



IHO Update

Bi-weekly News for Hospice Professionals in Iowa

February 2, 2007

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Special Message From the President...

It's cold outside, but it will (hopefully) soon pass and we will be looking at warmer, brighter days ahead. Just as it could be brighter days ahead as we improve the quality of the care and services for our hospice patients and their families.

Many of us have listened in on the conference calls in January to learn more about the QAPI Snapshot Survey partnership with OCS and Iowa hospices. This is a great opportunity for all hospices to benefit in quality improvement.

Small, medium, and large hospices are asking important questions about committing their limited resources to this initiative. Small hospices are concerned about comparisons with higher ADC hospices and large hospices want assurance that there will be enough participation by Iowa hospices to truly make it a smart investment.

To quote Oprah, "This one thing I know," that all Iowa hospices have in common is the passion to provide the highest quality of end-of-life care for our patients and families. We all think we do that. Through participation in the QAPI Snapshot Survey our programs will see a truer picture of just how good we really are and where we need to focus our improvements efforts, whether we have five, 50 or 500 patients.

The quality measures will work for all of us by providing direction to where we need to go and how we can get there - to meet our goal of being the best that we can be. And just as importantly, it assists us in meeting the upcoming QAPI COP. This COP is meant for all hospices, regardless of ADC. To benefit from this direction, take the first step and join the initiative.

High quality end-of-life care is never an accident; it is always the result of thoughtful planning, sincere effort and a commitment to excellence. Iowa hospices are just that - committed to excellence.

Stay warm!

Leanne Burrack, IHO President

Medicare Payment Concerns Memo Sent to IHO Members

On January 24 a memo was sent out to all IHO members regarding medicare payment concerns. Over the past couple weeks IHO has been working with Cahaba GBA, and the CMS Kansas City Regional Office on two distinct Medicare claims processing concerns.

Your hospice may be noticing slowed payment from Cahaba due to either one or both of the issues as detailed below.

1. In November, Cahaba and several other Medicare contractors transitioned their data centers to EDC. The original data center in Oregon notified CMS that it was discontinuing its Medicare business, and necessitated a transition to a new data center. Since this transition, there have been a number of claims processing issues Cahaba has been working on. However, one in particular is holding up payment for home health and hospice claims. These claims are suspending with reason code 38309.

As of Friday, January 19, Cahaba reports this is a priority issue, and 29,000 claims are suspended with reason code 38309. We do not have a date certain for this system fix.

2. The second concern is the requirement for providers to report the Taxonomy Code on claims with dates of service January 1, 2007. Claims with the Taxonomy Code are moving into suspense with reason code 32113.

Both the CMS Kansas City Regional Office and Central Office are aware of this issue.

Cahaba reported this morning that a system fix is expected to be implemented this week. As of January 19, 2007, 13,000 claims are suspended with reason code 32113.

The CMS Kansas City Regional Office has forwarded these concerns to the Alabama Regional Office where the Cahaba GBA headquarters is located.

Please see the Transmittal 1133 providing instruction on reporting the Taxonomy Code and Medicare Payment Floor Instructions enclosed with this week's issue of the *IHO Update*.

IHO will continue monitoring these concerns and provide updates as they become available. For further questions, please contact Heather Hulscher, Director, Finance Policy, IHO, at hulscherh@ihaonline.org.

CAHABA News:

Fiscal Intermediary Standard System (FISS) Will Not be Available March 1

On March 1, 2007, Cahaba GBA, LLC will transition the South Dakota fiscal intermediary workload to the new Medicare Administrative Contractor (MAC), Noridian Administrative Services, LLC (NAS). As a result, FISS will not be available March 1, 2007, for providers who submit claims to the Cahaba GBA, LLC office in Des Moines, Iowa. This means that providers will not be able to perform direct data entry (DDE) in FISS, or access the ELGA and ELGH eligibility inquiry screens. However, providers will be able to submit claims via file transfer.

Medicare staff will be available in Provider Contact Centers to answer telephone calls on March 1, 2007; however, they will not have access to FISS. Therefore, the customer service representatives will not be able to answer questions about specific claims.

2007 Social Work Peer Group Conference Agenda Set

The agenda is set for this year's Social Work Peer Group Conference March 23 at Mary Greeley Medical Center in Ames.

