

**INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
HOSPICE OF KONA**

I. PREAMBLE

Hospice of Kona (HOK) hereby enters into this Integrity Agreement (IA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this IA, HOK is entering into a Settlement Agreement with the United States.

II. TERM AND SCOPE OF THE IA

A. This IA shall have a term of five years from the Effective Date. The Effective Date shall be the date on which the final signatory signs this IA. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a “Reporting Period.”

B. Sections VII, X, and XI shall expire no later than 120 days after OIG’s receipt of: (1) HOK’s final annual report; or (2) any additional materials submitted by HOK pursuant to OIG’s request, whichever is later.

C. The term “Covered Persons” includes:

1. all owners and employees of HOK; and
2. all contractors, agents, and other persons who furnish patient care items or services or who perform billing or coding functions on behalf of HOK, excluding vendors whose sole connection with HOK is selling or otherwise providing medical supplies or equipment to HOK.

III. INTEGRITY OBLIGATIONS

HOK shall establish and maintain a Compliance Program that includes the following elements:

A. Compliance Officer

Within 120 days after the Effective Date, HOK shall appoint a Compliance Officer and shall maintain a Compliance Officer for the term of the IA. The Compliance Officer shall be an employee and a member of senior management of HOK, shall report directly to the Chief Executive Officer of HOK, and shall not be or be subordinate to a General Counsel or the Chief Financial Officer or have any responsibilities that involve acting in any capacity as legal counsel or supervising legal counsel functions for HOK. The Compliance Officer shall be responsible for, without limitation:

- a. developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this IA and with Federal health care program requirements;
- b. making periodic (at least quarterly) reports regarding compliance matters to the Chief Executive Officer of HOK and shall be authorized to report on such matters to the Chief Executive Officer at any time. Written documentation of the Compliance Officer's reports to the Chief Executive Officer shall be made available to OIG upon request; and
- c. monitoring the day-to-day compliance activities engaged in by HOK as well as any reporting obligations created under this IA.

Any noncompliance job responsibilities of the Compliance Officer shall be limited and must not interfere with the Compliance Officer's ability to perform the duties outlined in this IA.

HOK shall report to OIG, in writing, any changes in the identity of the Compliance Officer, or any actions or changes that would affect the Compliance Officer's ability to perform the duties necessary to meet the obligations in this IA, within five days after such a change.

B. Policies and Procedures

Within 120 days after the Effective Date, HOK shall develop and implement written policies and procedures regarding appropriate billing and medical record documentation for compliance with Federal health care program requirements (Policies and Procedures). Throughout the term of this IA, HOK shall enforce its Policies and Procedures and shall make such compliance an element of evaluating the performance of all employees.

The Policies and Procedures shall be made available to all Covered Persons.

At least annually (and more frequently, if appropriate), HOK shall assess and update, as necessary, the Policies and Procedures. Any revised or new Policies and Procedures shall be made available to all Covered Persons. All Policies and Procedures shall be made available to OIG upon request.

C. Posting of Notice

Within 90 days after the Effective Date, HOK shall post in a prominent place accessible to all patients and Covered Persons a notice that provides the name and phone number of the Compliance Officer and the HHS OIG Fraud Hotline telephone number (1-800-HHS-TIPS) as a confidential means by which suspected fraud or abuse in the Federal health care programs may be reported.

D. Training and Education

1. *Covered Persons Training.* All Covered Persons shall receive at least three hours of training during the first Reporting Period. Any individuals who become Covered Persons after the Effective Date and during the term of this IA shall receive at least three hours of training within 90 days of becoming a Covered Person.

Training may be completed in-person or online. These training requirements may be satisfied only by the completion of courses provided by the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN), HOK's Medicare contractor, or other training courses that are submitted to OIG, prior to registration for the training course, for review and approval.

At a minimum, the required training sessions must include the following topics:

- a. the Federal health care program billing, coding and claim submission statutes, regulations, and program requirements and directives relating to the items or services furnished by HOK;

- b. the Federal health care program medical record documentation requirements relating to items or services furnished by HOK; and
- c. the personal obligation of each individual involved in the medical record documentation and claims submission processes to ensure that medical records and claims are accurate.

The OIG may, in its discretion, require that all Covered Persons complete additional hours of training regarding the topics identified above, or additional topics, in the second or third years of the IA. The OIG shall provide notice to HOK of such additional required training at least 180 days prior to the required completion date for such training.

2. *Training Records.* HOK shall maintain written documentation (e.g., written or electronic certificates of completion from the training provider) that all Covered Persons required to receive training have in fact completed such training. The documentation shall specify the type of training received, the individual who completed the training, and the date received.

E. Review Procedures

1. *General Description.*

- a. *Engagement of Independent Review Organization.* Within 120 days after the Effective Date, HOK shall engage an individual or entity, such as an accounting, auditing, or consulting firm (hereinafter “Independent Review Organization” or “IRO”), to perform the reviews listed in this Section III.E. The applicable requirements relating to the IRO are outlined in Appendix A to this IA, which is incorporated by reference.
- b. *Retention of Records.* The IRO and HOK shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and HOK) related to the reviews.
- c. *Access to Records and Personnel.* HOK shall ensure that the IRO has access to all records and personnel necessary to

complete the reviews listed in this Section III.E and that all records furnished to the IRO are accurate and complete.

