Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting

Thursday, September 3, 2026
Crockett AB Room
1:30pm-2:30pm

5c. Fraud, Waste and Abuse---A Look Under the Microscope

Presented by:

Heidi Kocher, J.D., M.B.A., C.H.C., Esq, Liles Parker
Jennifer Papapanagiotou, Partner, Liles Parker

Thank you to our Partners:

Vesta®
HHAeXchange
MAC LEGACY
KanTime How better happens.
United Healthcare Community Plan
AXXESS

1

DISCLAIMER

The materials in this presentation are intended for general informational purposes only and do not constitute legal advice or create an attorney-client relationship. Attendees are encouraged to seek advice from independent legal counsel regarding their individual legal matters.

2

2

Today's Agenda

1 **The Enforcement Reality**

Why 2026 has become the most intense enforcement year in home health, hospice, and PAS history — including the August 13 NFED memo and the Takedown

2 **The Legal Foundation**

The federal fraud-and-abuse statutes, AKS safe harbors, Stark exceptions, and OIG Advisory Opinions every agency must know

3 **The Seven Elements**

OIG's General Compliance Program Guidance (GCPG) framework, applied to your agency

4 **Sector-Specific Risk & Action Steps**

Home health, hospice, and PAS risk areas — including Palmetto GBA's top denial patterns — plus a 90-day roadmap

2

3

PART 1

The Enforcement Reality

The most concentrated health care fraud enforcement environment in program history — through August 19, 2026

3

4

The 2026 National Health Care Fraud Takedown

Announced June 23, 2026 — the largest whole-of-government health care fraud enforcement action in DOJ history

455

Defendants charged, including 90 doctors and licensed medical professionals

$6.5B+

In alleged false claims across the operation

56 / 45

Federal districts / states & territories involved

50

State Medicaid Fraud Control Units participated — most in history

1,079 / 1,403

Providers suspended / had billing privileges revoked by CMS

$182M+

In cash, vehicles, jewelry, and other assets seized

Source: U.S. DOJ Office of Public Affairs, June 23, 2026

5

CASE STUDY

Hospice Fraud & Outlier-Metric Manipulation

Central District of California — $27.7M scheme

- A hospice owner and two marketers were charged in a $27.7 million Medicare fraud scheme built on enrolling patients who were not terminally ill.
- Concerned that CMS used data analytics to monitor live-discharge rates as a fraud indicator, the owner allegedly paid funeral home employees $1,000–$3,000 per name for recently deceased Medicare beneficiaries' information.
- The defendant then billed Medicare for hospice services for those deceased individuals and created fake, back-dated records claiming a physician visit — specifically to lower his outlier data metrics and evade detection.

Compliance takeaway: live-discharge rate monitoring is now an explicit government fraud signal. Run that same analysis on your own agency before CMS does.

6

CASE STUDY

Allograft Kickbacks Targeting Hospice Patients

District of Arizona — $4 billion+ billed

- A skin-substitute supplier relabeled tissue-bank allografts at up to a 2,000% markup and paid ~40% of revenue back to marketers and providers as illegal kickbacks.
- Providers billed Medicare over $4 billion for these allografts (Dec. 2021–June 2024), resulting in over $2 billion in payments. CMS responded by cutting the allograft payment rate to $127/sq cm effective January 1, 2026.
- Kickbacks drove providers to apply expensive grafts to hospice patients without physician coordination, on wounds too small to need them, and without proper infection care — patients died.

Compliance takeaway: vendor and referral-source arrangements need documented medical-necessity and fair-market-value review — especially when the arrangement gives a vendor access to your hospice patient population.

7

Hospice Fraud Beyond the National Takedown

State and regional enforcement escalating in parallel

$267M

California Hospice Fraud Ring (April 2026)

21 defendants charged after 14 hospice companies were purchased by straw owners and billed Medi-Cal for stolen identities — no hospice services were ever rendered.

75%

Live-Discharge Outlier (Valley Pacific Hospice)

Valley Pacific Hospice's live-discharge rate hit 75% vs. 17% national average; CMS audit found a pattern of claims failing to meet hospice eligibility standards; enrollment revoked.

$50M+

St. Francis Palliative Care, Glendale, CA (April 2026)

8 arrested including nurses, a chiropractor, and a psychologist for running sham hospice facilities. First Asst. U.S. Attorney Essayli: 'This is the beginning, not the end.'

