# IHO Update

*Bi-weekly News for Hospice Professionals in Iowa*

**April 27, 2007**

## Hospice Manager Development Program Registration Coming Soon!

NHPCO's Hospice Manager Development Program (MDP) will take place in Des Moines at the IHO Education Center on June 4 & 5, 2007. The Hospice MDP offers the specific knowledge and skills hospice managers need to meet today's changes and challenges. This program offers a broad range of learning opportunities and skills that NHPCO members say are needed most in today's environment. This two-day Hospice MDP intensive involves active learning and focuses on how to integrate the content into existing practice. Extensive handout materials, surveys, and additional resources are included. There is also dedicated time for participants to collaborate and network with other participants.

The initial component of the Hospice MDP is this two-day foundational course that provides five foundational modules of the Hospice MDP. Following the two-day course, participants complete two additional modules at their own pace to obtain their Level I Designation. Participants then begin Level II modules, choosing from a menu of options designed to meet their specific needs and enhance their effectiveness.

This Hospice MDP seminar consists of the following modules:

- Manager Roles and Skills*
- Leadership Style and Situational Leadership*
- Problem Solving, Decision Making and Critical Thinking*
- Interviewing, Feedback, and Evaluation Skills*
- Hospice Financial Management and IT Management

** Foundational Modules*

Faculty for the Iowa conference will be Kay Mueggenburg, PhD, RN, MSN, vice president of Education, Research and Community Integration, Hospice of the Bluegrass, and Joel Fry, MSW, LISW, president, TEAM Restoration Ministries, LLC.

The registration fee is $395 for IHO members and/or NHPCO members and $595 for non-members. However, due to a Wellmark grant received by IHO, each IHO member-hospice will receive a $100 credit toward the registration fee. *Note: This fee is a one-time credit per hospice, not per employee attending from each hospice.*

* Watch for registration materials in the coming week!

## 2007 Fall Conference Call For Presentations Deadline Approaching

**Friday, May 4,** is the last day to submit a Call For Presentations Application to become a member of the 2007 Fall Conference faculty on October 24-25 in Ames. The theme for this year's conference will be focused on the celebration of IHO's 25th Anniversary! We are looking forward to another great conference and are accepting applications from those professionals interested in presenting.

**Why Submit:**
More than 500 attendees from across Iowa are expected to attend the only statewide, multi-day conference designed solely to meet the educational needs of hospice staff and volunteers. This is your opportunity to join a group of speakers recognized for their hospice-related knowledge and expertise on issues relevant to today's hospice professionals. The IHO Fall Conference has been designed to provide insight and knowledge of issues affecting the delivery of hospice care.

**Who Attends:**
Hospice leadership and members of the interdisciplinary team will comprise the audience for this conference. Participants will include administrators and CEOs of hospice programs, directors, clinical managers, nurses, social workers, spiritual/pastoral care, volunteer managers and others serving those with life-limiting illnesses and their families.

**How to Apply:**

- **New this year* - Fill out your application online at www.iowahospice.org, Click on the last tab on the left-hand side of the Web site labeled, *2007 Fall Conference Presentation Application.* When completed, click the "Submit" button and you're done!

- Download the application form enclosed with this week's *IHO Update* or located on the Web site under the *Calendar* Tab. Then mail or fax in the application to Natalie Wilson, IHO, 100 E. Grand Avenue, Des Moines, IA 50309. Fax: 515.283.9366 ATTN: Natalie Wilson.

**Deadline:**
The deadline to submit an application is **Friday, May 4, 2007**.

**Questions:**
Contact Natalie Wilson, Director of Education, IHO, 515.243.1046

## OIG Report on Medicare Hospice Certification
*(source: California Hospice & Palliative Care Association)*

The Office of Inspector General (OIG) issued a report this past week entitled, "Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight." The report contains the findings of an evaluation OIG conducted to assess the timeliness and results of hospice certification

surveys performed by State agencies and the extent of the Center for Medicare & Medicaid Services (CMS) oversight of the Medicare hospice program.

