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Strategic partners in managed care may hold the key to network success

Integration could bring additional referrals

Hospices are at a crossroads. One path keeps them on the same road of dependence upon Medicare reimbursement, while the less traveled road leads in the uncertain direction of managed care.

To take the first road, a hospice needs only to continue business as usual, including battling the diminishing length of stays and per-diem payments that often do not cover the entire cost of patient care. To choose the more risky path, a hospice must be willing to enter into strategic partnerships with competitors or give up some autonomy to enjoy the vast resources offered by larger organizations, including integrated delivery systems.

Despite the negative publicity managed care has received lately, hospice and post-acute experts see managed care's growing influence on the health care marketplace as an opportunity for hospices to forge strategic partnerships.

> ***"Networks clearly provide hospice program leaders with options, as well as challenges . . ."***

"Networks clearly provide hospice program leaders with options, as well as challenges," says **Lisa Spoden**, president of Columbus, OH-based consulting firm Strategic Health Care and chairwoman of the National Hospice Organization's Managed Care Task Force. "They offer agencies a forum for competing in larger geographic arenas, as well as protecting their market share and leveraging their buying power."

As hospices become more familiar with managed care organizations (MCOs) such as HMOs, they will quickly find out that MCOs are often loath to deal with freestanding or independent hospices, instead preferring to contract with health systems or a consortium of providers.

Hospice leaders cannot ignore managed care as a frontier for added revenue. The majority of Americans are covered by some form of managed care, not limited to just HMOs. Furthermore, federal and state governments are becoming increasingly prudent about health care spending. This is evidenced by the 65% growth of Medicare risk plans between 1987 and 1994, according to Spoden's own research.

What do they want?

So the question for hospices becomes: What about this vast, untapped revenue source?

"With states such as California and Arizona leading the way with almost 40% of their Medicare populations covered through risk plans, providers cannot ignore managed care," Spoden says. "If an agency hopes to work with MCOs, it is critical that they be aware of the preferences and biases of MCOs and develop appropriate response strategies."

As mentioned, those biases focus on their desire to shop for health care services in a one-stop shop environment. They are looking for organizations that can either provide services over a wide geographic area or across an entire continuum. That propelled the Hospice of the Western Reserve in Cleveland to join 21 other hospices throughout Ohio, forming a statewide hospice network from which private and government-sponsored health plans can contract.

The impetus was the emergence of a state managed care Medicaid program. "At the time, it was imbued with anticipation that much of the resources would be purchased on a much broader level than they are now," says **David Simpson**, MA, executive director of the Hospice of the Western Reserve. "We felt we needed to organize ourselves as opposed growing an individual hospice to cover the entire state."

The Hospice of the Western Reserve represents one example of potential hospice strategic partnerships. While they can take on a number of shapes, including local networks, regional, state, and even national, they generally fall under two general forms:

- **Horizontal integration.** Like the Hospice of the Western Reserve, horizontal integration involves partnerships among like organizations.
- **Vertical integration.** This involves organizations from various segments of the health care industry in an attempt to form a seamless continuum.

Ohio's example of forming a statewide network of hospices offers some guidance on how potential competitors can come together. Trust is perhaps the most important ingredient, Simpson says. Because hospice administrators around the state were familiar with one another, trust was not something leaders had to gain.

Second, the network was set up to avoid geographic overlap to avoid referral disputes. Simpson advised that hospices looking to form a similar network also do the following:

- **Use centralized billing and referral office.** It enhances trust, Simpson says, when there is one place for members to review the books.
- **Set up a fair dues structure.** Members should pay based upon the number of referrals they receive.
- **Establish a quarterly quality assurance meeting and invite insurers to participate to show payors the organization's quality process.**

While vertical integration offers hospices safety in numbers, horizontal integration can perhaps anchor their spot in the health care continuum. "Affiliating with vertical networks can be another strategy," Spoden explains. "The right affiliations can ensure an agency referrals from physician groups and hospitals."

Having a continuum of services with effective linkages for coordinated discharge planning will be more important to managed care companies, says **Scott Buckley**, MPH, MsPH, executive director with Southfield, MI-based Superior Consultant Co., a post-acute consulting firm.

