The Hospice/Nursing Home Partnership: How to do it Right!

National Hospice and Palliative Care Organization – 29th Management and Leadership Conference

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Background: 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 Long Term Care Facilities: 42 C.F.R. Part 483 –
"highest practicable physical, mental and psychosocial well-being"

Two different reimbursement schemes.

Patient is both a LTCF Resident and a Hospice Patient with different assessment tools and criteria.

LTCF Medical Director vs. Hospice Medical Director.

Coordination of Care

Barriers

LTCF Resident or Legal Representative Must Elect Hospice Care.

Election of Hospice care for terminal illness (TI) in lieu of LTCF services for TI, complicated by patient's multiple chronic conditions that make it difficult to identify if treatments are curative or palliative.

When Medicare beneficiary, who resides in LTCF elects Hospice, there is no reimbursement for room and board, unless the beneficiary is also Medicaid recipient or has insurance.

Collaboration

LTCF/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

Collaboration Issues cont'd.

- Hospice can contract to purchase non-core services from LTCF: PT, OT, ST, Hospice aide, meds and supplies.
- Cannot contract for Hospice core services: RN, SW, Physician, Counseling – dietary, bereavement and spiritual. Waivers.
- Cannot provide continuous care services to patients in a SNF or skilled bed of NF. **MLN JA 6778**
- **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6778.pdf**

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 LTCF Residents

COP delineates Hospice responsibility for LTCF Resident receiving Hospice services:

1. Resident eligibility
2. Professional management
3. Written agreement
4. Hospice plan of care
5. Coordination of services
6. Orientation and training of staff

42 C.F.R. §483.75(t) Administration - COP for LTCF Residents Electing Hospice Care

New LTCF regulations apply to SNF/NF and ICF/IID (Individuals with Intellectual Disabilities), collectively Long Term Care Facilities (LTCF) Effective 8/26/13, delineate LTCF responsibility for Residents electing Hospice care. **http://www.gpo.gov/fdsys/pkg/FR-2013-06-27/pdf/2013-15313.pdf**

1. Written Authorized Contract
2. Contract Provisions
3. Hospice Services
4. Plan of Care

42 C.F.R. §483.75(t) - COP for LTCF Residents Electing Hospice Care (cont'd)

5. LTCF Services
6. Communication Process
7. Mutual Notifications
8. Level of Hospice Care
9. LTCF Personnel Administering Therapies
10. Reporting Alleged Violations
11. Bereavement Services
12. Coordination of Services
13. Cross Orientation

42 C.F.R. §418.112(c) - 9 Contract Provisions

1. Communication between LTCF and Hospice
2. Notification of changes in patient's status
3. Hospice responsible for determining care level
4. LTCF responsible to furnish room and board
5. Specific delineation of the Hospice's responsibilities
6. Provision specifying LTCF personnel can be used only to the extent that a patient's family would be used in implementing a plan of care
7. Hospice abuse reporting requirements
8. Hospice provision for bereavement services
9. Hospice responsibility to provide Hospice services at the same level as if patient residing in the community

42 C.F.R. §483.75(t)(2)(ii) - 11 Contract Provisions

1. Describe Hospice services provided
2. Hospice responsible for Hospice plan of care
3. Describe LTCF services provided per resident POC
4. Communication process
5. When LTCF must notify Hospice
6. Hospice responsible for level of Hospice care
7. LTCF provide 24 hour room and board, personal care and nursing needs as per resident POC
8. Delineate Hospice responsibilities for care of terminal illness and related conditions
9. Delineate when LTCF personnel are responsible for administration of prescribed therapies
10. LTCF reporting abuse to Hospice Administrator
11. Hospice bereavement services to LTCF staff

Contract and Practice Requirements

Resident Eligibility for Hospice Care - Medicare patients receiving Hospice services and residing in a LTCF must meet same Medicare Hospice eligibility criteria as Hospice patients in the community. §418.112(a)

Professional Management - Hospice must assume responsibility for professional management of resident's Hospice services in accordance with Plan of Care §418.112(b)

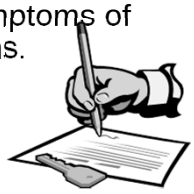
Professional Services and Timeliness – LTCF responsible to ensure that Hospice services comply with professional standards, and are provided in a timely manner to meet resident's needs. §483.75(t)(2)(i)

Level of Hospice Care – Hospice responsible to determine appropriate level of Hospice care or any changes in the level. §418.112(c)(3) and §483.75(t)(2)(ii)(F)

Hospice Services - §418.112(c) & §483.75(t)(2)(ii)(A)(H)

Contract Article One should describe regulatory definitions of key terms from Hospice and LTCF Federal and state regulations.