8

PAS / PERSONAL CARE

Attendant-Level Fraud Is the Most Common Medicaid Fraud Type

Updated with Philadelphia charges, August 4, 2026

- PCS attendant fraud accounted for 298 of all Medicaid Fraud Control Unit convictions in FY2024 — 36% of all convictions, the single largest provider category.
- AUGUST 4, 2026 — Philadelphia: DOJ charged 19 defendants (home care company owners, aides, Medicaid recipients) for $4M+ in fraudulent Medicare/Medicaid claims. Allegations include billing while incarcerated, hospitalized, traveling overseas, working other jobs — and billing for a deceased aide. Pennsylvania home care billing: $120M in 2019 → $8 billion last year.
- DOJ simultaneously announced expansion of the Northeast Health Care Fraud Strike Force into Philadelphia — joining Strike Force expansions to CA, AZ, NV, MA, and MN in 2026.
- A 2026 Takedown case: an Alaska PAS attendant billed for daily care at the same time the recipient was hospitalized for severe neglect.

9

CMS Enrollment Moratorium: Status as of August 19, 2026

Effective May 13, 2026 — six-month nationwide freeze; expires November 13, 2026 (extendable)

What the Moratorium Covers

- Applies to ALL new HHA and hospice Medicare enrollment applications and certain changes in majority ownership (CIMOs) that trigger termination of provider agreement.
- New branches and practice locations also blocked — any location addition requiring Medicare enrollment action is treated as a new enrollment during the moratorium.
- Does NOT affect existing enrolled providers, or permissible CHOWs or CIMOs so long as don't result in termination of provider agreement — current agencies may continue serving patients and must continue meeting all revalidation and change-of-information obligations.
- States are following: Texas froze new Medicaid hospice contracts on June 1. Indiana froze new HCBS enrollment as of August 1. Ohio matched the moratorium for Medicaid through November 14. NY froze all home care service agency Medicaid enrollment as of July 30. CMS has encouraged all states to evaluate parallel Medicaid or CHIP moratoria.

Post-Moratorium Developments

- CMS Hospice Election Notification Pilot: expanded from Nevada (May 2025) to California (December 2025). When an NOE is filed, a letter immediately goes to the beneficiary to confirm enrollment. Over 25,000 letters issued. Detects fraudulent elections in real time.
- NEW (July 2026): CMS withheld over $1 billion in Medicaid payments from California and Minnesota due to suspected fraud and noncompliance.
- Telehealth for hospice face-to-face recertification extended through December 31, 2027 (CAA 2026) — BUT carved out for providers in moratorium areas or under enhanced oversight.
- CMS moratorium FAQs published July 9, 2026. CIMOs that violate 36-month rule, and CHOWs where the buyer rejects assignment of the provider agreement will be subject to moratorium.

10

ENFORCEMENT UPDATE

Since the Takedown:

55 Days of Continued Enforcement — June 23 to August 19, 2026

July 30, 2026 — **DOJ Southeast Enforcement Partnership Announced**

National Fraud Enforcement Division charged 12 defendants in 7 Southeast states since July 4, with $90M+ in losses. DOJ signed formal data-sharing agreements with 10 state agencies across AL, FL, GA, LA, MS, NC, and SC — states that include multiple Palmetto GBA JM HHH jurisdictions. Focus: Medicaid, benefits, and health care fraud.

August 4, 2026 — **Northeast Strike Force Expands to Philadelphia — 19 Defendants Charged**

19 defendants charged for $4M+ in Medicare/Medicaid home care fraud including billing for a deceased aide, billing while incarcerated, overseas, or clocking >24 hours/day. PA Medicaid home care billing: $120M (2019) → $8B (2025). CMS Administrator Oz personally attended the announcement.

August 13, 2026 — **McDonald Memorandum: Home Health & Hospice Named NFED Priority Targets**

AAG Colin McDonald issued formal enforcement priorities memo to all NFED staff. Home health and hospice explicitly named as healthcare enforcement priorities alongside telemedicine and Medicaid fraud. Quote: *'Home health aide and hospice scams directly impact vulnerable elderly Americans and erode patient care*.' Division scaling to 500 attorneys by August 24.

