NURSING FACILITIES: FRIENDS OR FOES?

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Program Overview

• Status of Hospice Nursing Facility Relationships
  • Multiple contact points and transactions
  • Relationships in Flux

• Regulatory Environment
  • OIG and ZPIC Activity
  • OIG Special Fraud Alert

• Anti-Kickback Issues
  • Marketing and Referral Relationships
Program Overview

- Palliative Care in Nursing Facilities – Effect on Hospice
  - Palliative care expansion in NFs
  - SNF Benefit
  - SOM Interpretive Guidelines for NFs
  - Defining issues

- Friends or Foes?
  - Are you competing for the same patients or serving different patients with different needs?
  - How can hospice begin the dialogue to work with nursing facilities so that care is appropriate, patients make informed choices, and everyone wins, including the patients?
Current Hospice – NF Relationships

- Multiple contact points
- NF referrals of residents to Hospice
- Hospice placement of patients in Facilities
- Joint assessments of patient
- Integrated or coordinated Care Plans
- Hospice and Facility physicians, staff participating in care
- Two distinct regulatory schemes
- Two reimbursement systems
Legislative & Regulatory Environment

• Anticipated direct cuts or changes in reimbursement
• Future value-based purchasing by traditional Medicare and ACOs, based on quality criteria.
• Ongoing and increased scrutiny by OIG and other enforcement entities
  • Referral relationships
  • Marketing practices
  • Long stay patients (ZPIC), non-cancer
1998 OIG Special Fraud Alert

• Fraud and Abuse in Nursing Home Arrangements with Hospices
  • Exclusive arrangement with hospice = value to hospice
  • Longer LOS = advantageous for hospice, more reimbursement
  • Overlapping services allow both providers to reduce their services and costs (higher profits per patient)
  • Control of flow of business lies in the hands of NF operators, Administrators, who may solicit illegal remuneration.
  • Room and board payment for Medicaid patients in excess of State rate, for “additional” services.
  • Cross referrals.
  • Hospice furnishing free of below FMV care to SNF Part A patients with expectation of referral after Part A days are used.
Anti-Kickback Concerns

- Longstanding questionable marketing practices continue
- Offering value in exchange for referrals
- Clerical and clinical staff assistance
- “Continuous Care” or round-the-clock aides for actively dying patients.
  - Not appropriate as a marketing tool to the facility (kickback) or to the patients (inducement)
  - Individually-based, supportable, clinical determination made during course of care.
  - If not appropriate because not medically necessary, the hospice cannot bill for it.
  - Declining to bill does not “purge the taint” of the kickback.
Anti-Kickback, cont’d.

- Gifts to facility from hospice to benefit hospice patients?
  - Dressing up rooms
  - Lounge/living room furniture
  - TVs and other enhancements
Palliative Care Expansion

- What’s Going On in the Nursing Facilities?
- Patients with terminal diagnoses are referred to hospice, hospice shows up at the facility, and patients have changed their minds.
  - Staying on Part A SNF until benefit exhausted, then converting to hospice.
  - Staying on “Palliative Care” in the NF.
- Patients with terminal diagnoses are being offered “comfort care” without mention of hospice.
- Facilities are advertising “Comfort Care” or “end-of-life care” with no actual training or education of staff.
- Raises more questions than answers.
NF “Palliative Care”

- No uniform definitions, rules, or length of stay.
- Palliative Care/Comfort Care Services
  - What are these services?
  - Not skilled services
  - No defined set
- Palliative Care Beds
  - Not a bed licensure category
- Palliative Care Programs
  - SNF-designed?
    - Outside entity “Good Housekeeping Seal of Approval?”
- Includes “concurrent care”
SNF Benefit – Legal Concerns

• “Comfort Care” being offered by the NF without mention of hospice or discussion of available options.
• Patients not informed of or do not understand the distinctions in the services.
• Patients believe they are receiving hospice care from the Nursing Facility.
• Improper steering of patients?
• Informed decisionmaking/consent, based on full knowledge of the benefits and limitations being presented?
• Is patient freedom of choice being honored when a patient elects hospice and then changes his/her mind?
SNF Part A Benefit