2. *Claims Review.* The IRO shall review claims submitted by HOK and reimbursed by the Medicare and Medicaid programs, to determine whether the items and services furnished were medically necessary and appropriately documented and whether the claims were correctly coded, submitted and reimbursed (Claims Review) and shall prepare a Claims Review Report, as outlined in Appendix B to this CIA, which is incorporated by reference.

3. *Independence and Objectivity Certification.* Prior to performing the first Claims Review, and annually thereafter, the IRO shall submit to HOK a certification that the IRO has (a) evaluated its professional independence and objectivity with respect to the reviews required under this Section III.E and (b) concluded that it is, in fact, independent and objective, in accordance with the requirements specified in Appendix A to this IA. The IRO's certification shall include a summary of all current and prior engagements between HOK and the IRO.

F. Ineligible Persons

1. *Definitions.* For purposes of this IA:

- a. an "Ineligible Person" shall include an individual or entity who:
 - i. is currently excluded from participation in any Federal health care program; or
 - ii. has been convicted of (a) a criminal offense that is related to the delivery of an item or service under Medicare or any state health care program; (b) a criminal offense relating to neglect or abuse of patients; (c) a felony criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service or with respect to a government funded health care program (other than Medicare or a state health care program); or (d) a felony criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance, but has not yet

been excluded, debarred, suspended, or otherwise declared ineligible.

- b. “Exclusion List” means the HHS/OIG List of Excluded Individuals/Entities (LEIE) (available through the Internet at <http://www.oig.hhs.gov>).

2. *Screening Requirements.* HOK shall ensure that all prospective and current Covered Persons are not Ineligible Persons, by implementing the following screening requirements.

- a. HOK shall screen all prospective Covered Persons against the Exclusion List prior to engaging their services and, as part of the hiring or contracting process, shall require such Covered Persons to disclose whether they are Ineligible Persons.
- b. HOK shall screen all current Covered Persons against the Exclusion List within 30 days after the Effective Date and on a monthly basis thereafter.
- c. HOK shall require all Covered Persons to immediately disclose immediately if they become an Ineligible Person.

HOK shall maintain documentation (i.e., a print screen of the search results) in order to demonstrate that HOK: (1) has checked the Exclusion List and determined that its Covered Persons are not Ineligible Persons; and (2) has required its Covered Persons to disclose if they are an Ineligible Person.

Nothing in this Section III.F affects HOK’s responsibility to refrain from (and liability for) billing Federal health care programs for items or services furnished, ordered, or prescribed by an excluded person. HOK understands that items or services furnished by excluded persons are not payable by Federal health care programs and that HOK may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether HOK meets the requirements of Section III.F.

3. *Removal Requirement.* If HOK has actual notice that a Covered Person has become an Ineligible Person, HOK shall remove such Covered Person from responsibility for, or involvement with, HOK’s business operations related to the Federal health care program(s) from which such Covered Person has been excluded and shall remove such Covered Person from any position for which the Covered Person’s compensation or the items or services furnished, ordered, or prescribed by the Covered

Person are paid in whole or part, directly or indirectly, by any Federal health care program(s) from which the Covered Person has been excluded at least until such time as the Covered Person is reinstated into participation in such Federal health care program(s).

4. *Pending Charges and Proposed Exclusions.* If HOK has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)-(3), or is proposed for exclusion during the Covered Person's employment or contract term, HOK shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the quality of care rendered to any beneficiary or the accuracy of any claims submitted to any Federal health care program.

G. Notification of Government Investigation or Legal Proceeding

Within 30 days after discovery, HOK shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to HOK conducted or brought by a governmental entity or its agents involving an allegation that HOK has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. HOK shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the investigation or proceeding, if any.

H. Overpayments

1. *Definition of Overpayments.* An "Overpayment" means any funds that HOK receives or retains under any Federal health care program to which HOK, after applicable reconciliation, is not entitled under such Federal health care program.

2. *Overpayment Policies and Procedures.* Within 90 days after the Effective Date, HOK shall develop and implement written policies and procedures regarding the identification, quantification and repayment of Overpayments received from any Federal health care program.

3. *Repayment of Overpayments.* If, at any time, HOK identifies any Overpayment, HOK shall repay the Overpayment to the appropriate payor (e.g., Medicare contractor) in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and any applicable regulations and guidance from the Centers for Medicare and Medicaid Services (CMS). HOK should follow the payor's policies regarding the form of notification and the repayment process for any Overpayment refunds. Any questions regarding the repayment process should be directed to the payor.

I. Reportable Events

1. *Definition of Reportable Event.* For purposes of this IA, a “Reportable Event” means anything that involves:

- a. a substantial Overpayment;
- b. a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized;
- c. the employment of or contracting with a Covered Person who is an Ineligible Person as defined by Section III.F.1.a; or
- d. the filing of a bankruptcy petition by HOK.