"What's important to managed care, as well as to Medicare, is the ability of the provider to cost-effectively manage a patient across the entire continuum. Under previous reimbursement incentives, particularly under Medicare, the provider considered the provision of services in each component as a discrete episode of care. The philosophy now has to look not at individual units of care, but the entire episode of care, with each unit connected together in the continuum."

What's in a post-acute network

But in many communities, post-acute providers are still a collection of independent providers treating patients from the narrow scope of their own company. To be competitive, hospices and other segments of the health care industry will have to form partnerships that assure a seamless continuum.

Developing a vertical post-acute continuum

begins with identifying the components that exist within a community and gauging each provider's willingness to participate. Knowing which providers would be available will help organizers construct a seamless continuum. A hospice should consider a continuum that includes:

• **Acute care hospital.** Most likely, the acute care hospital will be the driver of the system. It is the facility with greater access to money, managed care contracts, and patients. It will act as a referral source to post-acute providers along the continuum. In many cases, it will act as the central case manager, working with case managers of the other post-acute providers to move patients along the continuum.

• **Long-term care hospital.** This is an acute care licensed facility that serves patients who require an average length of stay of 25 days or greater. Patients usually experience many comorbid or coexisting conditions along with the primary reason for the hospital admission. Patients requiring a long-term hospital stay need daily medical surveillance, 24-hour professional nursing care approximating seven to 10 average hours per patient day, and one to two hours of therapy intervention per day, five days a week.

• **Subacute care.** A facility for less intensive monitoring and assessment than an acute hospital stay, and provides continuous nursing services and more skilled medical services and procedures, such as rehabilitation. The care may occur before or after, or in lieu of an acute rehabilitation stay. Subacute care can be delivered in a hospital-based unit or in a skilled nursing facility.

• **Skilled nursing facility (SNF).** This site provides skilled nursing care to residents needing continuous nursing, rehabilitative, and other health or social services. The facility may be freestanding or part of a hospital. All Medicare-eligible facilities require a three-day hospital stay within the last 30 days prior to SNF admission. Medicare reimbursement pays up to 100 days per episode of illness. However, most nursing home patient days are not paid for by Medicare.

• **Assisted living.** This a specialized combination of housing, personalized supportive services, and health care services designed to respond to the individual needs of those who require help with activities of daily living, but do not need the skilled medical care provided in a nursing home. While many facilities are freestanding, many others are part of retirement communities that include skilled nursing facilities, independent living facilities, and geriatric centers. Health care services can be provided internally or contracted from a health care provider.

• **Home health care.** Provides complex medical services to homebound patients who do not require an acute facility stay and may have difficulty obtaining access to outpatient services. Services include nursing services, home health and personal care, social services, and other ancillary services, as well as home medical equipment, infusion therapy, enteral therapy, and clinical respiratory therapy.

• **Adult day care.** A site that provides programs committed to helping families care for older adults, allowing seniors to continue to live with their families. The primary emphasis is on promoting independence, self-esteem, and health. The adult day care programs provide needed emotional support and respite for families. Program components include: health monitoring, exercise retraining, community outings, group activities, hot lunches, and morning snacks.

• **Comprehensive rehabilitation facility.** A Medicare-funded facility that is required by the federal government to provide physical therapist, social services, and physician services. Optionally, the facility may provide occupational therapy, respiratory therapy, and speech therapy. Hospitals sometimes place comprehensive rehabilitation facility within a long term care facility, which includes a hospital-based therapist delivering therapy services.

Managed care, Buckley says, the more aggressively it is managed, exerts greater influence on a market. For continuum development, this means providers will need to develop programs to allow patients to be admitted directly to post-acute facilities rather than patients entering the health care system from an acute hospital because it is more cost-effective.

Integration will be a tough road

Certainly, the most sound method to bring all these services together would be in a formal organization, such as a health care system that integrates not only post-acute providers, but physicians and hospitals.

But the reality may be that unless market forces conspire to push post-acute providers into mergers or allowing themselves to be bought, most post-acute providers will remain independent businesses. So building a continuum will hinge on providers' ability to strike joint ventures

or an organization of loosely affiliated providers, similar to independent practice associations for physicians.

Organization interests vs. individual interests

Forming an organization of independent providers, the larger organization risks territorial battles and infighting once the individual interests of providers clash with one another. For example, if a post-acute organization takes capitation from an HMO for the entire post-acute continuum and distributes the per-member-per-month payment among the various providers, conflicts could arise as a result of patients moving along the continuum. A home care provider may find itself at odds with the subacute provider because patients are being discharged to home care too early, causing the home care provider to expend more money to care for its patients.