11

PART 2

The Legal Foundation

The federal fraud-and-abuse statutes, safe harbors, and OIG guidance tools that a compliance program must be built around

12

Two Pillars: False Claims Act & Anti-Kickback Statute

False Claims Act (31 U.S.C. § 3729)

- Prohibits knowingly submitting false or fraudulent claims for payment to a federal program.
- "Knowingly" includes actual knowledge, deliberate ignorance, or reckless disregard — intent to defraud is not required.
- Penalties: treble damages plus a per-claim penalty (adjusted annually for inflation).
- Enforced by DOJ and through qui tam whistleblower lawsuits — whistleblowers may receive 15–30% of recovery.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b)

- **Criminal law** barring any remuneration intended to induce referrals of federal health care program business.
- Applies to BOTH sides of an improper arrangement — the payer and the recipient.
- Marketing commissions, free services, excessive 'consulting' fees, and gifts to referral sources are common risk areas.
- A violation can also trigger automatic False Claims Act liability for the resulting claims.

13

Three More Authorities Every Agency Must Know

Physician Self-Referral Law ("Stark Law")

42 U.S.C. § 1395nn

Bars physicians from referring Medicare patients for certain designated health services (HHA services) to an entity with which the physician (or family) has a financial relationship, unless an exception applies. Strict liability — intent is irrelevant.

Civil Monetary Penalties Law

42 U.S.C. § 1320a-7a

Authorizes substantial civil penalties for a wide range of conduct, including improper claims, kickbacks, and employing or contracting with excluded individuals.

OIG Exclusion Authority

42 U.S.C. § 1320a-7

OIG can exclude individuals and entities from participating in federal health care programs. Screen all employees, contractors, and referral sources against the OIG LEIE monthly — not just at hire.

14

AKS Safe Harbors & Stark Law Exceptions

Understanding protected arrangements — and the limits of that protection

AKS Safe Harbors (42 C.F.R. § 1001.952)

- Safe harbors are defined arrangements exempt from AKS liability — but ALL conditions must be met. Partial compliance gives no protection.
- Bona fide employment: W-2 wages are protected. Marketers must meet bona fide employee test.
- Personal services & management contracts: Written, signed, 1-year minimum term, compensation at FMV set in advance. Medical directors, NPs, and contracted marketers must fit this structure.
- Space & equipment rental: Written lease, FMV rent, necessary space, 1-year minimum term. Above-FMV sub-leases from referring physicians or facilities are a red flag.
- Discounts: Properly disclosed price reductions are protected. Relabeling products at 2,000% markups is the opposite.

Stark Law Exceptions (42 C.F.R. § 411.350+) – HHA Only

- Stark is strict liability — if a prohibited financial relationship exists and no exception applies, every resulting referral and claim is improper regardless of intent. No 'good faith' defense.
- Bona fide employment exception: Compensation at FMV, not tied to referral volume, for identifiable services. Marketers must fit under this exception.
- Personal services exception: Written signed agreement, 1-year minimum term, services enumerated, compensation set in advance at FMV. Used for HHA Medical Directors and arrangements with any outside physician referral source.
- Fair market value is required by BOTH statutes. Any financial relationship between a certifying physician and the agency must be independently valued and documented.
- ***CRITICAL DISTINCTION***: A Stark exception does NOT satisfy the AKS. Both analyses always run separately — a Stark-compliant arrangement can still violate the AKS if improper intent exists.

15

OIG Advisory Opinions & Special Fraud Alerts

Proactive guidance tools every home health, hospice, and PAS agency should be using

OIG Advisory Opinions

- OIG issues written opinions on whether a proposed or existing arrangement violates the AKS, CMP law, or exclusion authorities — the most authoritative pre-clearance tool available.
- Opinions bind only the requesting party, but the full library of published opinions serves as a detailed industry roadmap for what OIG will and won't sanction.
- AO 26-15 (June 30, 2026): UNFAVORABLE — A home health agency's payment of fees to a vendor for an online referral management portal was flagged as potentially improper AKS remuneration.
- AO 25-12 (Jan. 2026): UNFAVORABLE — Sign on bonuses for in-home family member caregivers were denied protection.
- Request your own AO before entering novel marketing, vendor, or referral-fee arrangements — submit via OIGAdvisoryOpinions@oig.hhs.gov using the OIG Request Template.