A Reportable Event may be the result of an isolated event or a series of occurrences.

2. *Reporting of Reportable Events.* If HOK determines (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, HOK shall notify OIG, in writing, within 30 days after making the determination that the Reportable Event exists.

3. *Reportable Events under Section III.I.1.a. and III.I.1.b.* For Reportable Events under Section III.I.1.a and b, the report to OIG shall include:

- a. a complete description of all details relevant to the Reportable Event, including, at a minimum, the types of claims, transactions or other conduct giving rise to the Reportable Event; the period during which the conduct occurred; and the names of entities and individuals believed to be implicated, including an explanation of their roles in the Reportable Event;
- b. a statement of the Federal criminal, civil or administrative laws that are probably violated by the Reportable Event, if any;
- c. the Federal health care programs affected by the Reportable Event;

- d. a description of the steps taken by HOK to identify and quantify any Overpayments; and
- e. a description of HOK's actions taken to correct the Reportable Event and prevent it from recurring.

If the Reportable Event involves an Overpayment, within 60 days of identification of the Overpayment, HOK shall repay the Overpayment, in accordance with the requirements of 42 U.S.C. §1320a-7k(d) and any applicable regulations and Centers for Medicare and Medicaid Services (CMS) guidance and provide OIG with a copy of the notification and repayment.

4. *Reportable Events under Section III.I.1.c.* For Reportable Events under Section III.I.1.c, the report to OIG shall include:

- a. the identity of the Ineligible Person and the job duties performed by that individual;
- b. the dates of the Ineligible Person's employment or contractual relationship;
- c. a description of the Exclusion List screening that HOK completed before and/or during the Ineligible Person's employment or contract and any flaw or breakdown in the screening process that led to the hiring or contracting with the Ineligible Person;
- d. a description of how the Ineligible Person was identified; and
- e. a description of any corrective action implemented to prevent future employment or contracting with an Ineligible Person.

5. *Reportable Events under Section III.I.1.d.* If the Reportable Event involves the filing of a bankruptcy petition, the report to the OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program requirements implicated.

6. *Reportable Events Involving the Stark Law.* Notwithstanding the reporting requirements outlined above, any Reportable Event that involves solely a probable violation of section 1877 of the Social Security Act, 42 U.S.C. §1395nn (the Stark Law) should be submitted by HOK to CMS through the self-referral disclosure

protocol (SRDP), with a copy to the OIG. If HOK identifies a probable violation of the Stark Law and repays the applicable Overpayment directly to the CMS contractor, then HOK is not required by this Section III.I to submit the Reportable Event to CMS through the SRDP.

IV. SUCCESSOR LIABILITY; CHANGES TO LOCATIONS OR BUSINESS

In the event that, after the Effective Date, HOK proposes to (a) sell any or all of its locations or businesses that are subject to this IA (whether through a sale of assets, sale of stock, or other type of transaction), or (b) purchase or establish a new location or business related to the furnishing of items or services that may be reimbursed by any Federal health care program, the IA shall be binding on the purchaser of any such location or business and any new location or business (and all Covered Persons at each new location or business) shall be subject to the requirements of this IA, unless otherwise determined and agreed to in writing by OIG. HOK shall give notice of such sale or purchase to OIG within 30 days following the closing of the transaction.

If, in advance of a proposed sale or proposed purchase, HOK wishes to obtain a determination by OIG that the proposed purchaser or the proposed acquisition will not be subject to the requirements of the IA, HOK must notify OIG in writing of the proposed sale or purchase at least 30 days in advance. This notification shall include a description of the location or business to be sold or purchased, a brief description of the terms of the transaction and, in the case of a proposed sale, the name and contact information of the prospective purchaser.

V. IMPLEMENTATION REPORT, IRO REPORTS, AND ANNUAL REPORTS

A. Implementation Report

Within 150 days after the Effective Date, HOK shall submit a written report to OIG summarizing the status of its implementation of the requirements of this IA (Implementation Report). The Implementation Report shall, at a minimum, include:

1. the name, address, phone number, and position description of the Compliance Officer required by Section III.A, and a summary of other noncompliance job responsibilities the Compliance Officer may have;
2. a list of the Policies and Procedures required by Section III.B.;
3. a copy of the notice required by Section III.C, a description of where the notice is posted, and the date the notice was posted;

4. the following information regarding the IRO: (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the IRO has the qualifications outlined in Appendix A to this IA; and (d) a certification from the IRO regarding its professional independence and objectivity with respect to HOK;

5. a copy of the search result print screens demonstrating that HOK has screened all Covered Persons against the Exclusion List as required by Section III.F within 30 days of the Effective Date;

6. a copy of HOK's policies and procedures regarding the identification, quantification and repayment of Overpayments required by Section III.H;

7. a list of all of HOK's locations (including locations and mailing addresses), the corresponding name under which each location is doing business, and each location's Medicare and state Medicaid program provider number(s), and/or supplier number(s); and

8. a certification by the Compliance Officer that: (a) the Compliance Officer has reviewed the IA in its entirety, understands the requirements described within, and maintains a copy for reference; (b) to the best of his or her knowledge, except as otherwise described in the Implementation Report, HOK is in compliance with all of the requirements of this IA; (c) he or she has reviewed the Implementation Report and has made a reasonable inquiry regarding its content and believes that the information is accurate and truthful; and (d) he or she understands that this certification is being provided to and relied upon by the United States.