OIG found that, as of July 2005, 14 percent of the hospices were past due for certification and, on average, had not been surveyed for nine years – three years longer than the CMS standard at that time. Three states account for 41 percent of all hospices with past due certifications: California (17 percent), Illinois (12 percent), and Michigan (12 percent). In fiscal year 2005, CMS required that hospices be certified at least every six years, but for FY 2006, CMS changed the frequency to every eight years on average and directed state agencies to conduct targeted surveys for the hospices most at risk for having quality problems.

OIG also found that health deficiencies were cited for 46 percent of hospices surveyed and for 26 percent of hospices investigated for complaints. The most frequent health deficiencies cited during certification surveys and complaint investigations centered on patient care planning and quality. These deficiencies indicated that written care plans were not prepared or lacked important elements or that measures to ensure quality patient care were insufficient. Of the hospices with deficiencies cited during complaint investigations, 49 percent had already been cited for the same deficiencies during the regular certification surveys.

CMS and state agencies rarely use methods other than certification surveys and complaint investigations to monitor or enforce hospice performance. Neither law nor regulation specifies the frequency of Medicare certification surveys for hospices. Instead, CMS notifies states of the certification frequency for hospices through the annual budget request policy memorandum to the state agencies. CMS policy has consistently assigned a higher priority to certification surveys of hospitals, nursing homes, and home health agencies than it has to certification surveys of hospices.

Recommendations made to CMS include:

- Providing guidance to state agencies and CMS regional offices regarding analysis of existing data and identification of at-risk hospices.
- Including hospices in Federal comparative surveys and annual state performance reviews.
- Seeking regulatory changes to establish specific requirements for the frequency of hospice certification.
- Seeking legislation to establish additional enforcement remedies for poor hospice performance. At present, CMS's only enforcement remedy is termination of the hospice from the Medicare program.

CMS stated that any changes to the frequency of hospice certification should not be addressed with regulation and is primarily a statutory issue for consideration by the Congress. To read the full report, go to http://oig.hhs.gov/oei/reports/oei-06-05-00260.pdf.

## Resolution of FY03 and FY04 CAP Year Recomputations and OIG Survey Report

On Friday, April 20, 2007, CMS released a transmittal (CR 5596) which provides correction of the hospice cap for fiscal years 2003 and 2004.

| Cap Year | Published Amount | Corrected Amount** | Difference |
|---|---|---|---|
| FY 2003 | $18,661.29* | $18,143.26 | $ (518.03) |
| FY 2004 | $19,635.67** | $18,963.47 | $ (672.20) |

* Published on July 3, 2003
** Published in Published in CR 3386, September 24, 2004

**What does this mean for FY 2004?**
CMS has instructed the Regional Home Health and Hospice Intermediaries (RHHIs) the fiscal intermediaries (FIs) and Medicare Administrative Contractors (AB MAC) to re-compute the aggregate cap for each provider for the cap period ending October 31, 2004 utilizing the corrected cap amount. The revised calculations and letters to those affected providers also are to be issued by July 31, 2007.

Providers who have already received a cap overpayment letter from their FI will now have that calculation adjusted and a new letter issued. Some providers may have been just below the cap in 2004, but with the change in the cap amount, may now have a cap overpayment. Watch for additional information from the fiscal intermediary.

**What does this mean for FY 2003?**
CMS has instructed the Regional Home Health and Hospice Intermediaries (RHHIs) the FIs and Medicare Administrative Contractors (AB MACs) to re-compute the aggregate cap for the cap period ending October 31, 2003 **for those providers whose initial cap determination is within the three year reopening period.** The calculations and letters to affected providers are to be issued by July 31, 2007.

For providers who received a cap overpayment letter for FY 2003, the date of the cap determination letter will be used to calculate the three year reopening period. If the letter is within the three year period, the corrected cap amount will be used to calculate any additional liability. If no letter was issued for FY 2003, the date the provider submitted its 2003 cap report will be used to calculate the three year reopening period.

