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The Hospice/Nursing Home Partnership: Do It Right!

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Barrier vs. Collaboration

Two independent regulatory schemes with different goals:

COPs for Hospice: 42 C.F.R. Part 418 –
"Palliative care is patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering…[by] addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice."

COPs for NH: 42 C.F.R. Part 483 –
"highest practicable physical, mental and psychosocial well-being"

Two different reimbursement schemes:

Patient is both a Nursing Home (NH) Resident and a Hospice Patient. Resident Assessment Instrument Minimum Data Set (RAI/MDS).

NH Medical Director vs. Hospice Medical Director.

Barriers

NH Resident or Legal Representative Must Elect Hospice Care.

Election of hospice care for terminal illness (TI) in lieu of skilled services nursing home care for TI, complicated by elderly patient's multiple chronic conditions that make it difficult to identify if treatments are, in fact curative.

When Medicare beneficiary who resides in NH elects hospice, there is no reimbursement for room and board unless the beneficiary is also Medicaid recipient.

Collaboration

Nursing Home/Hospice Contracts

- **Routine Hospice Care**
- **Inpatient Hospice Care**
  - pain control and symptom management that cannot be managed elsewhere
  - respite purposes for caregiver breakdown (for hospice patients admitted from the community)
  - 24-hour RN not required for respite § 418.108(b)
  - Patient access and family-like areas
  - Hospice also provides care
- **Hospice can contract and purchase hospice non-core services from NH: PT, OT, ST, hospice aide, meds and supplies related to TI.**
- **Cannot contract for Hospice core services: RN, SW, Physician, Counseling – dietary, bereavement and spiritual. Waivers.**
- **Cannot provide continuous care services to patients in a skilled nursing facility. MLN JA 6778**

Collaboration

- **Contracts usually include mirror-image indemnification provisions so each is responsible for their own negligent acts or omissions – usually do not shift responsibility to other party.**
- **With more resources available to Hospice Residents, should be less risk of complaints or survey deficiencies, <u>but</u> problem can arise if respective responsibilities are not clear and each thinks the other was responsible. Coordination of care between NH and Hospice important.**
- **Hospice has professional responsibility for management of hospice care. Hospice Interpretive Guidelines.**

Hospice Conditions of Participation (COPs)

COPs focus on *"patient-centered, outcome-oriented, and transparent process"*

- COP specifically governing the relationship between hospice and NH when NH Residents are also hospice patients: 42 C.F.R. §418.112
- IDG must review the hospice plan of care at least every 15 calendar days. 42 C.F.R. §418.56
- Hospice must develop, implement, and maintain a quality assessment and performance improvement ("QAPI") program. 42 C.F.R. §418.58
- Aides are referred to as *"hospice aides"* rather than *"home health aides*". 42 C.F.R. §418.76

Hospice Conditions of Participation (COPs)

"Initial Assessment": defined as *"evaluation of the patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs."* 42 C.F.R. §418.3

- RN must complete an initial assessment within 48 hours after election of hospice care. 42 C.F.R. §418.54(a)

"Comprehensive Assessment": defined as *a "thorough evaluation of the patient's physical, psychosocial, emotional, and spiritual status related* to the terminal illness and related conditions*." 42 C.F.R. § 418.3*

- The hospice's interdisciplinary group ("IDG") must complete the comprehensive assessment within 5 calendar days after election. 42 C.F.R. §418.54(b)

42 C.F.R. §418.112: COP for Hospices that Provide Care to SNF Residents

COP delineates Hospice responsibility for SNF Resident receiving hospice services:

- Resident eligibility
- Professional management
- Written agreement
- Hospice plan of care
- Coordination of services
- Orientation and training of staff

42 C.F.R. §418.112 (a)-(b)

Resident Eligibility

- Medicare patients receiving hospice services and residing in a NH must meet same Medicare hospice eligibility criteria as hospice patients in the community.

Professional Management

- Hospice must assume responsibility for professional management of Resident's hospice services.

