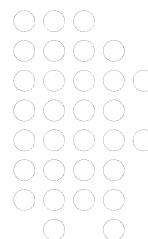


Home Care and Hospice: Compliance Update: 2014

Health Care Compliance Association

William A. Dombi
Vice President for Law
National Association for Home
Care & Hospice
March 31, 2014



COMPLIANCE: FOCUS ON HOME CARE & HOSPICE

- All enforcement entities looking at home care
 - Billing for services actually rendered
 - Medical necessity
 - Technical compliance/documentation
- High level fraud/False Claims Act investigations
- OIG continues home care efforts
 - Medicaid home care new on the agenda
 - Staff credentials including health screening a target
- Hospice honeymoon is over
- Unique business compliance issues
 - ACA Employer Mandate
 - Fair Labor Standards ACT

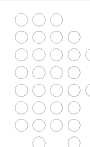


Affordable Care Act: What is in store for home care?



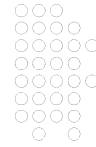
- Employer mandate
 - New issues?
 - Redefine “full-time”
 - Ongoing litigation?

ACA Employer Mandate: Home Care Impact



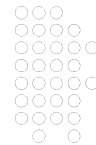
- Many, but not all HHAs have comprehensive health insurance
 - \$3000 per non-insured penalty a risk
- Most Medicaid home care providers do not have health insurance for employees
 - \$2000 per FTE penalty a risk
- Private pay home care companies rarely have employee health insurance
 - \$2000 per FTE penalty a virtual certainty

Employer Mandate: Options



- **CHANGE THE LAW!!!!**
 - Redefine full time to 40 hours per week (30 is current standard)
- **Stay below 50 FTEs and/or 30 full time employees**
 - Corporate re-organization to break up large companies into multiple small ones not an option
- **Limit the number of employees at 30 hours or more per week**
- **Offer bare bones, qualified health plan**
- **Seek higher Medicaid rates (good luck!)**
- **Raise charges to clients (tough sell)**

Private Pay Home Care: Companionship Services FLSA Exemption



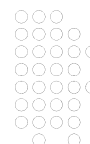
- **DoL rule effectively eliminates minimum wage and overtime exemption**
 - Eliminates exemption for 3rd party employment
 - Changes definition of companionship services
 - Excludes 3rd party employers from live-in exemption
 - Medicaid and disability rights advocates opposition
- **Increased litigation on W&H issues**
 - Validity of claimed FLSA exemption status
 - “hours worked”
 - Break time rights

Medicaid Home Care Compliance Risk Areas



- **New compliance efforts in Medicaid home care nationwide likely related to growth in spending**
- **Dual-eligibles (Medicare maximization)**
 - **Pre-payment conditions such as a full Medicare denial**
 - **Post-payment claim by claim review with Medicare claim submissions required**
- **Private duty nursing: pediatric and adults**
 - **Frequency and duration**
- **Personal care services**
- **Hospice**

OIG Oversight Activity



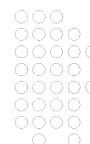
- **OIG Workplan (Medicaid Home Care)**
 - **Medicaid home care worker screenings**
 - **Medicaid home health claims and CoP compliance**
 - **CMS policies on Medicaid homebound requirements**
 - **HCBS: oversight of care quality**
 - **HCBS: vulnerabilities in providing services**
 - **HCBS: State administrative costs**
 - **Medicaid Personal Care Services**
 - **Home Health Services—Duplicate Payments by Medicare and Medicaid)**
 - **Hospice Services—Compliance With Reimbursement Requirements**
 - **State Procedures for Identifying and Collecting Third-Party Liability Payments**
 - **State Compliance With the Money Follows the Person Demonstration Program**

Medicaid Home Care Target Areas



- **CLAIMS**
- **SERVICES RENDERED**
- **FALSE BILLINGS**
- **STAFF CREDENTIALS**
- **REFERRAL KICKBACKS**

TARGET: CLAIMS



- **UTILIZATION**
- **AUTHORIZATION OF CARE**
- **COMPLIANCE/CONSISTENCY WITH APPROVED PLAN OF TREATMENT**
- **DOCUMENTATION**
- **TECHNICAL REQUIREMENTS**