B. Annual Reports

HOK shall submit to OIG a report on its compliance with the IA requirements for each of the five Reporting Periods (Annual Report). Each Annual Report shall include, at a minimum, the following information:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Compliance Officer described in Section III.A;

2. a list of any new or revised Policies and Procedures developed during the Reporting Period;

3. (in the first Annual Report) the following information regarding the training required by Section III.D: a copy of the training program registration for each

Covered Person who completed the training, the name of the training course, the name of the entity that provided the training, the location, date and length of the training; and a training program brochure or other materials from the training program or training program sponsor that describes the content of the training program. A copy of all training materials shall be made available to OIG upon request;

4. a complete copy of all reports prepared pursuant to Section III.E and HOK's response to the reports, along with corrective action plan(s) related to any issues raised by the reports;

5. a certification from the IRO regarding its professional independence and objectivity with respect to HOK;

6. a copy of the search result print screens demonstrating that HOK screened all prospective and current Covered Persons against the Exclusion List, as required by Section III.F;

7. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.G. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

8. a description of any changes to the Overpayment policies and procedures required by Section III.H, including the reasons for such changes;

9. a report of the aggregate Overpayments that have been returned to the Federal health care programs during the Reporting Period. Overpayment amounts shall be broken down into the following categories: Medicare, Medicaid, and other Federal health care programs;

10. a summary of Reportable Events (as defined in Section III.I) identified during the Reporting Period;

11. a summary of any audits conducted during the applicable Reporting Period by any Medicare or state Medicaid program contractor or any government entity or contractor, involving a review of Federal health care program claims, and HOK's response/corrective action plan (including information regarding any Federal health care program refunds) relating to the audit findings;

12. a description of all changes to the most recently provided list of HOK's locations (including addresses) as required by Section V.A.7; and

13. a certification signed by HOK's Compliance Officer that: (a) he or she has reviewed the IA in its entirety, understands the requirements described within, and maintains a copy for reference; (b) to the best of his or her knowledge, except as otherwise described in the Annual Report, HOK is in compliance with all of the requirements of this IA; (c) he or she has reviewed the Annual Report and has made a reasonable inquiry regarding its content and believes that the information is accurate and truthful; and (d) he or she understands that this certification is being provided to and relied upon by the United States.

The first Annual Report shall be received by OIG no later than 60 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Designation of Information

HOK shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. HOK shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this IA shall be submitted to the following entities:

OIG:

Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, SW
Washington, DC 20201
Telephone: (202) 619-2078
Facsimile: (202) 205-0604

HOK:

Laura Varney
75-5925 Walua Road, Kaulua-Kona, HI 96740
Telephone: (808) 324-7700
Facsimile: (808) 331-0767
E-mail: info@hospiceofkona.org

Unless otherwise specified, all notifications and reports required by this IA may be made by electronic mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. Upon request by OIG, HOK may be required to provide OIG with an electronic copy of each notification or report required by this IA in addition to a paper copy.

VII. OIG INSPECTION, AUDIT, AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may conduct interviews, examine and/or request copies of HOK's books, records, and other documents and supporting materials and conduct on-site reviews of any of HOK's locations, for the purpose of verifying and evaluating: (a) HOK's compliance with the terms of this IA and (b) HOK's compliance with the requirements of the Federal health care programs. The documentation described above shall be made available by HOK to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, and/or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of HOK's owners, employees, and contractors who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. HOK shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. HOK's owners, employees, and contractors may elect to be interviewed with or without a representative of HOK present.

VIII. DOCUMENT AND RECORD RETENTION

HOK shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs and to compliance with this IA for four years (or longer if otherwise required by law) from the Effective Date.

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify HOK prior to any release by OIG of information

submitted by HOK pursuant to its obligations under this IA and identified upon submission by HOK as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, HOK shall have the rights set forth at 45 C.F.R. § 5.42(a).

X. BREACH AND DEFAULT PROVISIONS

HOK is expected to fully and timely comply with all of its IA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations

As a contractual remedy, HOK and OIG hereby agree that failure to comply with certain obligations set forth in this IA may lead to the imposition of the following monetary penalties (hereinafter referred to as “Stipulated Penalties”) in accordance with the following provisions.