Orientation and Training of Staff - 42 C.F.R. § 418.112(f)

- Hospice staff must assure the orientation of NH staff to furnish care to hospice patients in the *"hospice philosophy"*.

42 C.F.R. §418.112 (c)

Written Agreement Between the Hospice and the NH

- The hospice and NH must both sign the written agreement.
- These agreements must include nine specific provisions dealing with the following:
  - Communication between NH and hospice;
  - Notification of changes in patient's status;
  - Hospice responsibility for determining care level;
  - NH responsibility to furnish room and board;
  - Specific delineation of the hospice's responsibilities;
  - Provision specifying NH personnel can be used only to the extent that a patient's family would be used in implementing a plan of care;
  - Hospice abuse reporting requirements;
  - Delineation of the provision of bereavement services; and
  - Hospice responsibility to provide hospice services at the same level as if in the community.

42 C.F.R. §418.112 (d)

Hospice Plan of Care

- Hospice must consult with NH representatives in establishing Plan of Care.
- The Plan of Care must identify the care and services needed, and specify which provider is responsible for performing functions.
- The Plan of Care must reflect the participation of the hospice, NH, patient and family.
- Changes to any Plan of Care must be discussed with the patient and the NH, and must be approved by the Hospice.

42 C.F.R. §418.112 (e)

Coordination of Services

- Hospice must designate an IDG member to coordinate NH Resident's overall hospice care.
- Hospice must ensure that the IDG communicates with the NH's medical director, the patient's attending physician, and any other physicians involved in the patient's care.
- Hospice must provide the NH with the following:
  - each patient's plan of care, hospice election form and any advance directives, physician certification of terminal illness and medication information, physician orders; and
  - names and contact information of hospice personnel and instructions for the hospice's 24-hour on-call system.

New Proposed Nursing Home Regulations

Proposed regulations to require NH to have a written contract with at least one Medicare certified hospice if the NH will arrange for hospice services, or the NH will be required to transfer the patient to a facility able to service the patient. 75 Fed Reg. 65282-01 10/22/2010

- Regulations are not scheduled to be finalized until October 2013.
  - Proposed 42 C.F.R. § 483.75 "Hospice Services"
  - Contracting requirements:
    - In writing
    - Signed by NH & hospice prior to servicing patients
    - Delineate responsibility and duties of the NH and hospice
  - Delineate how NH and hospice will communicate to ensure hospice patient needs are met
  - Circumstances as to when NH must contact hospice immediately

New Proposed Nursing Home Regulations

Requires NH to ensure timely services to hospice patients residing in the facility.

- NH must report all alleged violations of abuse, neglect or mistreatment to hospice administrator.
- Hospice must offer bereavement services to NH staff.
- Designation of a NH team member to be an interdisciplinary liaison with hospice.
- NH care plan must include hospice plan of care and services to be furnished by NH.
- Hospice must assume responsibility for hospice care, including determination to change level of services.

Reimbursement Rules for NH Resident Who Elects Hospice Care

Rules depend upon whether Resident is:

- Medicare only
- Dually Eligible – Medicare & Medicaid
- Medicaid Only
- Private Only
- Other Combination

Type of service:

- Room & Board by NH – Hospice pays NH if patient has Medicaid
- Non-core services by NH – contract
- Inpatient or Routine – contracted daily rates
- Routine – core services by Hospice

Regulatory Issues

Federal Definition of "Room and Board" (R&B):

- Performing personal care services;
- Assisting with activities of daily living;
- Administering medication;
- Socializing activities;
- Maintaining the cleanliness of Resident's room; and
- Supervising and assisting in the use of durable medical equipment and prescribed therapies.

Pass Through Provision – can Hospice pay NH more than 95% for room & board?

OIG Position: a Hospice may pay up to 100% of the Medicaid daily rate.
OIG Report OEI-05-95-00251 at p. 2.

Regulatory Issues

Can NH Ever Receive More than 100% of Daily Medicaid Rate for Hospice Care of NH Resident Who Elects Hospice Care?