• Pre-requisites:
  • “Qualifying hospital stay” – stay of at least 3 consecutive days, not including day of discharge.
  • SNF admission is within 30 days of hospital discharge.
  • Doctor order for skilled care (nursing or nursing + therapy) on a daily basis that can only be provided in a SNF on an inpatient basis. Skilled services are reasonable and necessary.
  • Care is related to reason for hospital stay, or for a different condition that was treated during SNF stay related to the hospital stay.
  • Skilled rehab-only stay requires therapy 5-6 days/week
SNF Part A Benefit

- Medicare covers 100 days of SNF care per benefit period
  - Days 1-20: no beneficiary copay
  - Days 21-100: daily co-pay (could be covered by Medigap, Medicare Advantage, or other plan)
  - Days 101 and higher: beneficiary pays all

- Once the benefit period ends, need another qualifying hospital stay to trigger another 100 days of SNF care.
SNF Part A Benefit

- If beneficiary is discharged from SNF and re-admitted within 30 days, no second qualifying hospital stay required. Beneficiary remains in the same benefit period (number of days remaining is less than 100).
- If re-admitted between 31-60 days, need new qualifying hospital stay, but remains in same benefit period.
- If re-admitted after 60 days, need new qualifying hospital stay and being new 100 day benefit period.

Benefit Period Ends
- If beneficiary has not been in a SNF or hospital for at least 60 days in a row; or
- Beneficiary remains in a SNF without receiving skilled care, for at least 60 days in a row.
SNF Part A Benefit

• Reimbursement to SNF for Part A
  • Consolidated billing (all inclusive rate)
• Minimum Data Set (MDS) guides amount of reimbursement. Obtained in assessments.
• Through MDS, patient are categorized into Resource Allocation Groups (RUGs) that correspond to payment rates.
• Patients with more complex medical needs, rehab, or reduced functional capability will generate higher reimbursement.
Quality of Care Regulation

• Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

• 42 CFR §483.25
SOM Revisions

- Survey & Certification Letter 12-48-NH (9/27/12)
- CMS made substantial revisions (additions) to the State Operations Manual (CMS Pub. 100-07), Appendix PP (Nursing Homes).
- Revised surveyor guidance on regulatory requirement related to Quality of Care. 42 CFR §483.25.
- Interpretive guidance for F-tag 309 - “Review of a Resident at or Approaching End of Life.”
SOM Revisions

• “Palliative Care” means--
  “Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.”

• “Palliative care” in the SOM focuses on symptom relief and comfort, but does not necessarily limit diagnostic, preventive, or curative interventions.
Assessment and Management of Care at EOL

- Identify resident’s prognosis, goals and preferences, including history, present illness, co-morbidities, physical, cognitive and functional status, psychological, emotional, spiritual and environmental issues, appropriateness for hospice, goals for care and treatment, etc.

- Perform “advanced care planning” (address treatment of acute illness and hospitalization).

- Recognize and advise patient/representative when patient is approaching EOL. Identify remediable symptoms and ways to optimize comfort and relieve suffering.

- Advise and educate about palliative care options including hospice.

- Re-assess on an ongoing basis to identify changes and periodically review POC.
SOM Revisions - NF Requirements

- **Assess:**
  - ADLs
  - Hygiene/Skin integrity
  - Medical Treatment (including meds/drugs)
    - Discussion of palliative meds
  - Nutrition and Hydration
  - Activities
  - Psychosocial Needs
  - Monitoring
SOM Revisions

