . . adversely affect the health and safety of patients"*
- HHA: G tags
- Hospice: L tags

AFTER THE SURVEY: STATEMENT OF DEFICIENCIES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Read it carefully to identify misstated facts:

- Are the facts accurate?
- Did the surveyors miss parts of the record?
- Are interview statements accurate?
- Are policies correctly represented?
- Are there instances where the findings do not support a deficiency?

AFTER THE SURVEY: STATE CITATION LETTER

Connecticut Example

- From DPH
- Outlining violations of the Connecticut licensure regulations
- Compliance office conference may be requested
  - Bring your compliance binder, containing all relevant documentation
  - Note that this meeting can be consolidated with the Informal Dispute Resolution
- Consent order may be requested

AFTER THE SURVEY: PLAN OF CORRECTION (POC)

- Federal and State
- Address the federal POC first (within 10 days of receiving the Statement of Deficiencies)
- Address the deficient practice being cited
- If findings are at the condition or immediate jeopardy (IJ) level, CMS will accept a final copy of the Fed POC in a Word format, along with the first page of the 2567 bearing the Administrator signature, title and date at the bottom

AFTER THE SURVEY: PLAN OF CORRECTION (POC)

- The HHA can state on the POC that it is disputing the alleged deficiency, but still needs to provide the POC in accordance with all instructions
- Disclaimer:

  The filing of this plan of correction shall not be construed as an admission in any forum by this agency, or any of its directors, officers, employees, agents or contractors, as to any of the violations set forth in the Statement of Deficiencies.

AFTER THE SURVEY: SANCTIONS

1. Termination
2. Civil Monetary Penalties (CMPs)
3. Suspension of all Medicare Payments
4. Temporary Management
5. Directed Plan of Correction
6. Directed In-Service Training

Plus . . . Loss of Home Health Aide Training

AFTER THE SURVEY: SANCTIONS

- When may sanctions be imposed?
  - Condition level deficiencies
  - Sometimes a single non-compliant standard can be a condition level deficiency
  - In tandem with termination
  - State Survey Agency makes a recommendation to CMS and CMS makes the final determination

AFTER THE SURVEY: CIVIL MONETARY PENALTIES (CMPs)

- Per Day CMP:
  - Up to $23,011 per day

Starts on the last day of the survey → Ends when substantial compliance with all requirements is reached or the date of termination, whichever occurs first

- **TIME IS OF THE ESSENCE! Watch out for accruing CMPs!**
  - CMPs start accruing BEFORE receipt of the 2567
  - CMPs don't stop accruing until the date that the HHA alleges that it is back in compliance in its POC
  - **This date is chosen by the HHA**
- Only sanction where advance notice is not required

AFTER THE SURVEY: CIVIL MONETARY PENALTIES (CMPs)

- Financial hardship consideration can be requested
- If CMS determines that financial hardship exists, then the CMP will be either reduced, eliminated, or subjected to a payment plan
- Within 15 days of the CMS notice of imposition of penalties, the following must be submitted:

1. Written, dated request specifying the reason financial hardship is alleged
2. Brief summary outlining the reason the documents are being submitted
3. Current balance sheet
4. Current income statements
5. Cash flow statements
6. Most recent full year audited financial statement prepared by an independent accounting form (including footnotes)
7. Most recent full year audited financial statements of the home office and/or related entities (including footnotes)
8. Disclosure of expenses and amounts paid/accrued to the home office and/or other related entities
9. Schedule showing amounts due to/from related companies, or individuals, included in the balance sheets
10. If requesting an extended payment schedule of more than 12 months, a copy of a letter from a financial institution denying the provider's loan request for the amount of the CMP

AFTER THE SURVEY: Suspension of Payment for New Admissions

- CMS is required to consider suspension of payment for any deficiency related to poor patient care outcomes, regardless of whether the deficiency poses immediate jeopardy
- Payments suspended for new admissions or readmissions that are made on or after the effective date of the imposition of the sanction
- Payments for individuals who are already receiving services will continue
- Once suspended, can't be recouped!
- Notice requirement