- Yes, if contract provides for Hospice to purchase non-core services from NH for care of terminal illness of Resident, and pays Fair Market Value (FMV).
- What about a per diem rate?
- Federal Authority in 1998 OIG Fraud Alert p. 2.
- *"Hospice and Nursing Home Contractual Relationships"* – OIG Report OEI-05-95-00251.

OIG Adv. Op. No. 01-20, 11/21/01

Facts – NH had contract with Hospice to provide routine hospice care to its Residents.

Issue – Whether payment to NH of 100% of Medicaid daily rate for room and board and separate payment for drugs used to treat the Medicaid hospice Resident's terminal illness was a kickback (KB).

OIG Conclusion – OIG held contract may involve prohibited remuneration under the AKS, but they had insufficient information about the drugs.

OIG Incorrect because R&B under Federal Law does not include medications, and hospice can purchase non-core items of medications related to TI from NH.

"Hospice and NH Contractual Relationships" OIG Report OEI-05-95-00251

<u>Findings</u> – both Hospice and NH benefit financially when terminally ill Resident elects hospice care because:

- Hospices benefited because length of stay (LOS) was increased and efficient utilization of their staff.
- NH benefited because received additional staff hours at no additional cost, increased patient census and reduced supply and medication costs when hospice provided them.

<u>Findings</u> – Affirmed fact that for Medicaid Resident who elects hospice care, *"Medicaid will continue to pay for services furnished by the patient's non-hospice attending physician and for the treatment of conditions unrelated to the terminal illness." Id.*, p. 1.

NH Reporting Obligations Under the Hospice COPs: 42 C.F.R. 418.52(b)(4)

1. **Immediate reporting to Hospice Administrator of any alleged violations involving mistreatment, neglect or verbal, mental, sexual and physical abuse, including, injuries of unknown sources, and misappropriation of patient property by anyone furnishing services on behalf of the Hospice.**

2. **Immediate notification to Hospice by NH if:**
   a) there is a change in patient's mental, social or emotional status
   b) clinical complications appear suggesting a need to alter the Plan of Care
   c) a need to transfer the patient from the Skilled Nursing Facility arises.
   d) a hospice patient dies.

Hospice Abuse Reporting Obligations for Patients in a Nursing Home

Section 1150B of the Social Security Act requires reporting of any reasonable suspicion of crimes committed against a resident of a nursing home

S&C: 11-30-NH, Issued June 17, 2011 and revised August 12, 2011, provides further information regarding the reporting requirements

<u>http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_30.pdf</u>

Requires a hospice that provides hospice services in a nursing home to report a reasonable suspicion of a crime leading to serious bodily injury within 2 hours, and any other reasonable suspicion of a crime within 24 hours, to at least one law enforcement agency with jurisdiction

OIG Concerns

- **Both parties have to provide the services for which they are responsible, and being paid by Medicare.**
- **No payments or in-kind services are given in return for referrals.**
- **Problem-solving mechanisms built into contract:**
  a) Case conferences between Hospice and NH
  b) Participation in Hospice IDG as requested
  c) Appointment of Liaisons
  d) Hospice 24-Hour On-Call System

What are the Potential Penalties for a Hospice that Engages in Fraudulent and/or Abusive Practices?

State and/or Federal Sanctions

- Criminal – money penalties and/or jail.
- Civil – money penalties and damages against person who knowingly submits fraudulent or false claim or statement in support of a claim.
- Administrative – exclusions, suspensions, recoupments, termination of provider agreement.

Criminal Sanctions

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

- Remuneration - In cash or in kind
- Direct or indirect
- Referring, arranging or recommending services or items
- Giver and receiver of kickback are liable

Health Care Fraud Statute – 42 U.S.C. § 1320a-7b(a)(3)

- Wrongful retention of overpayment

Other criminal statutes – title 18, U.S.C.