"It's going to have be something that the providers are going to have to resolve amongst themselves," Buckley says. "The home care agency will have to be more cautious about the patients it accepts and the development of their care plans to ensure they are taking patients whose needs can be appropriately met."

For the greater good

If that is the case, then the larger organization must decide whether to continue using the same care plan, revise care so that patients remain longer in the subacute facility, or adjust the capitation payment to reflect more home care services and less subacute care. Whatever the decision, somebody loses for the greater good of the organization.

Diminished independence will also come in the form of abdicating patient flow to central function: a case manager. There needs to be a central case management function that guides patients from one point in the continuum to the next, working closely with case managers at the individual provider level, Buckley says. While it would be difficult, if not impossible, to develop clinical paths that cover the entire continuum, the central case manager will have to work with provider case managers in developing clinical paths for each provider site.

"It's clear that you have to have [clinical] paths at each level of care, or at least the acute care, subacute, home health, and comprehensive rehabilitation facility," Buckley says. "You have them to make sure resources are being used correctly, and you need a strong case management at each level. And you have to have some integrating function to make sure that all these processes are working appropriately and effectively."

As managed care proliferates and Medicare reimbursement is reduced, the knee-jerk reaction of some post-acute providers would be to focus on reallocation of costs to compensate for reductions in payment. But the key to long-term success lies in managing costs by placing patients in the most appropriate setting.

"To succeed in the long term, providers must think not in terms of enhancing reimbursement, but in terms of controlling and managing costs, and in terms of episodes of care rather then units of service," Buckley says. "This requires placing patients in the most clinically appropriate and lowest cost setting and moving them through the continuum as dictated by patient needs." ■

Become a deal-maker, not an outsider

Hospices that insist on operating independently in a growing managed care market could find themselves on the outside looking in while hospitals and physicians are making the deals with HMOs.

By harnessing the collective powers of post-acute allies into a network, managed care organizations can be made to see the value hospices and the rest of their post-acute partners in a managed care environment, says **Donald Hutton**, MHA, founder of Morgan Consulting Group, an Atlanta-based health care consulting firm.

Avoid barriers

While forming a post-acute network will go a long way to building clout in a market, Hutton says the road to a viable network is laden with barriers that can stop network building dead in its tracks. These barriers are:

- **Lack of leadership and knowledge.**

Most hospice providers are focused on the day-to-day operations, so much so that their time and knowledge is spent managing expenses and trying to attract new revenue. Now hospices and other providers need to look at health care from a global perspective rather than from their parochial perspective. One thing is for sure —

hospice leaders and those heading up other post-acute facilities will have to exhibit a kind of leadership that does not stress any one organization's individual success.

The solution, Hutton says, is to re-educate and re-orient operational management, administrators, and directors. While the advice seems rather elementary, for many hospice leaders it represents a change in thinking similar to that of hospital administrators back in the early 1980s when DRGs took effect. "It took a lot of time and effort to educate and re-orient them. The best way to overcome it is to not only re-educate the top people but the operational people as well."

It sounds simple enough, but most hospice providers have not been paying attention to the growth of managed care in their own markets, focusing solely on their traditional Medicare business. Now these providers need to act like sales people and market their services to a new customer.

"They don't even know the right questions to ask or how to position themselves to market themselves to show the value they would bring to these HMOs," Hutton says.

Know your market

• **Lack of market awareness.**

Hospice leaders and their partners must become keenly knowledgeable of the market in which they do business. To start, know what percentage of Medicare beneficiaries are moving into Medicare managed care plans. The answer today may be zero, but that could change in as little as a year. The same inquiry should be made on a regular basis.

"If you think of the Medicare population as 100%, in the old days you could market to hospitals and doctors and get them to make admissions," Hutton says. "In this new era, when these beneficiaries are put into a managed care program, it isn't the doctors or the hospitals that get to pick where these patients go. It's the managed care plan. So when you start getting more of these patients shifting into managed care plans, you want to have a strategy to access those patients."

• **Not knowing how to access managed care organizations.**

Another barrier holding back the formation of post-acute provider networks is their ability to take their existing services and link them to managed care organizations in a manner that suits the MCO. It's an issue of being able to connect network services with the managed care organization.