AFTER THE SURVEY: LOSS OF HOME HEALTH AIDE TRAINING

- An HHA loses its ability to offer a home health aide training program if within the previous 2 years it has been:
  1. Found not in compliance with the requirements of 484.80(b), (c), (d), or (e) (standards related to home health aide training and competency);
  2. Subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of the CMS or the State);
  3. Assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction;
  4. Found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee the management of the HHA; or
  5. Subjected to a suspension of Medicare payments suspended

AFTER THE SURVEY: LOSS OF HOME HEALTH AIDE TRAINING

- Correction of a condition level deficiency does not relieve the 2-year restriction
- If a partial extended or extended survey is conducted, but substandard care (a condition out of compliance) is not found, the HHA would not be precluded from offering its own aide training and/or competency evaluation program
- An HHA may hire or contract for aides who have already completed a training and competency evaluation or competency evaluation program, or arrange for aides to attend a training and competency evaluation or competency evaluation program provided by another entity
- If an HHA, while conducting its own training and competency evaluation program or competency evaluation program, has either a standard, partial extended or extended survey in which it is found to be out of compliance with a Condition of Participation, it may complete that training and competency evaluation program or competency evaluation program for aides currently enrolled, but it may not accept new candidates into the program or begin a new program, for 2 years

AFTER THE SURVEY: INFORMAL DISPUTE RESOLUTION (IDR)

- Upon receipt of the CMS-2567, HHAs may request an informal opportunity to dispute **condition level survey findings**
- Face-to-face meeting
- Does not delay submission of POC
- Also does not delay imposition of penalties (unlike request to appeal CMPs)
- In determining whether or not to request an IDR, consider the impact of deficiencies on public relations, malpractice premiums, payor networks/ACO, five star ratings, and transactions, such as financing or acquisitions

AFTER THE SURVEY: INFORMAL DISPUTE RESOLUTION (IDR)

- Use it or lose it
- Request must be:
  - In writing
  - Specify disputed deficiencies
  - Made within the same 10 calendar day period the HHA has for submitting an acceptable plan of correction
    Standard level deficiencies are not subject to the IDR process
- Not a formal evidentiary hearing
- Counsel may accompany the HHA, but must indicate that in request for IDR

AFTER THE SURVEY: INFORMAL DISPUTE RESOLUTION (IDR)

The Rules:

- May not use IDR to challenge the following:
  - Severity assessment of a deficiency at the standard level that is IJ
  - Sanctions imposed by the enforcing agency
  - Failure of surveyors to comply with a requirement of the survey process
  - Inconsistency of surveyors in citing deficiencies among agencies
  - Inadequacy/inaccuracy of IDR process

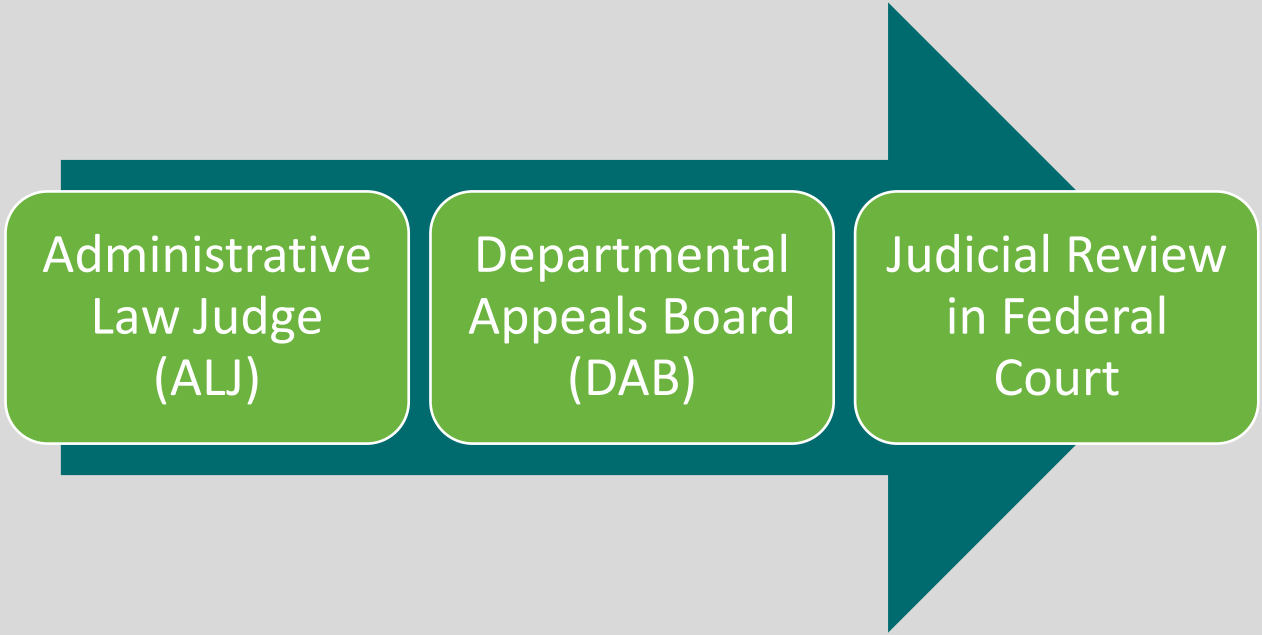
AFTER THE SURVEY: INFORMAL DISPUTE RESOLUTION (IDR)