1. A Stipulated Penalty of \$1,000 (which shall begin to accrue on the day after the date the obligation became due) for each day HOK fails to establish, implement or comply with any of the following obligations as described in Section III:
 - a. appoint a Compliance Officer as required by Section III.A;
 - b. written Policies and Procedures required by Section III.B;
 - c. post a notice in accordance with the requirements of Section III.C;
 - d. complete the training required for Covered Persons and maintain training records, in accordance with the requirements of Section III.D;
 - e. screen Covered Persons in accordance with the requirements of Section III.F; require Covered Persons to disclose if they are excluded in accordance with the requirements of Section III.F; or maintain copies of print screens from search results to demonstrate the required screening has been performed in accordance with the requirements of Section III.F;
 - f. notify OIG of a government investigation or legal proceeding, in accordance with the requirements of Section III.G;

- g. establish policies and procedures regarding the repayment of Overpayments;
- h. repay any Overpayments as required by Section III.H and Appendix B; or
- i. report a Reportable Event in accordance with Section III.I.

2. A Stipulated Penalty of \$1,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HOK fails to engage and use an IRO, as required by Section III.E, Appendix A or Appendix B.

3. A Stipulated Penalty of \$1,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HOK fails to submit a complete Implementation Report, Annual Report, or any certification to OIG in accordance with the requirements of Section V by the deadlines for submission.

4. A Stipulated Penalty of \$1,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HOK fails to submit any Claims Review Report in accordance with the requirements of Section III.D and Appendix B or fails to repay any Overpayment identified by the IRO, as required by Appendix B.

5. A Stipulated Penalty of \$1,000 for each day HOK fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date HOK fails to grant access.)

6. A Stipulated Penalty of \$50,000 for each false certification submitted by or on behalf of HOK as part of its Implementation Report, any Annual Report, additional documentation to a report (as requested by OIG), or as otherwise required by this IA.

7. A Stipulated Penalty of \$1,000 for each day HOK fails to grant the IRO access to all records and personnel necessary to complete the reviews listed in Section III.E, and for each day HOK fails to furnish accurate and complete records to the IRO, as required by Section III.E and Appendix A.

8. A Stipulated Penalty of \$1,000 for each day HOK fails to comply fully and adequately with any obligation of this IA. OIG shall provide notice to HOK stating the specific grounds for its determination that HOK has failed to comply fully and adequately with the IA obligation(s) at issue and steps the HOK shall take to comply with the IA. (This Stipulated Penalty shall begin to accrue 10 days after the date HOK

receives this notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1-7 of this Section.

B. Timely Written Requests for Extensions

HOK may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this IA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after HOK fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three days after HOK receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties

1. *Demand Letter.* Upon a finding that HOK has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify HOK of: (a) HOK's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter.* Within 10 days after the receipt of the Demand Letter, HOK shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event HOK elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until HOK cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this IA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG’s decision that HOK has materially breached this IA, which decision shall be made at OIG’s discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this IA

1. *Definition of Material Breach.* A material breach of this IA means:

- a. a failure by HOK to report a Reportable Event, take corrective action, or make the appropriate refunds, as required in Section III.I;
- b. repeated violations or a flagrant violation of any of the obligations under this IA, including, but not limited to, the obligations addressed in Section X.A;
- c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C; or
- d. a failure to engage and use an IRO in accordance with Section III.E, Appendix A, or Appendix B.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this IA by HOK constitutes an independent basis for HOK’s exclusion from participation in the Federal health care programs. The length of the exclusion shall be in the OIG’s discretion, but not more than three years per material breach. Upon a determination by OIG that HOK has materially breached this IA and that exclusion is the appropriate remedy, OIG shall notify HOK of: (a) HOK’s material breach; and (b) OIG’s intent to exercise its contractual right to impose exclusion. (This notification shall be referred to as the “Notice of Material Breach and Intent to Exclude.”)

3. *Opportunity to Cure.* HOK shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate that:

- a. the alleged material breach has been cured; or
- b. the alleged material breach cannot be cured within the 30 day period, but that: (i) HOK has begun to take action to cure the material breach; (ii) HOK is pursuing such action with due

diligence; and (iii) HOK has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If, at the conclusion of the 30 day period, HOK fails to satisfy the requirements of Section X.D.3, OIG may exclude HOK from participation in the Federal health care programs. OIG shall notify HOK in writing of its determination to exclude HOK. (This letter shall be referred to as the “Exclusion Letter.”) Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of HOK’s receipt of the Exclusion Letter. The exclusion shall have national effect. Reinstatement to program participation is not automatic. At the end of the period of exclusion, HOK may apply for reinstatement, by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights.* Upon OIG’s delivery to HOK of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this IA, HOK shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this IA. Specifically, OIG’s determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board (DAB), in a manner consistent with the provisions in 42 C.F.R. § 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter. The procedures relating to the filing of a request for a hearing can be found at <http://www.hhs.gov/dab/divisions/civil/procedures/divisionprocedures.html>.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this IA shall be: (a) whether HOK was in full and timely compliance with the obligations of this IA for which OIG demands payment; and (b) the period of noncompliance. HOK shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this IA and orders HOK to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless HOK requests review of the ALJ decision by the DAB. If the ALJ decision is properly

appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this IA shall be whether HOK was in material breach of this IA and, if so, whether:

- a. HOK cured such breach within 30 days of its receipt of the Notice of Material Breach; or
- b. the alleged material breach could not have been cured within the 30 day period, but that, during the 30 day period following HOK's receipt of the Notice of Material Breach: (i) HOK had begun to take action to cure the material breach; (ii) HOK pursued such action with due diligence; and (iii) HOK provided to OIG a reasonable timetable for curing the material breach.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for HOK, only after a DAB decision in favor of OIG. HOK's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude HOK upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that HOK may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. HOK shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of HOK, HOK shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this IA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this IA.