Contract Article Two should describe Hospice services to be provided and Hospice responsibilities for medical direction and management of the patient, nursing, counseling, social work, medial supplies, DME, medications, and all other services needed for the palliation of pain and symptoms of the terminal illness and related conditions.



Hospice Plan of Care - §418.112 (d) & §483.75(t)(2)(ii)(B)

- Hospice responsible for appropriate Hospice POC and must collaborate and consult with LTCF.
- POC must identify the care and services needed, and specify which provider is responsible for performing the respective functions agreed upon and identified in the Hospice POC.
- POC must reflect participation of Hospice, LTCF, patient and family, to the extent possible.
- Changes to POC must be discussed with the patient, representative and LTCF, and must be approved by the Hospice.

LTCF Services - §483.75(t)(2)(ii)(C) (G) & §418.112 (c)(4)

- **Contract ArticleThree -** should describe services LTCF will continue to provide per each resident's POC.
- LTCF must continue 24 hour room and board; and meet resident's personal care and nursing needs in coordination with the Hospice liaison or coordinator.
- Hospice regulation same result, but states LTCF must provide personal care and nursing needs that would have been provided by the primary caregiver at home, and at the same level of care provided before Hospice elected.
- If LTCF will provide other services based on resident's POC, describe the services in the contract.

Communication Process - §418.112 (c)(1) & §483.75(t)(2)(ii)(D)

Contract Articles Two and Three should both describe 24 hour per day communication process between Hospice and LTCF to ensure how:

- the needs of the resident will be met;
- how communication will be documented;
- and ensure quality of care.

Both articles must ensure that Hospice IDG communicates with the LTCF's Medical Director; that LTCF communicates with Hospice Medical Director; and that there is communication with the patient's attending physician, and any other physicians involved in the patient's care.

Coordination of Services - §418.112 (d)(e) & §483.75(t)(3)

Both entities must collaborate in developing Hospice POC.

- Both must designate an IDG member to coordinate Hospice care of LTCF resident.
- LTCF team member must have a clinical background or have access to someone who has skills, within State scope of practice, to assess the resident.

Coordination of Services - §418.112 (d)(e) & §483.75(t)(3) cont"d

- Hospice must provide the LTCF with the following:
  - most recent Hospice POC
  - Hospice election form
  - any advance directives
  - physician certification of terminal illness
  - Hospice medication information
  - Hospice and attending physician orders
  - names and contact information of Hospice personnel
  - instructions for the Hospice's 24-hour on-call system.

Mutual Notices - §418.112 (c)(2) & §483.75(t)(2)(ii)(E)

LTCF must notify Hospice if:

- there is a significant change in resident's physical, mental, social or emotional status
- there is a need to alter the POC because of clinical complications
- if resident has to be transferred for any reason, not just a condition related to the terminal illness
- resident dies

LTC F Personnel Administering Therapies - §418.112 (c)(7) & § 483.75(t)(2)(ii)(I)

Both regulations permit LTCF personnel authorized under state law to administer prescribed therapies in the Hospice POC.

The LTCF regulations do not have the limitation which appears in the Hospice regulations, i.e. only to the extent that the Hospice would routinely use the services of the patient's family in implementing the POC.

Cross Orientation - §418.112(f) & §483.75(t)(3)(v)

Orientation and Training of Staff -

- Both must orient each others staff in their own policies, procedures, patients" rights, forms, and record keeping.

- Hospice must train LTCF staff about *"Hospice philosophy"* and principles on death and dying.

Bereavement Services - §418.112(c)(9) & §483.75(t)(2)(ii)(K)

Bereavement Services –

Both require a delineation of responsibilities of Hospice and LTCF to provide bereavement services to LTCF staff.

Reporting Obligations - §418.112(c)(8) & §483.75(t)(2)(ii)(J)

If there is an alleged violation of mistreatment, neglect or verbal, mental, sexual and physical abuse, injuries of unknown sources, and misappropriation of patient property, there are mutual reporting obligations between LTCF and Hospice Administrator.