- Some generic, some aimed at healthcare

Civil and Administrative Sanctions

Civil Money Penalty Statute – 42 U.S.C. § 1320a – 7a

- CMPs and assessments
- Exclusion from Medicare and Medicaid
- Covers false claims, beneficiary inducements and others

The Civil False Claims Act 31 U.S.C. § 3729

- **Fraud Enforcement and Recovery Act of 2009 (FERA) – effective May 20, 2009 – amended the FCA.**
- **False or fraudulent claim for government payment exists regardless of whether the claim was presented to the government for payment.**
- **Actual knowledge, deliberate ignorance, or reckless disregard used to be intent requirement. Amended to eliminate the intent requirement: *"require no proof of specific intent to defraud."***
- **Sufficient that the false record or statement <u>may</u> be *"material to a false or fraudulent claim."***
- **Penalty from $5,500 to $11,000 per claim, plus treble damages.**
- **Other penalties include criminal prosecution, exclusions, costs and attorneys fees.**
- **Qui tam provisions – whistleblower.**

Return of Overpayments

- **Failure to return money a provider is not entitled to is considered a violation of the FCA and subjects the provider to a penalty of $5,500-$11,000 per claim.**
- **Knowingly concealing or failing to disclose occurrence of event affecting right to payment – 42 U.S.C.1320a-7b(a)(3). Criminal Sanction.**

Patient Protection and Affordable Care Act (PPACA) 3/23/10 and Health Care and Education Reconciliation Act (HCERA) 3/30/10 = Affordable Care Act (ACA)

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Return of Overpayments

- **§ 6402 defines overpayment as *"any funds that a person receives or retains under Medicare or Medicaid to which the person after applicable reconciliation is not entitled . . ."***
- **Person includes provider of services, Medicaid managed care organization, Medicare Advantage Plan and Prescription Drug Plan.**
- **Report and return the overpayment to Medicare or Medicaid within 60 days after overpayment is identified or date any corresponding cost report is due.**
- **State Medicaid programs have the same requirements.**

Proposed Regulations Regarding Reporting and Returning of Overpayments

Proposed Rule Published 2/16/12 in the Federal Register:

http://federalregister.gov/a/2012-03642

- If an overpayment is identified, provider has 60 days from the date the overpayment is identified to return the money
- Time period is 10 years
- Must use the self-reported overpayment refund process as set forth by the MAC
- Written report with providers name, tax ID#, how issue was discovered, reason for the overpayment, claim #, DOS, Medicare claim control #, NPI.

Proposed Regulations Regarding Reporting and Returning of Overpayments (cont'd)

- Description of corrective action plan to ensure error does not occur again.
- Whether the provider has a CIA with the OIG or is under the OIG self disclosure protocol.
- The timeframe and total amount of the refund.
- If a statistical sample was used to calculate the overpayment, a description of the statistically valid method used.
- The refund for the overpayment. A provider may request an extended repayment schedule.

Administrative Sanctions

1. **Exclusions From Participating In Medicare and Medicaid – 42 U.S.C. § 1320a–7**
2. **Suspension Of Payment – 42 C.F.R. § 405.370**
3. **Pre-payment Audit**
4. **Termination of Existing Medicare (and Medicaid) Provider Agreement**

OIG – Hospice/Nursing Home Issues

1. **1998 OIG Special Fraud Alert – "Fraud and Abuses In Nursing Home Arrangements With Hospice"**
2. **Medicare Advisory Bulletin on Hospice Benefits – 11/2/05**
3. **"Special Advisory Bulletin Regarding Provision of Gifts and Other Inducements to Medicare Beneficiaries," 8/30/02**
4. **OIG Advisory Opinions 00-03; 00-07; 01-19; 03-04; 08-07**
5. **Medicare Hospice Care For Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements, 2009**

OIG Reports – Hospice/Nursing Home Issues

Medicare Hospices that Focus on Nursing Facility Residents	**OEI-02-10-00070**	**7/11**
Questionable Physician Hospice Billing	**OEI-02-06-00224**	**9/10**
Hospice NF Medicare Coverage Rules	**OEI-02-06-00221**	**9/09**
Hospice Services to NF Residents	**OEI-02-06-00223**	**9/09**
Hospice Beneficiaries Use of Respite Care	**OEI-02-06-00222**	**3/08**
Beneficiaries in NH vs. Other Setting	**OEI-02-06-00220**	**12/07**
Hospice Beneficiaries Services and Eligibility	**OEI-04-93-00270**	**4/98**
Hospice and NH Contractual Relationships	**OEI-05-95-00251**	**11/97**
Validity of Medicare Hospice Enrollments	**A-05-96-00023**	**11/97**
Hospice Patients in Nursing Homes	**OEI-05-95-00250**	**9/97**