Joy Sutter, MA, ACSW, LCSW, MBA, NHA, vice president of operations in a continuing care retirement community in Lansdale, PA, will facilitate the meeting. In her current role, Joy oversees all the clinical operations for a large retirement community with three levels of care and a variety of programs and services offered to residents. She brings more than 15 years of experience in hospice and palliative care.

The morning session will focus on, "A Quality Partnership," which will help participants identify the qualities of an effective partnership between the nursing facility and the local hospice program and define tools and strategies used with the hospice nursing facility patient.

"Emotional Intelligence – How the Practitioner Can Survive the Long Haul," will comprise the afternoon session as Joy will identify a conceptual definition for Emotional Intelligence (EI) and help the practitioner's define their own role in EI. Triggers from within that indicate the need for further EI exploration will also be presented.

Watch your mailboxes and the Web site at www.iowahospice.org for registration information in the coming weeks.

Save the Date

Be sure to mark your calendars for IHO's Annual Meeting on Thursday, April 12, at the West Des Moines Marriot. This year's conference will feature Deb Grassman, a nurse

practitioner at Bay Pines VA in St. Petersburg, Florida and a nationally-recognized speaker on veterans and end-of-life. She will explore successful suffering and what veterans can teach us. Deb will continue her presentation with information on the value of providing prognoses to patients so end-of-life strategies can be developed.

The conference will also feature sessions on mental health and hospice. The annual business meeting that would normally take place in the spring will now be held at the Fall Conference in October.

Watch for registration information soon!

CMS Attempts to Clarify False Claims Policy Requirements

The article below was submitted by Mary Michal, JD, Reinhart Boerner Van Deuren s.c., Wisconsin, who will be providing IHO Update readers with periodic articles regarding updates on hospice compliance issues.

On January 11, 2007, the Centers for Medicare and Medicaid Services (CMS) conducted a conference call in an attempt to answer questions from health care providers and health plans that sought guidance on the requirements of section 6032 of the Deficit Reduction Act of 2005 (the "DRA"), which requires certain health care providers and health plans to establish written fraud and abuse/whistleblower informational policies for all employees, contractors and agents as of January 1, 2007. Although some of the questions were answered, Robb Miller, CMS' Program Integrity Group Acting Director, acknowledged that CMS would need to "drill down" on several questions that remain unanswered.

As described in our November 27, 2006 Reinhart E-Newsletter (available at <http://www.reinhartlaw.com/WebAdmin/publications/310.pdf>), providers and health plans that make or receive \$5 million or more in Medicaid reimbursement must establish written policies and procedures for all employees, contractors and agents that provide detailed information about certain fraud and abuse laws and whistleblower protection laws. Specifically, the policies must include detailed information about state and federal false claims laws, detailed provisions about the entity's relevant policies and procedures for detecting and preventing fraud, abuse and waste, and details about whistleblower protections that must be outlined in an employee handbook.

On December 13, 2006, CMS issued guidance to State Medicaid Directors (available at <http://www.cms.hhs.gov/smdl/downloads/SMD121306.pdf>) that provided some clarification to the section 6032 policy requirements. First, the guidance established that, when an entity furnishes items or services at multiple locations or under multiple contractual or other payment arrangements, section 6032 policy requirements apply if the aggregate Medicaid payments to that entity meet the \$5 million annual threshold, regardless of whether one or more provider identification or tax identification number is used to submit claims. Second, the December 13th guidance explained that a "contractor" or "agent" includes any contractor, subcontractor, agent or other person which or who, *on behalf of the entity*, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs

billing or coding functions, or is involved in monitoring of health care provided by the entity. The requirements would not apply to other contractors or agents (e.g., contractors that provide janitorial services, office supplies, etc.). Finally, the December 13th guidance indicated that there is no requirement for an entity to create an employee handbook if none already exists.

As evidenced by the more than 800 callers that participated in the January 11 conference call, providers and health plans were still confused and had questions even after the December 13 guidance was released. Some of these questions were answered while others remain open issues.