"Connectivity has to do with understanding where your organization plugs in so that admissions are directed to their [agency]," Hutton says.

The solution, he adds, is to know the requirements of payors and where the network needs to access managed care organizations to deal with both patient care and business development, such as an MCO's case manager.

Money requirements

• **Capital.**

If hospice and the rest of the community's post-acute providers can get past the mindset and social barrier of forming a post-acute network, there is still the very large practical barrier of raising enough capital to ensure proper start-up. Hospice leaders should avoid networks that are undercapitalized.

For post-acute providers to form a network, their capital needs can be as low as $250,000 or as high as $5 million, Hutton says. For their money, they should acquire infrastructure, coverage for operating losses in the start-up phase of the organization, and capital reserve to take on risk.

The capital barrier is overcome by strategically partnering with an entity that already possess the technology — an information system, for example — needed to operate the network.

"The reason for this is that you spread the cost of the required technology over a larger base by using their stuff, and therefore your per unit cost becomes less," Hutton says. "Second, you'll reduce the need for capital because your operating losses will be less if your partner is experienced and will help you avoid making mistakes as well as no having the personnel costs associated with running your systems.

• **Poor industry track record.**

When approaching managed care organizations, post-acute providers may discover that their respective industries have become the object of negative stereotyping. Hospice has long suffered from misinformation about its goal and mission. In the age of high-tech procedures, post-acute providers have been relegated to second-class citizen status because much of the care involves low-tech procedures and custodial care.

The phrases that best describe post-acute care — low-tech, hands-on care — are exactly what hospices and their partners need to be promoting because of its effective low-cost care, Hutton says. ■

OIG issues compliance program guidelines

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) issued draft guidance in July to assist hospice providers in designing effective voluntary compliance programs to prevent fraud, waste, and abuse in government health programs, including Medicare and Medicaid.

While all OIG compliance programs are optional, the guidelines place hospice providers on notice about potential violations and provide a laundry list of investigators concerns, including:

— uninformed consent to elect the Medicare hospice benefit;

— admitting patients to hospice who are not terminally ill;

— falsified medical records or plans of care;

— hospice incentives to actual or potential referral sources, such as physicians, nursing homes, hospitals, etc.;

— overlap in services that a nursing home provides, which result in insufficient care provided by a hospice to a nursing home resident; (See related story on p. 121.)

— improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately paid professionals;

— billing for higher level of services than necessary;

— billing for hospice care provided by unqualified or unlicensed clinical personnel;

— inadequate management and oversight of subcontracted services, which result in improper billing. (For a complete list of OIG concerns, see box on p. 119.)

"The most important aspect of our prevention efforts is the development of voluntary compliance guidance that will help the health care industry understand the government's expectations for a well-run program," says Inspector General **June Gibbs Brown**. "Compliance efforts should focus on establishing a culture within a hospice that promotes the prevention, detection, and resolution of instances of conduct that don't conform with the law, regulatory requirements, or a provider's internal standards and policies. Over time, an effective compliance program should become part of the fabric of a hospice's routine operations."

Following the voluntary guidelines and implementing a compliance program will go a long way to prove that federal regulations have been followed in good faith and that any billing mistakes were the result of human error rather than malice. Hospices that find themselves to the subject of federal scrutiny will find that a working compliance program will go a long way to swaying the opinion of investigators, says **David Queen**, JD, a Baltimore-based attorney who handles fraud cases for home health and hospice providers.

The National Hospice Organization (NHO), based in Arlington, VA, favors controls that ensure compliance with government regulations. But it expressed concern that the OIG guidance casts a shadow of criminal behavior among hospices, and many hospices lack the resources to implement an extensive compliance program.

"NHO is also concerned that a large number of hospices will find it very difficult to devote significant additional resources or to re-allocate already meager and stretched resources necessary to implement the extensive compliance program detailed in the guidelines," wrote NHO President **Karen Davie** in an Aug. 19 letter.

Similar to other guidance already issued by the OIG for clinical laboratories, hospitals, home health agencies, third-party medical billing companies, and durable medical equipment (DME) suppliers, the draft hospice guidance is based on the following seven elements:

1. Implementation of written policies, procedures, and standards of conduct.

2. Designation of a compliance officer.

3. Development of training and education programs.

4. Creation of a hotline or other measures for receiving complaints and procedures for protecting callers from retaliation.