Further questions about this CMS transmittal can be addressed to your FIs or to CMS directly. Read CMS's transmittal online:
http://www.cms.hhs.gov/transmittals/downloads/R1226CP.pdf.

## Questionable Practices by Hospices and Nursing Homes: Under Health Care Fraud and Abuse Rules

*Submitted by: Matthew McManus, JD, Reinhart Boerner Van Deuren s.c., Milwaukee, WI*
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Certain questionable practices by hospices and nursing homes may violate health care fraud and abuse laws enforced by the Department of Health and Human Services, Office of the Inspector General (OIG). Chief among these laws are the federal anti-kickback statute and the civil monetary penalties statute (CMP).

Hospices and nursing homes should be familiar with the types of practices that the OIG could consider to be violations of the anti-kickback statute and CMP and ensure that their policies address these questionable practices. Although the focus of this article is on hospice relationships with nursing homes, hospices should remember that the same anti-kickback statute restrictions apply to any hospice referral source.

### Anti-Kickback Statute

The anti-kickback statute makes it a criminal offense for any entity or individual to knowingly offer, pay, solicit or receive any remuneration to induce or reward referrals of patients for items or services that might be payable by a federal health care program. Courts have held that if one purpose of a remuneration arrangement is to reward referrals, this could violate the anti-kickback statute.

### CMP

One provision of CMP imposes civil penalties on any person or entity that knowingly offers or provides any form of remuneration to a Medicare or Medicaid beneficiary that the entity knows, or should know, is likely to influence the beneficiary to select a particular entity to provide items or services for which payment may be made by a federal health care program. The OIG will ask the following three questions when confronted with a potential violation under this provision of CMP: has anything of value been offered by an entity to a Medicare or Medicaid beneficiary; is the remuneration offered likely to influence a Medicare or Medicaid beneficiary in selecting a particular provider of items or services reimbursable by a federal health care program; and does the entity offering remuneration know (or should the entity know) that offering the remuneration is likely to influence the beneficiary to choose a particular provider of items or services. If the OIG answers each of these questions in the affirmative, it could find an arrangement to be in violation of CMP.

### Guidance from OIG

Hospice and nursing home arrangements have been an ongoing subject of regulatory scrutiny because of perceived vulnerabilities under such arrangements. The OIG has issued several forms of guidance related to hospice and nursing home arrangements including:

- March 1998 Special Fraud Alert for Fraud and Abuse in Nursing Home Arrangements with Hospices

- October 1999 OIG Compliance Program Guidance for Hospices
- March 2000 OIG Compliance Program Guidance for Nursing Facilities
- OIG Work Plans in 2007 and 2006

The OIG has stated that arrangements between hospices and nursing homes are vulnerable to fraud and abuse because nursing homes have control over the hospices permitted to provide hospice services to their residents. Therefore, nursing homes may request (or hospices may offer) illegal inducements to influence a nursing home's decision to do business with a particular hospice.

With respect to CMP, the OIG released an August 2002 Special Advisory Bulletin informing providers and suppliers of the CMP rules that affect an entity's ability to provide gifts or other inducements to Medicare or Medicaid beneficiaries.

The bulletin details the prohibition against providing inducements to influence a Medicare or Medicaid beneficiary's selection of a particular provider or supplier, and includes information on exceptions to this general prohibition. One exception allows providers to offer gifts (other than cash or cash equivalents) or services that are valued at not more than $10 per patient individually, and not more than $50 in the aggregate annually per patient. Other exceptions include waivers of cost-sharing amounts based on financial need, co-payment differentials in health plans, incentives to promote the delivery of certain preventative care services, and practices permitted under the anti-kickback statute.