XI. EFFECTIVE AND BINDING AGREEMENT

HOK and OIG agree as follows:

A. This IA shall become final and binding on the date the final signature is obtained on the IA.

B. This IA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this IA.

C. OIG may agree to a suspension of HOK's obligations under this IA based on a certification by HOK that it is no longer providing health care items or services that will be billed to any Federal health care program and it does not have any ownership or control interest, as defined in 42 U.S.C. § 1320a-3, in any entity that bills any Federal health care program. If HOK is relieved of its IA obligations, HOK shall be required to notify OIG in writing at least 30 days in advance if HOK plans to resume providing health care items or services that are billed to any Federal health care program or to obtain an ownership or control interest in any entity that bills any Federal health care program. At such time, OIG shall evaluate whether the IA will be reactivated or modified.

D. All requirements and remedies set forth in this IA are in addition to and do not affect (1) HOK's responsibility to follow all applicable Federal health care program requirements or (2) the government's right to impose appropriate remedies for failure to follow applicable Federal health care program requirements.

E. The undersigned HOK signatories represent and warrant that they are authorized to execute this IA [*change to singular if only one signatory*]. The undersigned OIG signatories represent that they are signing this IA in their official capacity and that they are authorized to execute this IA.

F. This IA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same IA. Electronically-transmitted copies of signatures shall constitute acceptable, binding signatures for purposes of this IA.

ON BEHALF OF HOSPICE OF KONA

/Laura Varney/
LAURA VARNEY
Chief Executive Officer

8/30/18
DATE

/Brett A. Tobin/
BRETT R. TOBIN, ESQ.
Counsel for Hospice of Kona

8/29/18
DATE

**ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL OF
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

/Lisa M. Re/
LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

9/04/2018
DATE

/Gregory J. Wellins/
GREGORY J. WELLINS
Senior Counsel

8/29/18
DATE

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.E of the IA.

A. IRO Engagement

1. HOK shall engage an IRO that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph E. Within 30 days after OIG receives the information identified in Section V.A.4 of the IA or any additional information submitted by HOK in response to a request by OIG, whichever is later, OIG will notify HOK if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, HOK may continue to engage the IRO.

2. If HOK engages a new IRO during the term of the IA, that IRO must also meet the requirements of this Appendix. If a new IRO is engaged, HOK shall submit the information identified in Section V.A.4 of the IA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives this information or any additional information submitted by HOK at the request of OIG, whichever is later, OIG will notify HOK if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, HOK may continue to engage the IRO.

B. IRO Qualifications

The IRO shall:

1. assign individuals to conduct the Claims Review who have expertise in the Medicare and state Medicaid program requirements applicable to the claims being reviewed;
2. assign individuals to design and select the Claims Review sample who are knowledgeable about the appropriate statistical sampling techniques;
3. assign individuals to conduct the coding review portions of the Claims Review who have a nationally recognized coding certification and who have maintained this certification (e.g., completed applicable continuing education requirements);
4. assign licensed nurses or physicians with relevant education, training and specialized expertise (or other licensed health care professionals acting within their scope

of practice and specialized expertise) to make the medical necessity determinations required by the Claims Review; and

5. have sufficient staff and resources to conduct the reviews required by the IA on a timely basis.

C. IRO Responsibilities

The IRO shall:

1. perform each Claims Review in accordance with the specific requirements of the IA;

2. follow all applicable Medicare and state Medicaid program rules and reimbursement guidelines in making assessments in the Claims Review;

3. request clarification from the appropriate authority (e.g., Medicare contractor), if in doubt of the application of a particular Medicare or state Medicaid program policy or regulation;

4. respond to all OIG inquiries in a prompt, objective, and factual manner; and

5. prepare timely, clear, well-written reports that include all the information required by Appendix B to the IA.

D. HOK Responsibilities

HOK shall ensure that the IRO has access to all records and personnel necessary to complete the reviews listed in Section III.E of this IA and that all records furnished to the IRO are accurate and complete.

E. IRO Independence and Objectivity

The IRO must perform the Claims Review in a professionally independent and objective fashion, as defined in the most recent Government Auditing Standards issued by the U.S. Government Accountability Office.

F. IRO Removal/Termination

1. *HOK and IRO.* If HOK terminates its IRO or if the IRO withdraws from the engagement during the term of the IA, HOK must submit a notice explaining (a) its reasons for termination of the IRO or (b) the IRO's reasons for its withdrawal to OIG, no later than 30 days after termination or withdrawal. HOK must engage a new IRO in accordance with Paragraph A of this Appendix and within 60 days of termination or withdrawal of the IRO.