Hospice Risk Areas

The OIG has identified 28 risk areas for hospices in its Model Compliance Program Guidelines for Hospices
www.oig.hhs.gov/fraud/complianceguidance.html

#3 **Arrangement with another health care provider who hospice knows submits claims for services already covered by the Medicare Hospice Benefit**

#4 **Under-utilization**

Hospice Risk Areas (cont'd)

#9 **Hospice incentives to actual or potential referral sources (e.g., physicians, nursing homes, hospitals, patients,) that may violate AKS or other similar Federal or State statute or regulation, including improper arrangements with NHs**

#10**: Overlap in the services that a NH provides, which results in insufficient care provided by a hospice to a NH resident.**

Ex.: If NH is billing Part D prescription benefit for drugs related to TI.

Hospice Risk Areas (cont'd)

#11 **Improper relinquishment of core services and professional management responsibilities to NHs, volunteers, and privately-paid professionals**

#12 **Providing hospice services in a NH before a written agreement has been finalized**

#18 **High-pressure marketing of hospice care to ineligible beneficiaries.**

#19 **Improper patient solicitation activities, such as *"patient charting"***

OIG 2011 Hospice Work Plan

Hospice utilization in the nursing facility.

- **OIG will be reviewing the characteristics of nursing facilities with high hospice utilization. OIG will also be reviewing the business relationships , as well as marketing practices and materials of hospices with high nursing facility utilization.**
- **OIG will be reviewing appropriateness of hospice inpatient claims.**
- **OIG will review services provided by hospices and nursing facilities to hospice patients residing in the nursing facilities. Reviews will include services provided by hospice aides, coordination of care, services to be provided by each entity, and payment arrangement.**
- **OIG will be reviewing appropriateness of Medicare Part D payments with respect to coverage of drugs under the Part A benefit as well as duplicate payments.**

OIG 2012 Hospice Work Plan

- **OIG will review claims for inpatient stays where the beneficiary was transferred to hospice care – OIG will review the relationship (financial or common ownership) between the acute care hospitals and hospices**
- **OIG will review hospice marketing materials and practices and financial relationships between hospices and nursing facilities**
- **OIG will review the appropriateness of the use of GIP**
- **OIG will review drug claims under Part D**
- **OIG will review Medicaid payments to determine if the hospice services complied with the federal reimbursement requirements**

OIG 2013 Hospice Work Plan

- **OIG will review hospices' marketing materials and practices and their financial relationships with nursing facilities.**
  - In a recent report, OIG found that 82% of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements.
  - OIG will focus their review on hospices with a high percentage of their beneficiaries in nursing facilities.
- **OIG will review the use of hospice general inpatient care in 2011, and will also assess the appropriateness of hospices' general inpatient care claims.**

OIG 2013 Hospice Work Plan (cont'd.)

- **OIG will review hospital discharges to hospice facilities – focusing on hospital DRG payments.**
- **OIG will review Medicaid payments to determine compliance with Federal reimbursement requirements.**

Will There Be a New Hospice NH Benefit?

- **End of Life Palliative Care Benefit for Nursing Home Residents with Chronic or Life Threatening Illness Regardless of Prognosis, *i.e.*, Dementia – recommended by Dr. Diane E. Meier, Betty Lim and Melissa S.A. Carlson**
- **Huskamp/Stevenson Proposal**
- **Medicare Payment Advisory Commission (Med PAC) and OIG Concerns**
- **OIG report OEI-02-10-0070 suggests reducing Medicare payments for hospices providing services to nursing facility residents**

Questions?

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