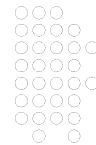
TARGET: UTILIZATION



- **Data analysis to target provider utilization**
 - **Aberrant patterns outside the norm**
 - **Statistical deviation**
 - **Percent increase billing, payment, number visits/services**
 - **High utilization services/items**
 - **High cost services/items**

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F2F Oversight



- **ACA requires F2F on Medicaid home health**
- **CMS yet to promulgate F2F Medicaid rule**
- **States may implement F2F on their own**

Medicaid Personal Care



- **OIG audit focus**
 - North Carolina,
<http://oig.hhs.gov/oas/reports/region4/41004003.pdf> (\$41.71M) Audit (A-04-10-04003, June 2011)
 - Missing documentation
 - Services not in accordance with plan of care
 - No supervisory nursing visits
 - No verification caregiver qualifications
 - No physician order

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Medicaid Personal Care



- Washington State,
<http://oig.hhs.gov/oas/reports/region9/90900030.pdf> Audit (A-09-09-00030, June 2011)
 - No timesheets supporting daily service
 - Billed more hours than on timesheets
 - Training deficiencies

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Medicaid Personal Care



- Attendants whose qualifications were not documented, <http://oig.hhs.gov/oei/reports/oei-07-08-00430.pdf> - 10 State review: CA, FL, GA, IL, IA, NE, NY, OH, TN, WV
- NYC, <http://oig.hhs.gov/oas/reports/region2/20701054.pdf> Audit (A-02-07-01054, June 2009)
 - No medical professional exam of beneficiary before service
 - No nursing assessment
 - No nursing supervision
 - No physician's order
- N.Y. State, <http://oig.hhs.gov/oas/reports/region2/20801005.pdf> Audit (A-02-08-01005, Oct. 2010)
 - Same as above for NYC and
 - No in-service training for aide
 - Time with patient not documented

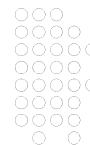
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Medicaid Hospice Risk Areas



- Billing for Medicaid personal care to a Medicare hospice patient
- Medicaid billing for services and items covered under Medicaid hospice benefit
 - Pharmaceuticals
 - Ambulance
- State Medicaid payment reductions that reflect beneficiary contribution obligation
 - <http://www.oig.hhs.gov/oas/reports/region1/11000004.a> sp.
 - OIG found that Massachusetts Medicaid did not reduce hospice payments to reflect "spend down" patients' contribution obligation

ENFORCEMENT ACTIVITY



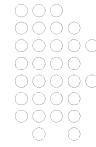
- Pure fraud
- Fraud, kickbacks, false records, and more
- Non-compliance
- Documentation weakness

PURE FRAUD



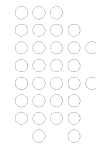
- SERVICES NOT RENDERED
 - Agency model
 - Owner
 - Employee
 - Owner + employee
 - Agency + client
 - Individual Provider (IP) model
 - Worker
 - Personal care attendant
 - Nurse
 - Worker + client
 - Client
 - Family

Fraud, kickbacks, false records, and more



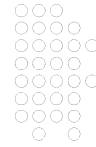
- Falsified credentials
- False care records
- Kickbacks for referrals/enrollment
- Bribes
- Client endangerment

NON-COMPLIANCE



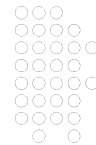
- Provider qualifications
 - Unqualified caregivers
 - Excluded caregivers
- Ineligible clients
- Utilization
- Conformance with care plan

DOCUMENTATION



- Provider qualifications
- Service provision
- Claims accuracy

PROGRAM INTEGRITY: OPERATIONAL IMPROVEMENTS



- What is working, what is not

- Time and attendance
- Staff credentialing
- Care plan compliance
- Service documentation
- Policies and procedures
- Staff training and oversight
- Internal auditing