2. *OIG Removal of IRO.* In the event OIG has reason to believe the IRO does not possess the qualifications described in Paragraph B, is not independent and objective as set forth in Paragraph E, or has failed to carry out its responsibilities as described in Paragraph C, OIG shall notify HOK in writing regarding OIG's basis for determining that the IRO has not met the requirements of this Appendix. HOK shall have 30 days from the date of OIG's written notice to provide information regarding the IRO's qualifications, independence or performance of its responsibilities in order to resolve the concerns identified by OIG. If, following OIG's review of any information provided by HOK regarding the IRO, OIG determines that the IRO has not met the requirements of this Appendix, OIG shall notify HOK in writing that HOK shall be required to engage a new IRO in accordance with Paragraph A of this Appendix. HOK must engage a new IRO within 60 days of its receipt of OIG's written notice. The final determination as to whether or not to require HOK to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

CLAIMS REVIEW

A. Claims Review. The Claims Review shall consist of two components, the Eligibility Review and the Appropriate Level of Services Review. The IRO shall perform the Eligibility Review and the Appropriate Level of Services Review annually to cover each of the five Reporting Periods.

1. *Definitions*. For the purposes of the Claims Review, the following definitions shall be used:

- a. Overpayment: The amount of money HOK has received in excess of the amount due and payable under Medicare or Medicaid requirements, as determined by the IRO in connection with the reviews performed under this Appendix B, determined in accordance with Section A.3 of this Appendix B.
- b. Hospice Population: Hospice of Kona.
- c. Beneficiary Population: The Beneficiary Population shall be defined as all Medicare or Medicaid beneficiaries whose length of stay exceeded 210 days at any time during the Reporting Period at HOK and for whom HOK submitted claims and received reimbursement.
- d. Claim Period: The period of time covered by a claim submitted to Medicare or Medicaid by HOK for services provided to a beneficiary.
- e. Beneficiary Sample: A Beneficiary Sample shall consist of a statistically valid random sample of 30 Medicare and/or Medicaid beneficiaries drawn from the Beneficiary Population HOK.
- f. Eligibility Review Error Rate: The Eligibility Review Error Rate shall be calculated by dividing the Overpayment in the Eligibility Review by the total dollar amount associated with hospice services reimbursed by Medicare or Medicaid for beneficiaries in the Beneficiary Population included in the Eligibility Review.

- g. Level of Services: One of the four categories of care reimbursed under the Medicare or Medicaid hospice benefit, which consist of:
 - i. Routine Home Care – when a patient is at home and is not receiving Continuous Care services;
 - ii. Continuous Care – when a patient is at home and receives services that consist predominantly of nursing care on a continuous basis for brief periods of crisis and as necessary to maintain the terminally ill at home. See 42 C.F.R. § 418.204;
 - iii. Inpatient Respite Care – when a patient receives care at an approved facility on a short term basis for respite; and
 - iv. General Inpatient Care – when a patient receives care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings.
- h. Appropriate Level of Services Review Error Rate: The Error Rate for the Appropriate Level of Services Review shall be calculated by dividing the Overpayment in the Appropriate Level of Services Review by the total dollar amount associated with hospice services reimbursed by Medicare or Medicaid for beneficiaries in the Beneficiary Population included in the Appropriate Level of Services Review.

2. *Description of Reviews.*

- a. Eligibility Review. The IRO shall select a Beneficiary Sample. The IRO shall review the medical records of the Medicare and Medicaid beneficiaries in the Beneficiary Sample to determine whether the beneficiaries were eligible for hospice services for each Claim Period for which a claim was submitted since the date of admission. The IRO shall review medical records for the Medicare beneficiaries selected based on the supporting documentation available at HOK's offices or under HOK's control and applicable billing and coding regulations and guidance to determine whether the Medicare or Medicaid beneficiary was eligible for the hospice

benefit during each Claim Period.

For any beneficiary in the Beneficiary Sample that results in a determination by the IRO that the beneficiary was not eligible for the hospice benefit during the Claim Period, the IRO shall perform a review of the system(s) and process(es) that resulted in HOK's erroneous determination that the beneficiary was eligible for the hospice benefit, to identify any problems or weaknesses that may have resulted in the identified error(s). The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) for determining eligibility for the hospice benefit.

- b. Appropriate Level of Services Review. The Appropriate Level of Services Review shall consist of a review to ensure that the medical record supports the appropriateness of the Level of Services provided and that the claim was properly submitted to and reimbursed by Medicare or Medicaid. This review shall be completed for each beneficiary in the Beneficiary Sample who was determined to be eligible for hospice services for one or more Claim Periods. The IRO shall review medical records for the Medicare and Medicaid beneficiaries selected based on the supporting documentation available at HOK's offices or under HOK's control and applicable billing and coding regulations and guidance to determine the appropriateness of the Level of Services billed and reimbursed.

For any beneficiary in the Beneficiary Sample that results in a determination by the IRO that the Level of Services billed was not appropriate, the IRO shall perform a review of the system(s) and process(es) that resulted in HOK's erroneous determination that medical necessity existed for the Level of Services billed, to identify any problems or weaknesses that may have resulted in the identified error(s). The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) for determining medical necessity for the Level of Services provided.