- If agency's IDR challenge is unsuccessful, DPH must notify the agency in writing
  If agency is successful at demonstrating that a deficiency should be revised/deleted:
  - The citation is marked revised/deleted
  - Signed and dated by the DPH supervisor
  - Any enforcement action imposed **solely** because of that revised/deleted deficiency should be rescinded or adjusted accordingly

AFTER THE SURVEY: INFORMAL DISPUTE RESOLUTION (IDR)

- Pick battles wisely
- Prepare, prepare, prepare
- Submit detailed written factual and legal analysis with supporting documentation
- Consider obtaining affidavits or letters from physicians and others
- Provide copies
- Bring the right people
- Be courteous
- Do not take it personally
- Do not forget about state enforcement

AFTER THE SURVEY: FEDERAL APPEAL PROCESS



AFTER THE SURVEY: FEDERAL APPEAL PROCESS

- What Can you Argue?
  - The facts
  - Designation as a condition level deficiency
    - Was the provider's capacity to furnish adequate care substantially limited?
    - Was there an adverse affect the health or safety of patients?
    - Look to CMS guidance for each G tag individually and for when should cited at the condition level
  - CMP range

AFTER THE SURVEY: FEDERAL APPEAL PROCESS

- A pending hearing does not delay the effective date of a sanction, including termination, against an HHA

- **Except for CMPs**

- Once a hearing is requested, CMPs cannot be collected until there is a final agency determination, however, sanctions may continue to accrue

TO APPEAL OR NOT TO APPEAL?

- Waiver = 35% reduction

- Payment must be made within 15 days of the HHA's receipt of CMS's notice approving the waiver and reducing the CMP

CMS Says:

"The regional office has the authority to settle civil money penalty cases at any time prior to a final administrative decision. If a decision is made to settle, the settlement should not be for a better term than had the HHA opted for a 35% reduction."

ALJ HEARINGS: REQUEST FOR A HEARING

- The request for a hearing must:
  - Be in writing
  - Identify the specific issues of contention
  - Identify the findings of fact and conclusions of the law with which the agency disagrees
  - Specify the basis for contending that the survey findings and determinations were invalid
- Use it or lose it: Must be requested within 60 days of the notice imposing the CMP

ALJ HEARING: PROCESS

- The filing occurs through a web portal **(https://dab.efile.hhs.gov)**
- The request and the initial determination must be filed
- Attorneys must file a written notice of appointment
- After the request is filed, a ALJ and a CMS lawyer are appointed
- Each ALJ has operating procedures that must be followed
- Hearing process is set forth in 42 CFR Part 498
- Negotiation is encouraged
- There is a procedure for ADR
- Must withdraw the request if the appeal is settled

DAB AND JUDICIAL REVIEW

DAB

- Either of the parties has a right to request Departmental Appeals Board review of the ALJ's decision or dismissal order
- Must be filed within 60 days of receipt of the ALJ's notice of decision or dismissal
- A request for review of an ALJ decision or dismissal must specify the issues, the findings of fact or conclusions of law with which the party disagrees, and the basis for contending that the findings and conclusions are incorrect

Judicial Review

- If dissatisfied with the DAB decision, the provider is entitled to judicial review
- Federal court
- Must commence civil action with 60 days of receipt of the notice of the DAB decision