MEDICARE COMPLIANCE: FOCUS ON HOME CARE



- ZPICs and RACS looking at home care
 - Homebound status
 - Medical necessity
 - Technical compliance incl. F2F
- High level fraud/False Claims Act investigations
 - E.g., \$375M physician-directed fraud allegation
- OIG continues home care efforts
 - New report alleges widespread fraud and abuse
 - Report is weak on facts and methodology, strong on hyperbole
- Medicare hospice is new on the agenda

MEDICARE HOSPICE



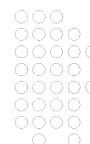
- FY2014 rates (October 1, 2013)
 - 1.7% MBI update
 - 0.3% MBI reduction under ACA
 - 0.5% Productivity adjustment reduction
 - Continued phase-out of the BNAF (approx impact of .7)
- New Payment Model is still in development (no earlier than October 2014)
 - U-shaped payment distribution
 - Site of service adjustment
 - Routing home care rebased rates
- Claims oversight increasing

Medicare Hospice



- **Hospice face-to-face rule**
- **Terminal illness documentation**
- **New Cost report**
- **Hospice and the nursing facility resident**

Medicare Hospice: OIG Focus



- **Hospice to residents of ALFs**
- **Hospice General Inpatient Days**
- **Hospice Marketing Practices and Financial Relationships with Nursing Facilities**

Home Health Regulatory Compliance Issues



- HPPPS 2014 rule
- Face to Face rule
- Therapy Assessment rule
- PECOS
- Medicare “improvement” standard lawsuit
- New Medicare CoP sanctions
- New ABN
- Moratorium on new HHAs

2014 Medicare Home Health Rate Final Rule



- CMS Proposed Rule (July 3, 2013) <http://www.gpo.gov/fdsys/pkg/FR-2013-07-03/pdf/2013-15766.pdf>
- CMS Final Rule (December 2, 2013) <http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28457.pdf>
- Rebased payment rates
 - Full cut (3.5%) allowed under law (14 points total)
 - Recalibrated case mix weights
 - Limits increases in LUPA visit rates
 - “average cost” calculation
- Outlier eligibility remains same despite low spending
- Remember 2% payment sequestration (February 1 and later payments)
- Remember wage index changes (net reduction of \$30M in expenditures)

2014 Medicare Home Health Rate Final Rule: Assessment



- **CMS chose unfavorable calculation method**
 - **Used proxies for episode revenue and costs**
- **Better alternatives available**
- **Ignored cost increases and costs not on cost report**
 - **Telehealth**
 - **F2F; therapy assessment**
- **Silo-ed rebasing rather than aggregation**
- **Failed to include capital needs**

Face to Face Physician Encounters



- **Revisions 2013**
 - **Allow facility-based NPP to perform encounter**
 - **Require communication with the physician with whom collaborating (i.e. inpatient or community)**
 - **Allow the facility-based physician to complete the F2F and either certify or communicate findings to the certifying physician in the community**
 - Documentation title and date**
 - **Allow any party to title and date F2F documentation**

Who Are F2F Inpatient Physicians



- Physicians caring for patient during:
 - Acute care stay
 - Post acute inpatient stay
 - ED visit
 - Observation stay at an acute care facility

Includes

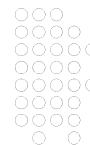
- Residents (however documentation and communication via supervising physician)

F2F Documentation



- Face-to-face description should be a brief narrative describing the patient's clinical condition and how the patient's condition supports homebound status and the need for skilled services.
 - Standardized language prohibited (e.g. considerable and taxing effort)
 - Diagnosis alone is not sufficient to support skilled services
- CMS example
 - "The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new COPD medical regimen."