The following are short responses to some questions that we have received regarding fraud and abuse considerations in nursing home arrangements with hospices and in provider gifts to Medicare or Medicaid beneficiaries. We would like to emphasize that in discussing these arrangements, we are not addressing a hospice's ability to provide charity care to its patients. Of course, as part of its mission, a hospice may provide medically necessary care at reduced rates to a person who cannot afford such care. Typically, we recommend that such care is provided on a sliding scale and in accordance with a hospice charity care policy that is consistently applied to all patients regardless of their referral source.

**Q1:**
**Can a nursing home violate the anti-kickback statute by requesting something of value from a hospice in exchange for referring patients to the hospice or for contracting with the hospice? Similarly, can a hospice violate the anti-kickback statute by offering something of value to a nursing home in exchange for patient referrals?**

Yes. The anti-kickback statute covers both sides of a remuneration arrangement – the party offering or paying the remuneration and the party soliciting or receiving the remuneration. Therefore, if a nursing home knowingly solicits or receives anything of value from a hospice, or if a hospice offers or pays something of value to a nursing home, in exchange for referring patients to the hospice for services that are payable by Medicare or Medicaid, this would violate the anti-kickback statute.

**Q2:**

**How does the OIG define "remuneration"? If a nursing home solicits a free service or item from the hospice (instead of cash) in exchange for patient referrals, could that still violate the anti-kickback statute?**

Yes. "Remuneration" includes not only cash or cash equivalents, but also free goods or services, or goods or services provided at below fair market value. Therefore, if a hospice provides staff to the nursing home at the hospice's expense (or if a nursing home solicits such staff from the hospice) to perform duties that otherwise would be performed by the nursing home, this could violate the anti-kickback statute. Similarly, if a nursing home requests that the hospice automatically provide items, such as low air loss mattresses or Geri-Chairs, for hospice patients who are nursing home residents in order to serve patients within their facility, this could violate the anti-kickback statute. Hospices must provide these items to hospice patients if determined necessary as part of a patient's individualized plan of care, but these items should not be provided automatically as a matter of course. Needless to say, if the hospice provides such items for free or for below market value to nursing home residents who are not hospice patients, this could also violate the anti-kickback statute.

**Q3:**
**Our hospice would like to pay for all of a potential hospice patient's medications (including those unrelated to the patient's terminal illness) by using funds from our hospice's foundation. Is this OK under CMP?**

In answering this question, we are cognizant of the fact that it is sometimes very difficult to ascertain whether medications are truly unrelated to the terminal illness. A hospice may take a liberal and consistent view for all patients, regardless of referral source, regarding which medications are related to and necessary for the palliation of the terminal illness. However, a hospice arrangement in which it (or its foundation) pays for all patient medications, even those clearly unrelated to the patient's terminal illness, could violate CMP.

When reviewing this type of arrangement under CMP, the OIG would consider three questions. The first question is whether paying for a patient's medications unrelated to a hospice patient's terminal illness would constitute remuneration paid to the beneficiary who receives the drugs. Because the value of these medications could be considerable, the answer to this question is likely yes. A second question is whether the remuneration provided to the beneficiary is likely to influence the beneficiary to choose a particular hospice to provide hospice services. Again, the answer is likely yes, because the beneficiary could reasonably choose the hospice solely because of the value of the free medications provided by the hospice's foundation. Finally, the OIG must determine whether the hospice foundation knows, or should know, that offering this remuneration is likely to influence the beneficiary's choice in hospice providers.

Again, the answer to this question is “yes” because the beneficiary is likely to connect the hospice's foundation to the hospice. The presence of these free medications is likely to influence the beneficiary to choose the hospice for his or her hospice care. Therefore, this practice could violate CMP, and should be closely analyzed to determine whether it could fit within an exception to the law. Remember that it does not matter whether the remuneration comes from a hospice's foundation or the hospice directly. The analysis is simply whether

remuneration provided to a beneficiary is likely to influence that beneficiary's choice of hospices. In addition, if a hospice would target only nursing home patients under such an arrangement, this could lead to criminal penalties under the anti-kickback statute, because this action could be viewed as an inducement to the nursing home to refer patients to the hospice.