5. Performance of internal audits to monitor compliance.

6. Enforcement of standards through well-publicized disciplinary directives.

7. Prompt corrective action of detected offenses.

Those elements, according to OIG, should represent the basic structure of a hospice's compliance program. In its proposed guidelines, OIG offers a detailed explanation of each element and how these items should be implemented.

• **Written policies and procedures.** Standards must communicate to all affected employees, hospice agents and contractors, such as physicians and therapists, the hospice's commitment to comply with federal and state standards. There

OIG's fraud and abuse concerns

Here are some of the special areas of OIG concern included in the draft compliance program for hospice:

- Uninformed consent to elect the Medicare hospice benefit.
- Discriminatory admission.
- Admitting patients to hospice who are not terminally ill.
- Arrangements with other providers that a hospice knows is submitting claims for services already covered by the Medicare benefit.
- Falsified medical records or plans of care.
- Untimely and/or forged physician certifications on plans of care.
- Inadequate or incomplete services rendered by the interdisciplinary group.
- Hospice incentives to actual or potential referral sources, such as physicians, nursing homes, hospitals, etc.
- Overlap in services that a nursing home provides which result in insufficient care provided by a hospice to a nursing home resident.
- Improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately paid professionals.
- Providing hospice services in a nursing home before a written agreement has been finalized.
- Billing for higher level of services than necessary.
- Inadequate justification in the medical record when a patient revokes the Medicare hospice benefit.
- Billing for hospice care provided by unqualified or unlicensed clinical personnel.
- False dating of amendments to medical records.
- High pressure marketing of hospice care to ineligible beneficiaries.
- Improper solicitation activities, such as "patient charting."
- Inadequate management and oversight of subcontracted services, which result in improper billing.
- Sales commissions based on length of stay. ■

should be a particular emphasis on preventing fraud and abuse.

OIG recommends that hospices creating a compliance program include appropriate training and educational programs to avoid the risk areas listed above, such as uniformed consent and improper admission.

In addition, OIG states that policies must create a mechanism for billing staff to communicate effectively with the clinical staff. Policies and procedures should include:

— **timely documentation of clinical factors that qualify a patient for the Medicare hospice benefit;**

— **instruction on who has the authority to make entries in the patient record;**

— **emphasis on admission only when documentation supports the applicable reimbursement eligibility criteria;**

— **provide an indication that the diagnosis and procedure codes for hospice services reported on the reimbursement claim are based on a patient's clinical condition as reflected in the medical chart and other documentation.**

A provision that compensation for hospice billing and admission staff not include any incentive to bill for hospice care regardless if proper criteria is met.

OIG recommends hospices create oversight mechanisms to verify terminal illness and eligibility for the Medicare hospice benefit, as well as providing documentation of factors the prove eligibility. If the OIG or fiscal intermediary questions whether a patient is terminally ill, the hospice will be requested to provide information necessary to prove terminal illness.

• **Designation of a compliance officer.** Every hospice should designate a compliance officer, according to the guidelines. The hospice compliance officer will be responsible for being the focal point of the organization's compliance activities. Primary responsibilities include:

— **oversight of the compliance program;**

— **routinely reporting to the hospice governing body, top administrator and compliance committee on the progress of program implementation;**

— **revising the program as needed;**

— **reviewing employees' certifications and gauging their understanding of compliance standards and conduct;**

— **developing training programs to make**

employees and contractors aware of potential fraud and abuse;

— independently investigate and act upon compliance-related matters.

Hospice compliance officers take on various shapes, ranging from a full-time equivalent position to an added responsibility placed upon an existing job position. The OIG is aware that small hospices may not have the resources to hire a full-time compliance officer. Instead, the OIG is more focused on the authority of the employee given the task of monitoring compliance. The designated compliance officer must have the appropriate authority critical to the success of the compliance program. That means the assigned compliance officer should be allowed to review documents, such as the patient record and scrutinize financial arrangements with other providers.

Queen says the compliance officer should be a high-level official in the organization with direct access to the president and CEO, its governing body, senior management, and legal counsel. While seemingly logical, providers should avoid using people with accounting backgrounds to monitor compliance programs. While accounting skills are valuable, Queen says, they represent a small portion of overall job responsibilities. Instead, compliance chiefs should have a human relations background that includes management skills.