4. *Other Requirements.*

- a. Supplemental Materials. The IRO shall request all documentation and materials required for its review of the medical records of the Medicare and Medicaid beneficiaries selected as part of each Beneficiary Sample and HOK shall furnish such documentation and materials to the IRO prior to the IRO initiating its review of each Beneficiary Sample. If the IRO accepts any supplemental documentation or materials from HOK after the IRO has completed its initial review of any Beneficiary Sample (Supplemental Materials), the IRO shall identify in the Claims Review Report the Supplemental Materials, the date the Supplemental Materials were accepted, and the relative weight the IRO gave to the Supplemental Materials in its review. In addition, the IRO shall include a narrative in the Claims Review Report describing the process by which the Supplemental Materials were accepted and the IRO's reasons for accepting the Supplemental Materials.
- b. Claims without Supporting Documentation. If HOK cannot produce documentation for any beneficiary selected as part of any Beneficiary Sample, then the total reimbursement received by HOK for hospices services furnished to such beneficiary shall be deemed an Overpayment. Replacement sampling for Medicare beneficiaries with missing documentation is not permitted.
- c. Use of First Samples Drawn. For the purposes of all samples discussed in this Appendix, the Medicare and Medicaid beneficiaries selected in each first sample shall be used (i.e., it is not permissible to generate more than one list of random samples and then select one for use with a Beneficiary Sample).

5. *Repayment of Identified Overpayments.* HOK shall repay within 60 days any Overpayment(s) identified by the IRO in each Beneficiary Sample, in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and 42 C.F.R. § 401.301-305 (and any applicable CMS guidance) (the "CMS overpayment rule"). If HOK determines that the CMS overpayment rule requires that an extrapolated Overpayment be repaid, HOK shall repay that amount at the mean point estimate as calculated by the IRO. HOK shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor. OIG, in its sole discretion, may refer the findings of any Beneficiary Sample (and any related work papers) received from HOK to the appropriate Federal health care program payor (e.g., Medicare contractor or state Medicaid program) for follow up by that payor.

B. Claims Review Report. The IRO shall prepare a Claims Review Report as described in this Appendix for each Claims Review performed. The following information shall be included in the Claims Review Report.

1. *Eligibility and Appropriate Level of Services Reviews Methodology.*

- a. Review Population. A description of the Beneficiary Population.
- b. Review Objective. A clear statement of the objective intended to be achieved by the Eligibility Review and the Appropriate Level of Services Review.
- c. Source of Data. A description of (1) the process used to identify the beneficiaries in each Beneficiary Population and (2) the specific documentation relied upon by the IRO when performing the Eligibility Review and the Appropriate Level of Services Review.
- d. Review Protocol. A narrative description of how the Eligibility Review and the Appropriate Level of Services Review were conducted and what was evaluated.
- e. Supplemental Materials. A description of any Supplemental Materials as required by A.4.a., above.

2. *Statistical Sampling Documentation.*

- a. A copy of the printout of the random numbers generated by the “Random Numbers” function of the statistical sampling software used by the IRO.
- b. A description or identification of the statistical sampling software package used to select the samples described in this Appendix.

3. *Claims Review Findings.*

- a. Narrative Results.
 - i. A description of HOK’s hospice eligibility certification, recertification, and determination of

appropriate Level of Service processes, including the identification, by position description, of the personnel involved.

- ii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, concerns relating to the eligibility for hospice or appropriateness of hospice services, etc.) regarding the Eligibility Review and the Appropriate Level of Services Review.

b. Quantitative Results.

- i. Total number and percentage of instances in which the IRO determined that the documentation for a Medicare or Medicaid beneficiary did not support that the beneficiary was eligible for the Medicare or Medicaid hospice benefit or did not support that the beneficiary received the appropriate Level of Services based on medical necessity, regardless of the effect on the payment.
- ii. Total number and percentage of instances in which the documentation for a Medicare or Medicaid beneficiary did not support that the beneficiary was eligible for the Medicare or Medicaid hospice benefit or did not support that the appropriate Level of Services was provided and in which such difference resulted in an Overpayment to HOK.
- iii. Total dollar amount of all Overpayments in the Claims Review.
- iv. Error Rates for the Claims Review.
- v. An estimate of the actual Overpayment in the Beneficiary Population at the mean point estimate.
- vi. A spreadsheet of the Claims Review results that includes the following information for each Medicare or Medicaid beneficiary: beneficiary health insurance claim number, date(s) of service, allowed amount reimbursed by payor, correct allowed amount (as

determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount.

- c. Recommendations. The IRO's report shall include any recommendations for (1) improvements to HOK's systems and processes for the certification and recertification of eligibility for the Medicare or Medicaid hospice benefit to address the specific identified problems or weaknesses; and (2) improvements to HOK's systems and processes for the determination of medical necessity for the Level of Services to be provided to address the specific identified problems or weaknesses.

- 4. *Credentials.* The names and credentials of the individuals who:
(1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review and (2) performed the Claims Review.