If anyone furnishing services on behalf of Hospice causes abuse, Hospice employee or contracted staff must report immediately to Hospice Administrator. §418.52(b)(4)

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-LTC, Issued June 17, 2011 and revised August 12, 2011, provides further information regarding the reporting requirements

http://www.cms.gov/SurveycertificationgenInfo/downloads/SCLetter11_30.pdf

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

Reimbursement Rules for LTCF 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 LTCF – Hospice pays LTCF if patient has Medicaid
- Non-core services by LTCF – contract
- Inpatient or Respite – 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 LTCF more than 95% for room & board? Yes 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 LTCF Ever Receive More than 100% of Daily Medicaid Rate for Hospice Care of LTCF Resident Who Elects Hospice Care?

- Yes, if contract provides for Hospice to purchase non-core services from LTCF 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
- *"Hospice and Nursing Home Contractual Relationships"* – OIG Report OEI-05-95-00251.

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:
  - Case conferences between Hospice and LTCF
  - Participation in Hospice IDG as requested
  - Appointment of Liaisons
  - Hospice 24-Hour On-Call System

What are the Potential Penalties for a Hospice/ LTCF 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

Exclusions From Participating In Medicare and Medicaid – 42 U.S.C. §1320a–7

Suspension Of Payment – 42 C.F.R. §405.370

Pre-payment Audit

Termination of Existing Medicare (and Medicaid) Provider Agreement

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

- Fraud Enforcement and Recovery Act of 2009 (FERA) – effective May 20, 2009
- 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 is knowledge requirement. Amended to eliminate the intent requirement: *"require no proof of specific intent to defraud."*
- Sufficient that the false record or statement may be *"material to a false or fraudulent claim."*
- Penalty $5,500 to $11,000 per claim, 3X damages.
- Other penalties include criminal prosecution, exclusions, costs and attorneys fees.
- Qui tam provisions – whistleblower.

Return Overpayments

- Failure to return money a provider is not entitled to is considered a violation of the False Claims Act 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.

Return Overpayments

- §6402 of ACA 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 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 #, and NPI.

Proposed Regulations Regarding Reporting and Returning 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.
- A provider may request an extended repayment schedule in order to refund the overpayment

OIG – Hospice/Nursing Home Issues

1. 1998 OIG Special Fraud Alert – "Fraud and Abuses In Nursing Home Arrangements With Hospice“ **http://oig.hhs.gov/fraud/docs/alertsandbulletins/hospice.pdf**
2. Medicare Advisory Bulletin on Hospice Benefits – 11/2/95 **http://oig.hhs.gov/fraud/docs/alertsandbulletins/hospice2.pdf**
3. "Special Advisory Bulletin Regarding Provision of Gifts and Other Inducements to Medicare Beneficiaries," 8/30/02 **http://oig.hhs.gov/fraud/docs/alertsandbulletins/sabgiftsandinducements.pdf**

OIG Advisory Opinions

Hospice of Martin & St Lucie 2000-03 - **http://oig.hhs.gov/fraud/docs/advisoryopinions/2000/ao00_3.htm**

Free Transportation Services 2000-07 **http://oig.hhs.gov/fraud/docs/advisoryopinions/2000/ao00_7.htm**

Free Office Space to End of Life Program 2001-19 **http://oig.hhs.gov/fraud/docs/advisoryopinions/2001/ao01-19.pdf**

Free Medical Alert Pagers to HH 2003-04 **http://oig.hhs.gov/fraud/docs/advisoryopinions/2003/ao0304.pdf**

Gift Cards to Patients 2008-07 **http://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-07.pdf**

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 LTCF 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 Patients In Nursing Facilities

OEI-05-95-00250 - September 1997

http://oig.hhs.gov/oei/reports/oei-05-95-00250.pdf

1. OIG concluded a lower frequency of services, an overlap of services, and questionable enrollment of NF patients in Hospice. Findings suggest the current payment levels for Hospice care in nursing facilities may be excessive.
2. NF Hospice patients received nearly 46 % fewer nursing and aide services from Hospice staff than Hospice patients living at home. Three out of four patients received only basic nursing and aide visits. Despite these differences Hospices received the same level of payment as for patients living at home.

Hospice Patients In NF (cont'd)

OIG made two recommendations:

1. to modify Medicare or Medicaid payments for Hospice patients living in nursing facilities, which include lowering Hospice payments for patients who reside in nursing facilities; or
2. to revise nursing facilities' requirements for services provided to their terminal patients.

However, this report did affirm that the Medicare Hospice benefit for patients living in nursing facilities should not be eliminated.

Hospice and NF Contractual Relationships

OEI–05-95-00251 - November 1997

http://oig.hhs.gov/oei/reports/oei-05-95-00251.pdf

OIG findings:

1. Almost all Hospices reviewed paid nursing homes the same or more than what Medicaid would have paid for nursing home care, if the patient had not elected Hospice.
2. The six Hospices paying more than 100% of the Medicaid daily rate for nursing home care had a higher percentage of patients in nursing homes.