Sources: oig.hhs.gov/compliance/advisory-opinions/ | oig.hhs.gov/compliance/alerts/ — hyperlinked in references

Special Fraud Alerts & Bulletins

- OIG publishes Special Fraud Alerts and Advisory Bulletins warning providers about practices that appear to violate federal health care laws — industry-wide, not just to the requesting party.
- Key home health/hospice alerts include: hospice arrangements with nursing homes involving kickbacks; physician liability for certifying ineligible home health patients.
- Courts and juries treat a defendant's knowledge of a relevant Fraud Alert as evidence of 'knowing and willful' conduct — ignorance of published alerts is not a defense.
- OIG GCPG directs compliance officers to monitor and incorporate Advisory Opinions and Fraud Alerts into their risk assessments — include this on your quarterly compliance calendar.

16

Why a Formal Compliance Program Matters Legally

A Mitigating Factor

An effective compliance program is treated by the government as a mitigating factor in fraud and abuse cases — but only if it is genuinely effective and well-documented, not merely a binder on a shelf.

A Sentencing Consideration

The Seven Elements trace back to the Federal Sentencing Guidelines for organizations — having a documented, functioning program affects how the government and courts evaluate culpability.

A Self-Disclosure Pathway

A working compliance program is what allows an agency to detect issues early and use OIG's Self-Disclosure Protocol — generally resulting in far better outcomes than waiting to be caught.

The McDonald Memo Makes It Explicit

The August 13 DOJ enforcement memo calls for voluntary disclosure incentives — 'companies that voluntarily self-disclose, cooperate, and remediate will be treated more favorably.' This is your path to a better outcome if you find a problem.

17

PART 3

The Seven Elements

OIG's General Compliance Program Guidance (GCPG), applied to home health, hospice & PAS

18

The Seven Elements of an Effective Compliance Program

Per HHS-OIG General Compliance Program Guidance (GCPG), issued November 6, 2023 | ICPGs for Nursing Facilities (Nov. 2024) and Medicare Advantage (Feb. 2026) now published

1. Written policies, procedures & standards of conduct
2. Designated compliance officer & compliance committee
3. Effective training & education
4. Effective lines of communication
5. Auditing & monitoring, including formal risk assessment
6. Enforcement of well-publicized disciplinary standards
7. Prompt response to detected issues & corrective action

19

ELEMENT 1

Standards of Conduct & Written Policies

What OIG Expects

Every organization should have a code of conduct outlining ethical expectations, endorsed and signed by the CEO and/or board to demonstrate organizational commitment. Written policies must address the operational areas most prone to fraud, waste, and abuse, and be reviewed and updated regularly.

Applied to Home Health, Hospice & PAS

- Hospice: written eligibility-certification, election-statement, and level-of-care policies tied directly to CMS conditions of participation.
- Home health: documented face-to-face encounter and homebound-status verification procedures.
- PAS: written attendant qualification, EVV use, and supervisory visit documentation standards.

20

ELEMENT 2

Compliance Officer & Compliance Committee

What OIG Expects

The compliance officer should not lead or report to legal or financial functions, should not provide legal/financial advice, and should report directly to the CEO with independent access to the governing board. The role requires real authority and 'stature' to be effective — not just a title.

Applied to Home Health, Hospice & PAS

- Small agencies: OIG allows a single 'compliance contact' if a dedicated officer isn't feasible — but that person's other duties cannot include legal services.
- Large agencies/health systems: a full compliance department supporting the officer is expected.
- PAS/home health franchises: designate one accountable compliance contact per branch reporting to a central officer.

21

ELEMENT 3

Effective Training & Education

What OIG Expects

Training must reach the board, executives, managers, and all employees — tailored to each role's actual compliance risk exposure. OIG recommends documenting training content, attendance, and hours, and providing targeted training when new risks, regulations, or enforcement trends emerge.

Applied to Home Health, Hospice & PAS

- Hospice clinicians: eligibility/recertification documentation and election-statement training tied to current CMS scrutiny.
- Home health intake/billing staff: face-to-face and homebound documentation standards.
- PAS attendants: EVV use, mandatory reporting, and abuse/neglect recognition — directly responsive to the Philadelphia and Alaska patient-harm cases.

22

ELEMENT 4

Effective Lines of Communication

What OIG Expects

Employees, contractors, patients, and families need accessible, confidential (and where appropriate, anonymous) channels to raise concerns without fear of retaliation — a compliance hotline, open-door policy, and a clear non-retaliation commitment, all well publicized.