- Requirements for Hospice patients in the NF
  - Refers to the Hospice CoP on furnishing services to patients in a S/NF and ICF
  - NF coordinates care planning with hospice and updates according to regulatory requirements. POC incorporates hospice philosophy.
  - Both providers comply with applicable Medicare/Medicaid CoPs, but each provider retains responsibility for quality and appropriateness of care it provides.
  - Beneficiaries should not experience any lack of services or personal care because they have elected hospice (Facility continues to provide general nursing care, assist with ADLs, administer meds, give personal care, activities, etc.).
  - Hospice assesses the patient’s signs and symptoms related to terminal illness and related conditions.
SOM Revisions - Effect

• Nursing facilities are doing more with less.
• Facilities are required to do more to take care of terminal patients who have not elected hospice or who are not hospice appropriate.
  • Not just the imminently dying (defined as expected to die in hours to 2 weeks).
• Many non-cancer diagnoses/ long LOS patients.
What Does this Mean for Hospice?

• Are you competing for the same Patients?
  • Because SOM standards are high, some NFs might try to go into hospice business or compete with hospices in palliative care.

• Are you competing for the same money?
  • Are there patients who are not hospice appropriate but who would benefit from a palliative approach?
    • Terminal but not within 6 months
    • Not ready/willing to make hospice election
    • Seeking concurrent care

• How can hospice work with NFs to identify, educate, and appropriately assist patients in making truly informed choices?
What are the Drivers?

• Nursing Facilities
  • If facility can retain a patient who would otherwise qualify for hospice on Part A, under a “palliative” program, more reimbursement to the facility. Increase in RUG amount if patient is “skilled” and on “palliative care.”
  • No increase in RUG if patient is “palliative” and not skilled. Facility is responsible for all end-of-life care as outlined in the SOM.
  • If a NF patient is re-designated as “Comfort Care,” there may be an opportunity to submit an updated MDS indicating a SCIC. Quality indicators will not carry the same weight for a comfort care patients as they would for a regular patient. Affect on quality report.
What are the Drivers?

- Nursing Facilities
  - Facilities are expected to provide high quality EOL care with same reimbursement.
  - Facilities may try to keep hospice out altogether and do it all themselves.
  - Others may want to clearly delineate between NF and hospice service lines.
What are the Drivers?

- Hospice
  - Desire to retain hospice appropriate patients.
  - Admit patients earlier, not after SNF Part A benefit exhausted.
  - Need to distinguish how hospice is different from NF end-of-life care.
  - Market differences to nursing facilities.
  - Ensure that patients who are hospice appropriate are given information and educations about their options.
  - Avoid long LOS patients who may be “palliative” appropriate but not terminal within 6 months.
What are the Drivers?

• Patients/family
  • Want the “best” care, regardless of what it’s called.
  • Goals are likely to be the same – pain and symptom control, “good death.”
  • Holistic approach, treating the family, spiritual, bereavement component?
  • Need to understand available options and significance of selecting one over the other in order to make informed choices.

• Medicare, ACOs and Insurance
  • Highest value at lowest cost.
  • Appropriate placement
  • Quality Indicators
Can Hospices Work Side by Side in Collaboration with NFs?

- Follow Hospital Models?
- Independent hospice contracts with NF for access to provide hospice care in the facility, in coordination with the facility.
- Hospice program based in NF/system (facility owns).
- Hospice provides advice and training to hospital under contract, pursuant to written agreement for fmv.
  - Hospice “consults” to the facility, provides nursing, education, etc.
  - Facility Medical Director creates and supervises the plan of care.
Identifying Palliative Care Patients

- Patients with chronic or life-limiting illnesses that are not within the 6 month prognosis period (are not “terminal” for hospice) but do not want aggressive or curative care.
- Patients who are terminal within 6 months, but not ready to elect hospice.
- Patients who want to seek concurrent care.
- Others?
Collaboration

- Are there paths for different patient types?
- How can patients be identified and directed appropriately?
- Educated and informed of all options, including:
  - Distinctions in services
  - Differences in coverage criteria
  - Financial obligations
- Make meaningful elections based on personal goals.
- Probably not okay – kickback and clinical
  - Facility using hospice to perform assessments.
  - Facility using hospice to “staff” palliative beds.
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