Among the questions answered included how the \$5 million dollar threshold would be calculated. Robb Miller explained that the threshold amount would be calculated based on the total dollar amount actually paid out by the Medicaid program (i.e., not the claimed amount). However, the states will be able to decide whether the date of service or the date of payment will be used for purposes of calculating the sum of all payments made annually (i.e., between October 1st and September 30th). In addition, Robb Miller explained that, in a multi-entity health system, section 6032 policy requirements will apply to each entity in the system if the aggregate Medicaid collections for all of the system's entities total \$5 million or more. However, multi-state entities/systems do not need to aggregate payments received in separate states. Finally, with respect to calculating the threshold amount, any "patient paid amount" is not included.

In addition to clarifying the threshold dollar amount calculation, Robb Miller stated that there is no training requirement mandated by section 6032. Thus, although entities must establish and distribute the section 6032 policies, they do not need to conduct training sessions in order to educate employees, contractors and agents about such policies.

The primary question that was not definitively answered by CMS was whether an entity must require its contractors and agents to adopt, or comply with, its section 6032 policy or whether the entity is simply required to document that it sent a copy of the policy to each agent and contractor. Robb Miller indicated that CMS would "follow up" on that question. That said, from a risk standpoint, it is probably a good idea for an entity to require its contractors and agents to comply with the section 6032 policy. Depending on the provisions contained in the current agreements between an entity and its contractors/agents, this could potentially be accomplished by simply providing notice of the policy (along with a copy of the policy) to the agent/contractor. An entity may also have the ability to unilaterally amend some agreements to require compliance with its section 6032 policy. However, the terms of some contractor/agent agreements may require a mutually agreed-upon amendment which could give rise to a renegotiation.

This Health Care Client Alert provides general information about health care issues. It should not be construed as legal advice or legal opinion. Readers should seek counsel concerning specific fact situations confronting them.

Home Health Campaign Aims to Reduce Avoidable Hospitalizations

The Centers for Medicare & Medicaid Services has launched a yearlong campaign to reduce acute-care hospitalizations for home health patients, improve clinical outcomes, and raise patient satisfaction. Hospital-based and other home health agencies are encouraged to participate in the Home Health Quality Improvement National Campaign by registering online. Best practices on reducing avoidable acute care hospitalizations will be shared monthly, and each participating home health agency can select the strategies that best support their organization. Participants also will receive CMS reports comparing their actual and risk-adjusted acute care hospitalization rates to national and statewide benchmarks. More information, including online registration, is available at <http://www.homehealthquality.org/hh/>.

HNN Notes

- *Living With Grief Before and After the Death* has been published by the Hospice Foundation of America (HFA). The book offers insight into the most current theoretical perspectives on loss and grief. It was developed in conjunction with HFA's annual "Living With Grief Teleconference," which will be broadcast by live satellite on March 22. (*PR Newswire*, 1/16)
- A new **American Cancer Society report** finds that cancer deaths have fallen in each of the last two years, but blacks experience significantly higher rates of death than whites. Although black women have a 9 percent lower cancer rate than their white peers, black women have an 18 percent higher death rate for all forms of cancer. Black men have a 15 percent higher rate of cancer and a 38 percent higher death rate than white men, a trend that extends from 1999 to 2003. (*USA Today*, 1/18)
- Five teenagers from San Francisco's East Bay area recently died in car accidents, and an article in the *Contra Costa Times* says **technology is transforming this experience** dramatically changing everything – from the speed with which tragic news spreads to the way young people mourn." IM's and text messages quickly spread word of the deaths and joined those who visit the memorial books at Facebook.com. Hospice of Contra Costa bereavement program manager Lee Ann Morgan said that it's essential to reach out to the people you are most comfortable with and that the online posts and messages "allow teenagers to share emotions and recollections without the vulnerability of being face to face." (*Contra Costa Times*, 1/18)
- The **American Hospital Association** strongly urged Congress to stop [CMS] from implementing a proposed rule that would reduce Medicaid funding by \$3.8 billion over five years and significantly disrupt care delivered through Medicaid programs around the nation. The AHA called on the Bush administration to work with Congress and hospitals to properly protect and improve Medicaid rather than bypass needed input and propose drastic changes through a regulatory process. (*AHA News Now*, 1/16)

HNN is sponsored by Glatfelter Insurance Group that provides property and liability insurance for hospices and home healthcare agencies through their Hospice and Community Care Insurance Services division. Ask your insurance agent to visit their website at www.hccis.com.

Enclosures

Transmittal 1133
Medicare Payment Floor Instructions