Applied to Home Health, Hospice & PAS

- Hospice/home health: post hotline information in break rooms, employee handbooks, and new-hire onboarding materials.
- PAS: ensure attendants working independently in patients' homes know how to report concerns even without daily in-office contact.
- Document every call, its resolution, and trend it over time — OIG specifically lists hotline logs as evidence of program effectiveness.

23

ELEMENT 5

Auditing, Monitoring & Formal Risk Assessment

What OIG Expects

The 2023 GCPG places heightened emphasis on a FORMAL, ongoing risk assessment process — conducted at least annually — where the compliance officer and committee evaluate internal and external risks and use data analytics to identify compliance vulnerabilities.

Applied to Home Health, Hospice & PAS

- Hospice: monitor live-discharge rate, length of stay, and level-of-care distribution against state/national benchmarks — the same analytics the government used to detect the 2026 Takedown hospice outliers.
- Home health: track face-to-face documentation completeness and homebound-status audit findings per Palmetto GBA's published denial codes.
- PAS: monitor EVV exception reports, attendant overtime/impossible-hours patterns, and excluded-provider screening results monthly.

24

ELEMENT 6

Enforcement of Disciplinary Standards

What OIG Expects

Disciplinary standards must be well-publicized, consistently applied at every level of the organization (including management), and visibly enforced. Inconsistent enforcement — disciplining frontline staff while excusing leadership — undermines the program's credibility and its legal protective value.

Applied to Home Health, Hospice & PAS

- Apply the same standards to a clinical director who falsifies documentation as to a new hire who does.
- Document every disciplinary action taken in response to a compliance violation, including outcome.
- Include compliance expectations explicitly in job descriptions and performance evaluations for managers and executives.

25

ELEMENT 7

Prompt Response & Corrective Action

What OIG Expects

When potential noncompliance is detected — through audits, hotline reports, or otherwise — agencies should investigate promptly, take corrective action, and consider whether overpayments must be refunded or self-disclosure to OIG is appropriate. Delay itself can create liability.

Applied to Home Health, Hospice & PAS

- Hospice/home health: refund identified overpayments within the 60-day window — retaining a known overpayment beyond 60 days is itself an independent FCA violation.
- PAS: when an EVV or documentation discrepancy is found, investigate the specific attendant, the specific time period, and any systemic pattern — not just the single instance.
- Maintain a documented overpayment and self-disclosure protocol — the August 13 McDonald Memo explicitly mentions favorable treatment for companies that voluntarily disclose.

26

OIG's Compliance Program Guidances: A Library Built for Your Sector

Legacy CPGs, the 2023 GCPG, and ICPGs now rolling out — nursing facilities (Nov. 2024), Medicare Advantage (Feb. 2026), hospice & HHA expected

1998/1999

Home Health Agency CPG

OIG's original HHA Compliance Program Guidance set the template for home-health-specific risk areas. Now archived but still instructive; will be superseded when the HHA ICPG is published.

1999

Hospice CPG (64 Fed. Reg. 54031)

OIG's 1999 Hospice CPG addresses eligibility documentation, IDG composition, election statements, and referral arrangements — the same risk areas driving 2026 enforcement. Still cited by auditors.

2023–2026

GCPG (2023) + ICPGs Rolling Out

OIG's 2023 GCPG is the current authoritative baseline. Nursing Facility ICPG published November 2024. Medicare Advantage ICPG published February 3, 2026. Hospice and HHA ICPGs coming — monitor oig.hhs.gov/compliance.

How to Use These Guidances Practically

Self-Audit Template
The risk areas in the hospice and home health CPGs map directly to what MAC reviewers and OIG auditors check — use them as audit checklists.

Anticipate the ICPG
When the HHA and Hospice ICPGs arrive, they will identify updated risk areas. Review them immediately upon publication — they will likely address outlier metrics, eligibility, and referral practices.

Special Fraud Alerts
OIG's Special Fraud Alerts supplement with real-time warnings about specific practices. Courts have used a provider's knowledge of a relevant alert as evidence of willful violation.