Inpatient F2F Encounter No Certification



- **Communication of clinical information from medical record to community physician (i.e. verbal, clinical notes, discharge summary, referral, etc.)**
 - Information compilation may be by inpatient support staff
 - Community physician may obtain supplementary information via phone, email, if needed
- **Community physician may “adopt” the document as his /her own encounter document but must sign and dates the documents(s)**
 - CMS will allow the certifying physicians to “adopt” an allowed NPPs clinical notes
- **Community physician creates the F2F encounter document based on the facility physician’s encounter findings**
 - Note: Inpatient physician or NPP signature not required

Inpatient F2F Encounter with certification



- **Facility–based physician**
 - **Completes the F2F encounter document based on his/her findings or the findings of an NPP**
 - **Information compilation may be by inpatient support staff**
 - **Signs and dates the document ; “hands off” to community physician**
 - **Signature not required by the physician who signs the POC**

Requirements for Home Health Services Certification



- **Certification**
 - **Physician certifies eligibility for home health services**
 - The home health services are or were needed because the patient is or was confined to the home
 - The patient needs or needed skilled services ;
 - A plan of care has been established and is periodically reviewed by a physician; and
 - The services are or were furnished while the patient is or was under the care of a physician.
 - **Includes F2F attestation**

F2F Certification Statement(s)



- 42 CFR 424.11 General procedures.
- (a) *Responsibility of the provider.* The provider must—
- (1) Obtain the required certification and recertification statements;
- (2) Keep them on file for verification by the intermediary, if necessary; and
- (3) Certify, on the appropriate billing form, that the statements have been obtained and are on file.
- (b) *Obtaining the certification and recertification statements.* No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form.....
- (c) *Required information.* The succeeding sections of this subpart set forth specific information required for different types of services. If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found.

Other important considerations



- Checkboxes created by the physician are acceptable
- Home health agencies may not create, transcribe, add to , or alter F2F documentation
- F2F samples may not be patient specific
- Start of Care may be revised if late encounters
 - Count back 30 days
 - Realignment of SOC: may use original OASIS, updated
 - Delete original OASIS
 - Realignment of SOC due to late F2F requires realignment of therapy 13 and 19

F2F



- **MLN Clarification on documentation:**
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1405.pdf>
 - Not very helpful
- **Lawsuit???**
 - Excess documentation in relation to ACA requirements
 - Failure to provide adequate and clear guidance on acceptable documentation

Therapy Reassessment



- For late assessments, the visit on which the reassessment is conducted will be covered
- The visit prior to the late reassessment will not be covered
 - Reassessment conducted on visit 14
 - Visit 14 will be covered but not visit 13
- In single therapy cases reassessment must be conducted on the 13th /19th therapy visit
- In multi-discipline cases:
 - Each discipline must conduct a reassessment on therapy visit 11, 12, or 13
 - Each discipline must conduct the reassessment on therapy visit 17, 18, or 19 for each discipline
 - Non-coverage will apply only to the discipline that fails to conduct the reassessment on time
 - Reassessments may be conducted on the visit closes to , but no later than the 13/19th therapy visit, if there is no scheduled visit for that discipline within the required time frame.

MEDICARE HOME HEALTH: Alternative Sanctions



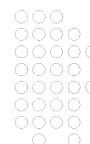
- Applies to condition level deficiencies
- Sanctions include:
 - Directed corrective action
 - Temporary management
 - Payment suspension
 - Civil monetary penalties
 - \$500-\$10,000
 - Per diem/per instance
 - Termination
- Informal dispute resolution possible
- CMPs and payment suspension no earlier than 7/1/14,
- Appeal rights w/o penalty suspension

The New Survey and Sanctions Rule



- **77 Fed. Reg. 67068 (November 8, 2012)**
- **Codifies HHA survey process**
- **Establishes intermediate sanctions**
 - **Civil money penalties and payment suspensions effective 7-1-14**
 - **Other sanction effective 7-1-13**
- **Establishes Informal Dispute Resolution process**
 - **Effective 7-1-14**

Alternative Sanctions: 488.800 et seq.