Hospice and NF Contractual Relationships (cont'd)

3. Both the Hospice and NF can benefit financially by enrolling patients in Hospice:
   - Hospices benefited because length of stay (LOS) was increased and efficient utilization of their staff.
   - LTCF benefited because received additional staff hours at no additional cost, increased patient census and reduced supply and medication costs when Hospice provided them.
4. Some Hospice contracts with nursing homes contained language that raised questions regarding inappropriate referrals between the Hospice and NF.

Medicare Hospice Care: A Comparison Of Beneficiaries in NF and in Other Settings

OEI-02-06-00220 - December 2007

http://oig.hhs.gov/oei/reports/oei-02-06-00220.pdf

OIG Objective:

1. To determine the percentage of Medicare Hospice beneficiaries who reside in NFs.
2. To describe the characteristics of Medicare Hospice beneficiaries who reside in NFs, and compare these characteristics to those of Hospice beneficiaries who reside in other settings.

Medicare Hospice Care: A Comparison of Beneficiaries in NFs and Other Settings (cont'd)

OIG Findings:

1. 28% of Medicare Hospice beneficiaries resided in nursing facilities in 2005.
2. Hospice beneficiaries in nursing facilities were more than twice as likely as beneficiaries in other settings to have terminal diagnoses of ill-defined conditions, mental disorders, or Alzheimer's disease.
3. On average, beneficiaries in nursing facilities spent more time in Hospice care and were associated with higher Medicare reimbursements than beneficiaries in other settings.

Medicare Hospice Care for Beneficiaries in NFs: Compliance With Medicare Coverage Requirements

OEI-02-06-00221 - September 2009

http://oig.hhs.gov/oei/reports/oei-02-06-00221.pdf

OIG's Objective:

- To determine the extent to which Hospice claims for beneficiaries in nursing facilities in 2006 met Medicare coverage requirements.

Medicare Hospice Care for Beneficiaries In NFs: Compliance with Medicare Coverage Requirements (cont'd)

OIG Findings: 82% OF HOSPICE CLAIMS FOR BENEFICIARIES IN NURSING FACILITIES DID NOT MEET AT LEAST ONE MEDICARE COVERAGE REQUIREMENT

1. **82%** of claims did not meet at least one Medicare coverage requirement pertaining to election statements, plans of care, services, or certifications of terminal illness. An additional **1%** of claims were undocumented. Medicare paid approximately $1.8 billion for these claims.
2. Claims from not-for-profit Hospices were less likely to meet Medicare coverage requirements than those from for-profit Hospices. Specifically, **89%** of claims from not-for-profit Hospices did not meet Medicare requirements, compared to **74%** of claims from for-profit Hospices.

Medicare Hospice Care for Beneficiaries in NFs: Compliance with Medicare Coverage Requirements (cont'd)

3. **OIG Findings:**
   - 33% of claims did not meet election requirements.
   - 63% of claims did not meet plan of care requirements.
   - 31% of claims, Hospices provided fewer services than outlined in beneficiaries' plans of care.
   - 4% of claims did not meet certification of terminal illness requirements.

Medicare Hospice Care for Beneficiaries In NFs: Compliance with Medicare Coverage (cont'd)

OIG Recommendations:

- Educate Hospices on coverage requirements and their importance in ensuring quality of care.
- Provide tools and guidance on coverage.
- Strengthen monitoring practices on Hospice claims. CMS should effectively use targeted medical reviews and other oversight mechanisms to improve Hospice performance and compliance with Medicare requirements, i.e., establishing POCs and providing services that are consistent with POCs.
- CMS should conduct more frequent certification surveys of Hospices as a way to enforce the requirements

Medicare Hospice Care: Services Provided to Beneficiaries Residing in NFs

OIE-02-06-00223 –September 2009

https://oig.hhs.gov/oei/reports/oei-02-06-00223.pdf

OIG 31% of Medicare Hospice Beneficiaries Resided in NF in 2006; Medicare Paid $2.59 Billion for Hospice Care:

- Based on claims data for all Medicare beneficiaries receiving Hospice care, OIG found **31%** of Hospice beneficiaries resided in NF in 2006, compared to **28%** in 2005. In 2006, 289,544 beneficiaries received Hospice while residing in NFs.
- Medicare paid Hospices approximately $2.59 billion for care provided to beneficiaries residing in NFs in 2006. On average, Medicare paid $960 per week for each Hospice beneficiary in a NF. This amount did not cover physician services, which were paid for separately from the daily rate.