Sources: oig.hhs.gov/compliance/ | oig.hhs.gov/compliance/general-compliance-program-guidance/ | oig.hhs.gov/compliance/ma-icpg/ — hyperlinked in references

27

PART 4

Sector Risk & Your Action Plan

Translating today's framework into a 90-day roadmap for your agency

28

Top Risk Areas by Sector

Home Health

- Face-to-face encounter & homebound status documentation
- Therapy/visit utilization outliers vs. plan of care
- Referral-source marketing & compensation arrangements
- Branch and ownership-change (CIMO) scrutiny under 2026 moratorium through November 13

Hospice

- Terminal-prognosis eligibility & recertification support
- Live-discharge rate and length-of-stay outlier metrics
- Election statements & informed consent documentation
- Vendor/allograft and other product arrangements affecting hospice patients

PAS / Personal Care

- Electronic Visit Verification (EVV) compliance and exception review
- Attendant qualification, background checks & unique identifiers
- Services billed during hospitalization, incarceration, or overseas travel (Philadelphia pattern)
- Patient abuse/neglect detection and mandatory reporting

29

MAC AUDIT DATA

Palmetto GBA JM HHH:

Home Health Top Denial Reasons

Jurisdiction M states: AL, AR, GA, IN, KY, LA, MS, NM, OK, SC, TN, VA, WV + others

#1 Face-to-Face (F2F) Encounter Deficiencies

The F2F note must: (a) occur within 90 days before or 30 days after SOC; (b) be signed and dated by the certifying physician; (c) document WHY the patient needs home health — not just a diagnosis list, but clinical findings. Blanket co-signatures are not sufficient.

#2 Plan of Care / Certification Deficiencies

Medicare requires a signed, dated Plan of Care established before services are provided. Denials occur when the POC is missing, unsigned, undated, or not received before billing.

#3 Physician Orders Not Met or Exceeded

All services billed must be ordered by a physician with the correct discipline, frequency, and duration. Services not covered by orders — or that exceed ordered parameters — are denied.

#4 Homebound Status Not Documented

Documentation must show leaving home requires considerable effort due to illness/injury. 'Patient is homebound' is not sufficient. Document functional specifics: gait devices, ambulation distance, fall risk, cognitive status.

#5 OASIS / HIPPS Code Mismatch

Denials occur when the OASIS assessment generating the HIPPS code is not present in the state repository, or the submitted OASIS does not match the billed period.

30

MAC AUDIT DATA

Palmetto GBA JM HHH:

Hospice Top Denial Reasons

Active prepayment reviews: AZ, CA, NV, TX (expanding). All hospices should treat these as best-practice benchmarks.

Part 4: Sector Risk & Action Plan

#1 Terminal Illness Eligibility — Insufficient Physician Narrative

CMS requires a physician narrative in the initial certification supporting a 6-month prognosis — not just a diagnosis or performance scale score. Palmetto reviewers deny when the narrative is absent, boilerplate, or fails to explain clinical trajectory. KPS, PPS, and ECOG scales must integrate into the narrative, not substitute for it.

#2 Missing or Deficient Certification / Recertification

All dates billed must be covered by a valid certification signed by the hospice physician or medical director. Missing, unsigned, or improperly dated certifications result in denial of the entire billed period.

#3 Invalid or Deficient Plan of Care

The POC must be established before services begin, reviewed and updated at least every 15 days, and include scope/frequency of services, symptom management goals, and beneficiary-specific needs. Outdated or generic POCs are routinely denied.

#4 Election Statement Deficiencies (Code 5FNER / 5CNER)

The hospice election statement must include: hospice name, patient acknowledgment of palliative (not curative) care, waiver of other Medicare services for the terminal condition, and BFCC-QIO contact information. Missing elements void eligibility for those dates.

#5 Notice of Election (NOE) Timeliness & MBI Errors

NOEs must be submitted within 5 calendar days of admission. Invalid or terminated MBIs on NOEs cause them to be returned and may result in late submission penalties. Verify MBI validity via eServices before submitting.