- **Condition-level deficiencies only**
 - **Repeat standard-level deficiencies may trigger condition-level finding**
- **CMS developing detailed guidance on sanction process in SOM**
 - **Progressive action approach**
- **Sanction determinations made by CMS RO**
 - **Survey recommendations**
 - **State agency recommendations**
- **No CMP funds can be used to finance survey activities**
 - **Avoids “bounty hunter” risk**

General Provisions: 488.810



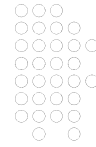
- Sanctions imposed only for condition-level deficiencies
- Accrediting Organizations report condition-level findings to CMS RO
 - Sanctions lead CMS and SA to take over oversight and enforcement
- Branch deficiencies counted against parent
- Subunit deficiencies do not apply to parent
- All deficiencies require a Plan of Correction
 - CMS approval required
- Written notification of intent to impose sanction
- Appeal rights under 42 CFR Part 498
 - Penalties accrue during appeal, but collection delayed

Sanction Factors: 488.815



- Choice reflects “the impact on patient care and the seriousness of the HHA’s patterns on noncompliance
- Whether deficiencies pose immediate jeopardy to patient health and safety
- The nature, incidence, degree, manner, and duration of the deficiencies
- The presence of repeat deficiencies; compliance history in general and specific to cited deficiencies
- Whether deficiencies directly relate to patient care
- Whether the HHA is part of a larger organization with documented problems
- Whether the deficiencies indicate system wide failure

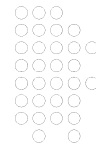
Available Sanctions: 488.820



- **Civil Money Penalties (CMP)***
- **Suspension of payment on new admissions***
- **Temporary management***
- **Directed plan of correction****
- **Directed in-service training****

- *** required by statute**
- **** required by regulation**

Civil Money Penalties: 488.845



- **Per instance CMPs: \$1000-\$10,000**
- **Per day CMPs: \$500-\$10,000; three tiers**
- **Factors considered**
 - **488.5 factors**
 - **Size of the HHA**
 - **Accurate and credible resources such as PECOS, cost reports, claims information providing information on operations and resources of HHA**
 - **Evidence of built-in, self-regulating quality assessment and performance improvement system**
- **Discretion to increase or decrease CMP at revisit**

Civil Money Penalties: 488.845



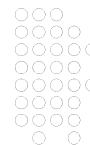
- **Penalty start**
 - **Per-day: day of the survey that identified noncompliance**
- **Penalty ends: date of correction of all deficiencies/date of termination**
 - **Correction=revisit survey finding date**

Civil Money Penalties: 488.845



- **Appeal Rights: 42 CFR Part 498**
- **CMPs held pending outcome, but still accruing during appeal**
 - **Payment due 15 days after final administrative decision**
- **Written request for hearing w/in 60 days of notice**
- **Waiving right to appeal reduces CMP 35%**
 - **Payment due w/in 15 days of waiver request receipt**
- **IDR option**
 - **Request w/in 10 days of notice of penalty**
- **CMP may be offset against Medicare or Medicaid payments**

PECOS



- ACA and regulation requires all home health certifying and ordering physicians be enrolled in Medicare
- Medicare requires an approved enrollment record in PECOS
 - HHAs only have access to “ordering and referring” file
- Physician name and NPI as they appear in PECOS on the claim
- Edit effective with SOC January 6, 2014
 - Watch for expanded enrollment focus in claims reviews

PECOS



- Full Implementation of Edits Set for January 6, 2014.
- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf>
- See also
- 8441 : Home Health Agency Reporting Requirements for the Certifying Physician and the Physician Who Signs the Plan of Care - Effective July 2014
- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2789CP.pdf>
- 8356: Handling of Incomplete or Invalid Claims once the Phase 2 Ordering and Referring Edits are Implemented
- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2767CP.pdf>

Medicare coverage guidelines



- *Jimmo v Sebelius* settlement
- <http://www.medicareadvocacy.org/wp-content/uploads/2012/12/Jimmo-Settlement-Agreement-00011764.pdf>.
- Focused on illegal “improvement” standard
- CMS is clarifying existing guidelines; provider education will follow
- Permit coverage of skilled maintenance therapy
- Permit coverage of chronic care/terminal patients
- Existing guidelines recognize such coverage but MACs changed the “rules”

Implementation Game Plan



- CMS clarified guidelines with specific prohibition of an improvement standard (w/in 6 months) <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf>
- Training of Medicare contractors and providers (following issuance of guidelines)
- Reopening of select claims denied since 1/11
- Ongoing oversight of claim determinations