Fraud Enforcement Update

OVERVIEW OF ENFORCEMENT 20-23

Hospice

- 14 hospice civil settlements
- FCA and CMPL
- Conduct includes:
  - Non-covered hospice services
  - Claims for services provided by unlicensed individuals / **non-active or expired licenses**
  - Services for patients not eligible or not qualified for hospice
  - Services lacked recertifications of terminal illness
  - Services provided to benes who did not qualify
  - Services provided by unqualified social worker
  - Unlawful kickbacks to referring physician - **AKS**

Home Health

- 17 home health civil settlements
- FCA and CMPL
- Conduct includes:
  - Claims for home health services based on orders signed by a qualified clinician but not cosigned by a physician or allowed practitioner
  - Services provided by **non-active licenses**
  - Employed an individual excluded from participating in any federal health care program
  - Paid kickbacks to referring physicians –**AKS**
  - Failure to timely repay overpayments
  - Skilled nursing home health billed at higher rates

SETTLEMENTS – HOSPICE

SETTLEMENT AGREEMENTS	PARTIES & REPRESENTATIVES	ORIGIN OF COMPLAINT	TYPE OF ENTITY	ALLEGED VIOLATION	DOCKETS	COURT	AMOUNT	SUMMARY OF ALLEGATIONS	CIA	EFFECTIVE DATE
☐ 1. Familia Healthcare Services, Inc. d/b/a Del Cielo Hospice and Palliative Care	**Familia Healthcare Services, Inc. d/b/a Del Cielo Hospice and Palliative Care** **Andres Elizondo II** *Brian G. Flood, Husch Blackwell LLP* **Relator:** **Katie Hougham** *Amanda Bridson, Sumner Schick LLP*	Whistleblower	Hospice, Director, President	Billing For Medically Unnecessary Services, Failure To Meet Coverage Requirements, Medical Billing Fraud	2:19-cv-00351	U.S. District Court, Southern District of Texas	$990,478	A hospice services provider allegedly billed Medicare for hospice care services for patients who were not eligible for, and did not qualify for hospice care benefits.	No	08/11/22
☐ 2. Geisinger Community Health Services	**Geisinger Community Health Services** *Robert Ramsey, Buchanan Ingersoll & Rooney, P.C.*	Self-Disclosure	Home Health Agency, Hospice	Failure To Meet Coverage Requirements		U.S. District Court, Middle District of Pennsylvania	$18,513,621	A company that provides hospice and home health care services to Medicare beneficiaries through several affiliated entities self-disclosed that the company billed Medicare for: (1) hospice services that violated the applicable Medicare rules and regulations regarding physician certifications of terminal illness and patient elections of hospice care; and (2) home health services that violated the applicable Medicare rules and regulations regarding physician face-to-face encounters with home health patients.	No	10/28/21

SETTLEMENTS – HOSPICE

☐ 3. Carrefour Associates, LLC	**Carrefour Associates, LLC** **Crossroads Hospice of Cincinnati, LLC** **Crossroads Hospice of Cleveland, LLC** **Crossroads Hospice of Dayton, LLC** **Crossroads Hospice of Northeast Ohio, LLC** **Crossroads Hospice of Tennessee, LLC** *Michael E. Paulhus, King & Spalding LLP* **Relator:** **Leanne Robinson** **Relator:** **Angela Corman** **Relator:** **Jackie Ann Morgan** *Donald Gallick, Law Office of Donald Gallick, LLC* **Relator:** **David Weber** *Janel Quinn, The Employment Law Group*	Whistleblower	Practice Management Company, Hospice	Failure To Meet Coverage Requirements, Medical Billing Fraud	16-02684, 15-cv-00460	U.S. District Court, Southern District of Ohio	$5,500,000	A corporation that provides administrative, management, and back-office support to various related corporate entities that provide hospice and palliative care services allegedly billed Medicare for non-covered hospice services. Specifically, the company allegedly billed Medicare for hospice services provided to beneficiaries with a terminal diagnosis of Alzheimer's disease or dementia who received hospice services for three years or longer but who were ineligible for hospice care under Medicare requirements.	No	10/28/21	Hospice Group Settles False Claims Allegations for $5.5 Million

NON-COVERED SERVICES

Summit Hospice to Pay Over $1M to Settle False Claims Liability
March 3, 2023

Crossroads Hospice Agrees to Pay $5.5 Million to Settle False Claims Act Liability
November 23, 2021