Let it all be heard

The OIG also wants to see hospices form compliance committees. A compliance committee should advise the compliance officer and assist in the implementation of the compliance program. The committee should be made up of employees in various positions within the hospice.

The benefit of compliance committee, according to the OIG, is that it allows for the various perspectives of those holding different responsibilities within a hospice to be heard. In addition, members of the committee should be senior managers who have the ability to make necessary changes within their own departments that have been agreed upon by the compliance committee.

• **Developing effective lines of communication.** To create an atmosphere that is sensitive to potential fraud and abuse, hospices must be able to open the lines of communications between employees and compliance officers. OIG recommends written polices that forbid retaliation and ensure confidentiality be developed and distributed to all employees.

"The OIG encourages the establishment of a procedure so the hospice personnel may seek clarification from the compliance officer or members of the compliance committee in the event of any confusion or question with regard to a hospice policy, practice, or procedure," Brown wrote.

In addition, the OIG recommends that hotlines and other forms of communication be established in order to root out fraud and abuse. "The OIG encourages the use of hotlines, e-mails, written memos, newsletters, suggestion boxes, and other forms of information exchange to maintain these open lines of communication," Brown wrote. "If the hospice establishes a hotline, the telephone number should be readily available to all employees and independent contractors."

The OIG recognizes that small hospices don't have the necessary resources to establish a telephone hotline. Instead, those smaller organizations should consider other alternatives, such as outsourcing the hotline or establishing a written method of confidential disclosure.

Hospices should also employ the practice of exit interviews for departing employees as a way of discovering potential fraud and abuse, Brown says.

• **Auditing and monitoring.** An effective compliance program should incorporate thorough monitoring of its implementation and regular reporting to senior hospice or corporate managers. Reporting of compliance activities should go outside hospice leadership if a hospice is owned by larger organization, and appropriate reports should be provided and explained to the parent organization.

According to OIG, an effective tool for monitoring compliance programs is periodic compliance audits by internal or external auditors who have expertise in federal and state health laws and regulations.

Audits should focus on a hospice's programs and relationships with external providers. At a minimum, OIG is concerned that hospices check for potential kickback arrangements, problems in claim development and submission, reimbursement, eligibility, and marketing.

"The audits and reviews should inquire into the hospice's compliance with Medicare conditions of participation and the specific rules and policies that have been the focus of particular attention on the part of the fiscal intermediaries or carriers, and law enforcement, as evidenced by educational and other communications from the OIG Special Fraud Alerts, OIG audits and evaluations, and law enforcement initiatives," Brown

wrote. "In addition, the hospice should focus on areas of concern that are specific to the individual hospice and have been identified by any entity, whether federal, state or internal."

Among the techniques OIG recommends are:

— patient interviews in their homes;

— testing clinical and billing staff on their knowledge reimbursement coverage criteria;

— mock audits and investigations;

— re-evaluation of deficiencies from past audits;

— regular review of clinical documentation and source documents;

— trend analyses that detect deviations in specific areas over a given time period.

• **Enforcing standards through well-publicized disciplinary guidelines.** An effective compliance program will include clear disciplinary guidelines for officers, managers, and employees who violate policies and standards of conduct. The OIG says that compliance programs for all health care settings need to set forth the degrees of disciplinary action and ensure that workers are aware of the consequences of illegal or unethical behavior.

"It is vital to publish and disseminate the range of disciplinary standards for improper conduct and to educate officers and other hospice employees regarding these standards," Brown wrote. "The consequence of non-compliance should be consistently applied and enforced in order for the disciplinary policy to have the required deterrent effect."

• **Respond to detected offenses.** Detected but uncorrected misconduct can have detrimental effect, including legal problems for a hospice. Prompt reporting of violations will demonstrate good faith and show that the hospice is willing to work with governmental authorities to remedy the problem. According to Brown, reasonable reporting should take place no later than 60 days after an internal inquiry determines enough evidence exists to prove misconduct.

Judging program's effectiveness

The draft hospice guidance also includes information on how to assess the effectiveness of a compliance program. The government views the existence of a compliance program as a mitigating factor in fraud and abuse cases only if the compliance program is effective.