**Q4:**
**Our hospice informs patients that they can receive a set number of days of inpatient care in our inpatient unit, without charge to the patients. If a patient is not clinically appropriate for general inpatient care, our hospice foundation pays the difference between routine home care rates and our rates for inpatient care. Could this violate CMP or the anti-kickback statute?**

Yes, this practice could potentially violate both statutes. With respect to CMP, the OIG could affirmatively answer the three key questions in a potential CMP violation: does paying the difference between routine home care and the standard rate for inpatient care constitute remuneration; are these payments likely to influence a beneficiary's choice of the hospice to provide services; and should the hospice foundation know that offering this remuneration is likely to influence the beneficiary's choice of hospice providers? Therefore, this practice could violate CMP, and should be closely analyzed to determine whether it could fit within an exception to the law.

With respect to anti-kickback, if the inpatient care is provided to patients in a facility other than the hospice's own inpatient facility, there is a potential anti-kickback violation. If a hospice is promising (or a nursing home or hospital is requesting) that patients will be treated at the general inpatient level of care, this could be viewed as remuneration in exchange for future referrals. A hospice patient receiving general inpatient care in a nursing home or hospital facility will bring the facility more revenue under the contract with the hospice, and could serve to fill otherwise empty beds in the facility. Therefore, this practice could violate the anti-kickback statute.

Finally, this practice could also violate the Medicare conditions of participation for hospice care, because each patient is to be treated at the appropriate level of care according to his or her individualized plan of care. To automatically place a patient in a higher level of care, regardless of the patient's individualized plan of care is improper under Medicare hospice rules.

**Q5:**
**If a hospice offers a nursing home a predetermined number of aide hours for hospice patients residing in the nursing home, could this violate the anti-kickback statute?**

As with all other services provided by a hospice to its patients, the frequency of hospice aide services must be determined by the interdisciplinary team as part of each hospice patient's individualized care plan. Because of the individualized nature of hospice care, it is impossible for a hospice to credibly guarantee a nursing home a certain number of aide hours when contracting with the facility. A hospice making such a promise is exposing itself (and the nursing home) to scrutiny by the OIG and other government fraud and abuse

investigators. If even one purpose of the hospice's offer of a predetermined number of aide hours to the nursing home is to gain access to patients residing in the nursing home, or to secure referrals of hospice patients from the nursing home, this may violate the anti-kickback statute.

**Conclusion**
Hospices and nursing facilities should carefully analyze their relationships with one another, and any programs offering incentives or other remuneration to Medicare or Medicaid beneficiaries to ensure that none of their practices could violate the anti-kickback statute or CMP.

**References**:
1. March 1998 Special Fraud Alert for Fraud and Abuse in Nursing Home Arrangements with Hospices (available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/hospice.pdf)
2. October 1999 OIG Compliance Program Guidance for Hospices (available at http://oig.hhs.gov/authorities/docs/hospicx.pdf)
3. March 2000 OIG Compliance Program Guidance for Nursing Facilities (available at http://oig.hhs.gov/authorities/docs/cpgnf.pdf)
4. OIG Work Plans (available at http://oig.hhs.gov/publications/workplan.html)
5. August 2002 Special Advisory Bulletin on Offering Gifts to Beneficiaries (available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf)

## NHPCO News

- **Figures Released for Expected FY2008 Cap Amount**
  The Bureau of Labor Statistics has released the March Consumer Price Index – the medical care component of the Consumer Price Index is used to calculate the cap amount for the Medicare Hospice Benefit for the next fiscal year. The expected cap amount for FY2008 is $21,410.04. The official notification about the cap amount for FY2008 will be released by CMS sometime this summer.

## Member-Abilia

Hospice of Fort Dodge has changed their name to Trinity Hospice.

## Enclosure

2007 IHO Fall Conference Call for Presentations Application