Medicare Home Health Oversight Target Areas



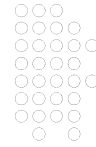
- False Claims
- Homebound
 - Absences documented or reported by patient
 - Conflicting documentation
- Medical Necessity
 - Therapy is a big target
 - Improper “improvement” standard
 - Documentation weakness on skilled nature of care
- Coding
 - diagnoses
- Face-to-Face Encounter
- Therapy Assessments

Medicare Home Health: OIG Focus



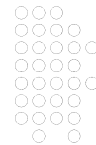
- Workplans
 - Home health Prospective Payment System requirements
 - Employment of individuals with criminal convictions
 - Home health face-to-face physician encounter requirements
 - Missing OASIS
 - Trends in Revenues and expenses

Recent Enforcement Activity



- DOJ very active in certain states, including MI, IL, FL, and TX
- Indictment of Texas physician and 6 HHAs for false claims and billing for unnecessary or non-provided care
- Indictment of FL owners, administrators, nurses, and physicians for billing unnecessary care
- Indictment of IL owners and marketers for referral kickbacks

Claims



- MAC, RAC, ZPIC
- MAC
 - Pre-payment review for new providers
 - Pre-payment edits
 - Target providers
 - High volume services
 - High cost
 - RAC, OIG, CERT, GAO identify vulnerability

Claims

- **Data analysis to target providers**
 - **Claims**
 - **Aberrant patterns outside the norm**
 - **Statistical deviation**
 - **Percent increase billing, payment, number visits/services**
 - **High utilization services/items**
 - **High cost services/items**

5

RAC Approved HH Issues

- **Region C: Connolly, Inc.**
- **States: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands**
 - **Home Health Agency - Medical Necessity and Conditions to Qualify for Services: Complex**
 - **RAP claim without corresponding home health claim: Automated**
 - **Incorrect billing of Home Health Partial Episode Payment claims: Automated**
 - **Validation of late episode timing: Automated**
 - **Core-based statistical area: Automated**
 - **Hospice related services billed with Condition code 07- Home Health: Automated**
 - **Non-Routine Medical Supplies and Home Health Consolidated billing: Automated**

HHABN



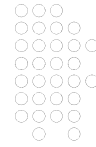
- No change in policy
- ABN CMS-131 for financial liability protection
 - Replaces Option Box 1
- Home Health Change of Care Notice (HHCCN)
 - prior to reducing or discontinuing care related HHA reasons
 - Prior to reducing or discontinuing care related to physician orders
 - New form replaces Option BOX 2 and Option Box 3
- Mandatory December 9, 2013
- <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html>

Confined to the Home



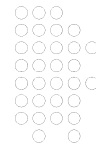
- Change Request 8444
- Clarifies that homebound must met both:
 - 1) The individual has a condition due to an illness or injury that restricts his or her ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.
 - AND
 - (2), the condition of the patient should be such that there exists a normal inability to leave home and, consequently, and leaving home would require a considerable and taxing effort.

Moratorium on New HHAs



- **January 31, 2014---6 months**
 - **Miami – Dade, FL and Cook County (Chicago area) extended**
 - **Fort Lauderdale, Detroit, Dallas, and Houston added**
 - **New providers**
 - **Branches included**

HIPAA Breach



- Home Health and Hospice agencies are particularly vulnerable to breaches due to the nature of the business
 - Stolen and lost lap tops /records

Program Integrity Proposals



- Implement a targeted, temporary moratorium on new home health agencies
- Require credentialing of home health agency executives
- Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care
- Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan
- Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment , prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors

Program Integrity Proposals



- Establish targeted systemic payment safeguards focused on abusive utilization of home health services
- Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries
- Require criminal background checks on home health agency owners, significant financial investors, and management
- Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight
- Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of program standards

CONCLUSION



- Home Care and Hospice is diverse
- Range of legal/regulatory issues is endless
 - **Significant regulatory energy directed towards home care and hospice**
 - **Compliance issues/concerns**
- Center of innovation in care is home care; change triggers action