30

31

Closing the Loop: How Your Compliance Program Prevents These Denials

Mapping Palmetto GBA's top denial categories directly to the Seven Elements framework

Denial Category	Element(s)	Compliance Program Control
HH Face-to-Face encounter deficiencies	1 · 3 · 5	Written F2F documentation policy (E1); mandatory pre-billing F2F completeness training for clinical & billing staff (E3); monthly internal audit of F2F notes against Palmetto's checklist before claim submission (E5)
HH Plan of Care / certification gaps	1 · 5	POC-signature workflow policy with billing hold until physician signs (E1); quarterly audit of unsigned or outdated plans of care (E5)
HH Homebound status not documented	1 · 3	Documentation policy requiring functional specifics, not conclusions (E1); clinical staff training on 'considerable effort' standard with concrete examples (E3)
HOSP Physician narrative insufficient	1 · 3 · 5	Narrative template/checklist policy for medical directors (E1); training on KPS/PPS as narrative support, not substitutes (E3); pre-certification narrative review audit for every new admission (E5)
HOSP Certification / recertification missing	1 · 5	Tickler system for cert period expiration with billing hold until signed (E1); billing audit confirming all dates billed are covered by a valid cert (E5)
HOSP Election statement deficiencies	1 · 3	CMS-compliant election statement template with required-elements checklist (E1); staff training on each mandatory component and BFCC-QIO contact requirement (E3)

HH = Home Health HOSP = Hospice E = Seven Elements (1 = Written Policies 3 = Training 5 = Auditing & Monitoring)

Part 4: Sector Risk & Action Plan

31

32

Your 90-Day Compliance Action Plan

Days 1–30: Assess

- Confirm a designated compliance officer/contact with documented independence from legal & finance
- Run an exclusion-database screen of your full workforce, contractors & referral sources
- Pull your own live-discharge rate, face-to-face audit results, or EVV exception report — compare to peers

Days 31–60: Build

- Update written policies for your top 3 identified risk areas; obtain CEO/board sign-off on the code of conduct
- Stand up or refresh the confidential hotline and publicize it agency-wide
- Schedule role-specific training for clinical, billing, and field staff

Days 61–90: Operationalize

- Conduct a documented formal risk assessment using data analytics per OIG GCPG
- Test your overpayment identification & 60-day refund protocol
- Calendar quarterly auditing/monitoring and an annual program effectiveness review

33

Key Takeaways — Updated August 19, 2026

- Enforcement is still accelerating — the August 13 McDonald Memorandum formally named home health and hospice as National Fraud Enforcement Division priority targets. A dedicated 500-attorney division with a specific mandate over these sectors is operational now.
- The $120M → $8B growth in Pennsylvania Medicaid home care billing shows why PAS agencies face the same concentrated enforcement pressure as hospice — and why the Philadelphia Strike Force expansion is a permanent structural change.
- Compliance programs are judged on function, not paperwork — OIG and DOJ both expect documented evidence the Seven Elements are actually operating: audits, training records, hotline logs, and disciplinary actions.
- The government's data analytics are now your analytics too — run your own outlier analysis before the government does. The McDonald Memo confirms the NFED will use cutting-edge data analysis as its primary detection method.
- Speed matters when issues are found — the 60-day overpayment rule creates independent FCA liability, and the McDonald Memo explicitly offers favorable treatment to agencies that voluntarily self-disclose, cooperate, and remediate.

34

References & Sources (1 of 3)

DOJ, 2026 National Health Care Fraud Takedown press release (June 23, 2026) — https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-455-defendants-charged-connection-over-65

HHS-OIG, 2026 National Health Care Fraud Takedown media materials — https://oig.hhs.gov/newsroom/media-materials/2026-national-health-care-fraud-takedown/

DOJ Criminal Division, 2026 Takedown case summaries & court documents — https://www.justice.gov/criminal/criminal-fraud/2026-national-health-care-fraud-takedown

DOJ, Philadelphia home care fraud charges & Northeast Strike Force expansion (August 4, 2026) — https://www.justice.gov/opa/pr/fraud-division-announces-charges-against-19-defendants-medicaid-home-health-aid-schemes

DOJ, Southeast Enforcement Partnership announcement (July 30, 2026) — https://www.justice.gov/opa/pr/justice-departments-fraud-division-announces-unprecedented-fraud-enforcement-actions

DOJ, AAG McDonald Enforcement Priorities Memorandum (August 13, 2026) — https://www.justice.gov/opa/pr/assistant-attorney-general-colin-m-mcdonald-issues-memorandum-national-fraud-enforcement

California DOJ, Los Angeles Hospice Fraud Ring (April 9, 2026) — https://oag.ca.gov/news/press-releases/attorney-general-bonta-dismantles-los-angeles-hospice-fraud-ring-responsible-267