HEIGHTENED LEVELS OF CARE

New York Hospice Provider Settles Civil Healthcare Fraud Allegations / Metropolitan Jewish Health System Hospice to Pay $5.2 Million (EDNY)
August 19, 2020

Metropolitan Jewish Health System Hospice and Palliative Care ("MJHS Hospice"), a New York nonprofit hospice provider, has agreed to pay the United States $4,850,000 to resolve civil allegations that it billed Medicare and Medicaid for services rendered to hospice patients at heightened levels of care for which the patients did not qualify, in violation of the False Claims Act, and has agreed to pay the State of New York $375,000.

VIOLATIONS OF THE ANTIKICKBACK STATUTE

Oklahoma City Home Health Company and Two Former Corporate Officers Agree to Pay $22.9 Million to Settle Federal False Claims Act and Kickback Allegations Arising From Improper Payments to Referring Physicians
October 18, 2022

Allegations that Carter Healthcare wrongfully paid physicians to induce referrals of home health patients under the guise of medical directorships, resulting in the submission of false claims to the Medicare and TRICARE programs

FALSE CERTIFICATIONS

Physician pays nearly half million dollars to resolve home health care fraud allegations
March 18, 2021 (SD TX)

A doctor of osteopathic medicine from Bellaire has paid to resolve allegations he falsely certified patients for home health services and received improper payments. Truc Le, 51, is a primary care physician in southwest Houston. In 2016, authorities began an **investigation into a home health agency** known as Unified Medical Group Inc. That investigation appeared to show **Le had certified patients for home health services without any knowledge of the patients' medical condition or homebound status**. Instead, Le signed forms that Unified representatives provided to him on a regular basis... Le has agreed to pay $475,000 to resolve the allegations.

COVID-19

MorseLife Nursing Home Health System Agrees to Pay $1.75 Million to Settle False Claims Act Allegations for Facilitating COVID-19 Vaccinations of Ineligible Donors and Prospective Donors

June 30, 2022

$1.75 million to resolve potential liability under the False Claims Act for facilitating COVID-19 vaccinations for hundreds of individuals ineligible to participate in the Centers for Disease Control and Prevention's (CDC) Pharmacy Partnership for Long-Term Care Program (LTC PPP), a program specifically designed to vaccinate long-term care facility (LTCF) residents and staff when doses of COVID-19 vaccine were in limited supply at the beginning of the CDC COVID-19 Vaccination Program. MorseLife is a not-for-profit corporation located in West Palm Beach, Florida, that oversees health care facilities on its campus, including a nursing home and an assisted living facility.

VOLUNTARY DISCLOSURE

Geisinger Community Health Services Agrees To $18 Million Civil Settlement
November 1, 2021 (MD PA)

$18,513,621.05 to resolve allegations of civil liability for submitting claims to Medicare for hospice and home health services that violated Medicare rules. GCHS **voluntarily disclosed the violations**. Between January 2012 and December 2017, GCHS submitted claims to Medicare that violated Medicare rules and regulations regarding **physician certifications of terminal illness, patient elections of hospice care, and physician face-to-face encounters with home health patients**. After it discovered the problems, **GCHS took corrective action and disclosed the matter** to the United States Attorney's Office.

"The $18 million payment in this matter reflects the priority healthcare providers should place on making sure they closely follow all Medicare rules and regulations."

IMPORTANCE OF ACCOUNTABILITY

USA from MDPA:

"Healthcare fraud remains a focus of the DOJ and the ACE Unit of the USAO. I **commend** GCHS for taking this seriously, voluntarily disclosing these issues to our office and working to address the problems that led to these violations."

IMPORTANCE OF PATIENT CARE

USA from NDGA:

"Hospice is not a blank check for unscrupulous medical providers willing to admit patients who are not terminally ill."

"It is reserved for those who truly need it. We will also continue to **prioritize cases** where it appears that a medical decision, especially **the decision to forego curative treatment, has been influenced by a kickback**."

QUESTIONS?

This presentation is a summary of legal principles.
Nothing in this presentation constitutes legal advice, which can only be obtained as a result of a personal consultation with an attorney.
The information published here is believed accurate at the time of publication, but is subject to change and does not purport to be complete statement of all relevant issues.

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