Medicare Hospice Care: Services Provided to Beneficiaries Residing in NFs (cont'd)

- The most common level of Hospice care provided to these beneficiaries was routine care. **91%** of Hospice claims were for routine care only. Another **3%** were for general inpatient care only. Most of the remaining claims were for a combination of routine care, and one or more other levels of care.
- Hospices most commonly provided NF with Hospice aide, medical social services, and drugs.
- Differences in percentages between for-profit and not-for-profit was not statistically significant.

Medicare Hospices That Focus On NF Residents

OEI-02-10-00070 - July 18, 2011

http://oig.hhs.gov/oei/reports/oei-02-10-00070.pdf

Medicare spending on Hospice care for NF residents grew nearly **70%** since 2005.

Additionally, hundreds of Hospices had a high percentage of their beneficiaries residing in NF, and most of these Hospices were for-profit.

Compared to Hospices nationwide, these high-percentage Hospices received more Medicare payments, and served beneficiaries who spent more time in care.

High percentage Hospices typically enrolled beneficiaries whose diagnoses required less complex care, and who already lived in NF before they elected Hospice care.

Definition of High Percentage Hospices

- 8% of Hospices
- 263 Hospices in country
- More than 2/3 of beneficiaries received Hospice care in NFs in 2009
- 72% of high percentage Hospices were for-profit, compared to 56% of all Hospices
- On average, high percentage Hospices served beneficiaries in 20 NFs.

Characteristics of High Percentage Hospices

- Received more Medicare payments per beneficiary and served beneficiaries who spent more time in care
- Medicare paid an average of $3,182 more per beneficiary for beneficiaries served by high-percentage Hospices than it paid per beneficiary for those served by Hospices overall
- By the end of 2009, the median number of days in Hospice care for a beneficiary served by a high-percentage Hospice was 3 weeks longer than the median number of days for a typical Hospice beneficiary.

Medicare Hospices That Focus On NF Residents OIG Conclusions

Medicare payment for Hospices providing care in NF is the same rate as for care provided in other settings, such as private homes. Unlike private homes, NFs are staffed with professional caregivers and are often paid by third party payers, such as Medicaid. These NFs are required to provide personal care services, which are similar to Hospice aide services that are paid for under the Hospice benefit.

The OIG concluded that some Hospices may be seeking beneficiaries with particular characteristics, including those with conditions associated with longer, but less complex care. Such beneficiaries are often found in NFs. By serving these beneficiaries for longer periods, the Hospices receive more Medicare payments, which can contribute to larger profits.

Hospice Risk Areas Impact Hospice/LTC

The OIG has identified 28 risk areas for Hospices
in its Model Compliance Program Guidelines for Hospices

http://oig.hhs.gov/authorities/docs/hospicx.pdf

#3 Arrangement with another health care provider who Hospice knows submits claims for services already covered by the Medicare Hospice Benefit. For example, Inpatient Hospital stay, LTCF, DME, or Home Health Agency.

#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 LTCFs

#10 Overlap in the services that a LTCF provides, which results in insufficient care provided by a Hospice to a LTCF resident. Ex., if LTCF bills Part D for TI drugs.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Recovery-10-30-13.pdf

Hospice Risk Areas (cont'd)

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

#12 Providing Hospice services in a LTCF 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 2014 Hospice Work Plan

Hospices in Assisted Living Facilities

OIG will review Hospice services to Medicare beneficiaries who reside in ALF concentrating on length of stay, levels of care received, and common terminal illnesses. Affordable Care Act §3132 requires that CMS reform Hospice payment system, collect data relevant to revising Hospice payments, and develop quality measures. Hospice care may be provided in various settings. The Medicare Payment Advisory Commission recommends these long stays be examined.

OIG 2014 Hospice Work Plan

Hospice General Inpatient Care

OIG will review the use of GIP for:

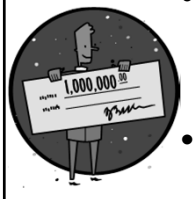
- appropriateness of claims
- content of election statements
- review of medical records due to concerns of misuse of GIP level of care

OIG 2013 Hospice Work Plan

- OIG will review Hospices' marketing materials and practices and their financial relationships with nursing facilities.
  - 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 NFs.

OIG 2013 Hospice Work Plan (cont'd.)

- 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 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 LTCF 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
- 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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