DOJ Central District of California, 8 arrested in hospice fraud takedown (April 24, 2026) — https://www.justice.gov/usao-cdca/pr/8-arrested-health-care-fraud-takedown-including-owners-hospices-billed-taxpayers

CMS Newsroom, Hospice & HHA Enrollment Moratoria announcement (May 13, 2026) — https://www.cms.gov/newsroom/press-releases/cms-announces-aggressive-nationwide-crackdown-fraud-six-month-hospice-home-health-agency-enrollment

35

References & Sources (2 of 3)

CMS, Provider Enrollment Moratoria reference page — https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/provider-enrollment-moratoria

CMS, Hospice & HHA Moratorium Q&A (updated July 9, 2026) — https://www.cms.gov/files/document/hh-hospice-moratorium-faqs.pdf

Federal Register, Hospice Moratorium Notice (May 15, 2026, 91 Fed. Reg. 27958) — https://www.federalregister.gov/documents/2026/05/15/2026-09718/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-nationwide-temporary

CMS, Hospice Beneficiary Notification/Confirmation Letters pilot (2025–2026) — https://www.cms.gov/FRAUD

HHS-OIG, General Compliance Program Guidance (GCPG), issued Nov. 6, 2023 — https://oig.hhs.gov/compliance/general-compliance-program-guidance/

HHS-OIG, GCPG full PDF (Seven Elements, federal authorities, resources) — https://oig.hhs.gov/documents/compliance-guidance/1135/HHS-OIG-GCPG-2023.pdf

HHS-OIG, Medicare Advantage ICPG (issued February 3, 2026) — https://oig.hhs.gov/compliance/ma-icpg/

HHS-OIG, Compliance Guidance archive — CPGs for Home Health Agencies & Hospices — https://oig.hhs.gov/compliance/compliance-guidance/

HHS-OIG, Advisory Opinions index (AO 26-15: home health portal — June 30, 2026) — https://oig.hhs.gov/compliance/advisory-opinions/

36

References & Sources (3 of 3)

HHS-OIG, Advisory Opinion Process & FAQ — https://oig.hhs.gov/compliance/advisory-opinions/process/

HHS-OIG, Special Fraud Alerts & Other Guidance — https://oig.hhs.gov/compliance/alerts/

HHS-OIG, General Questions on Fraud and Abuse Authorities (AKS safe harbors) — https://oig.hhs.gov/faqs/general-questions-regarding-certain-fraud-and-abuse-authorities/

Palmetto GBA, Jurisdiction M Home Health and Hospice (JM HHH) — main resource portal — https://palmettogba.com/jmhhh

Palmetto GBA, JM HHH TPE Top Denial Reasons — Home Health — https://www.palmettogba.com/palmetto/jmhhh.nsf/DIDC/BMMPPK0334~Medical%20Review~Targeted%20Probe%20and%20Educate

Palmetto GBA, Home Health Face-to-Face Documentation Checklist (rev. Apr. 2024) — https://dominoapps.palmettogba.com/palmetto/providers.nsf/files/Home_Health_Face_to_Face_revised_Checklist_rev04112024_.pdf/$FILE/Home_Health_Face_to_Face_revised_Checklist_rev04112024_.pdf

Palmetto GBA, Hospice Coalition Q&A — Oct. 30, 2024 — https://www.palmettogba.com/palmetto/jmhhh.nsf/DIDC/3JG70ZRZA6~Hospice~Coalition%20Questions

KFF, Understanding Medicaid Home Care Amid CMS Focus on Fraud (2026) — https://www.kff.org/medicaid/understanding-medicaid-home-care-amid-cms-focus-on-potential-fraud-and-abuse/

Foley & Lardner, DOJ's 2026 Takedown: Wound Care & Hospice Details — https://www.foley.com/insights/publications/2026/06/dojs-2026-health-care-fraud-takedown-details-behind-the-headline-number-and-what-it-means-for-health-care-providers/

37

Questions & Contact Information

Heidi Kocher, Esq.
Partner
Liles Parker PLLC
hkocher@lilesparker.com
(214) 952-5169

Jennifer Papanagiotou, Esq.
Partner
Liles Parker PLLC
jpapa@lilesparker.com
(571) 416-0035

LILES PARKER
Attorneys & Counselors at Law

38