"Documentation is key to demonstrating the effectiveness of a provider's compliance program," warns the OIG. That includes documentation for audit results, hotline calls and their resolution, due diligence efforts of business transactions, employee training, disciplinary actions, as well as distribution of policies and procedures. The documented practice of refunding overpayments and self-disclosing incidents of non-compliance with federal health care program requirements can also provide evidence of an effective compliance program." ■

Government wary of new arrangements

Amidst the Office of Inspector General's (OIG) compliance program guidelines is a warning. The OIG has put hospices and nursing homes on notice that it intends to crack down on questionable referral arrangements, and offered guidance on how the two can work ethically together.

Specifically, the compliance program cites the following hospice-nursing home risk areas:

• **Overlap in services that a nursing home provides, which result in insufficient care provided by a hospice to a nursing home resident.**

• **Hospice incentives to actual or potential referral sources that may violate the anti-kickback statute or other similar government regulation.**

• **Improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately paid professionals.**

• **Providing hospice services in a nursing home before a written agreement has been finalized.**

• **Hospices that overlap services provided by nursing homes.** According to the OIG, this often leads to hospices providing insufficient care to nursing home residents.

"Recent OIG reports found that residents of certain nursing homes receive fewer services from their hospice than patients who receive hospice services in their own homes," the compliance program guidelines stated. The guidelines were published in the July 21 *Federal Register* (64 *FR* 39,155-39,168 [1999]).

The OIG continues: "Upon review, it was found that many nursing home hospice patients were receiving only basic nursing and aide visits that were provided by nursing home staff as part

of room and board when hospice staff were not present."

The answer OIG says is for hospices and nursing homes to coordinate care, and for hospices to retain professional responsibility for services furnished by nursing home staff. This would include the dispensing of medication and personal care.

In a comment letter to Inspector General June Gibbs Brown, the National Hospice Organization (NHO) in Arlington, VA, argues that nursing facility employees are akin to family caregivers in the home and should be allowed to perform certain tasks as long as the hospice retains professional management of the patient.

"The overlap in the services provided by the SNF [skilled nursing facility] and hospice do not necessarily result in insufficient care, even if the hospice providing less direct care to a patient residing in an SNF than to a home patient," wrote **Karen Davie**, NHO's president.

• **Incentives to referral sources.** Among the many risk areas the OIG identified in its explanation of why hospices need to implement a compliance program, Brown included hospice incentives to actual or potential referral sources, such as physicians, nursing homes, and hospitals, that may violate the anti-kickback statute or government regulations.

According to the OIG, investigators have observed instances of potential kickbacks between hospices and nursing homes where unlawful influence can affect patient referral.

OIG is concerned that hospices are paying nursing homes more for room and board than the nursing homes would receive if patients were not enrolled in hospice. In Medicaid programs, for example, the normal procedure should be that Medicare pays the hospice at least 95% of the daily nursing home rate and the hospice is responsible for paying the nursing home for patient room and board.

"Any additional payment must represent the fair market value of additional services actually provided to the patient that are not included in the Medicaid daily rate," instructs the OIG.

The compliance program guidelines also included concern over arrangements with nursing homes because a nursing home can choose which hospices they want to partner with, leaving the arrangement vulnerable to fraud and abuse.

• **Improper relinquishment of core services and professional management.** OIG reminds hospice providers that core services — nursing, medical, social services, and counseling — must be provided directly to the patient by the hospice's employees. And while other non-core services may be provided under contractual arrangements, the hospice must still retain professional management of those services.

• **Providing hospice services in a nursing home before a written agreement is finalized.** According to the OIG, a patient residing in a skilled nursing facility or nursing home may elect the Medicare hospice benefit if:

— **The residential care is paid by either the beneficiary/ private insurance or Medicaid if the patient is dual-eligible.**

— **The hospice and nursing facility have a written agreement that clearly states the hospice takes full responsibility for the professional management on the patient's hospice care and the facility agrees to provide room and board.**

The OIG compliance program guidelines also offer specific examples that might cause investigators to believe there is cause for fraud and abuse concern. These include:

— **offering gifts or provide free services to patients or their relatives; physicians; or nursing facilities;**

— **offering nursing homes below market goods;**

— **paying above market value for room and board in a nursing facility;**

— **offering free care to patients in a nursing home;**

— **providing and paying staff to perform services in nursing homes that otherwise should be performed by nursing home staff.**

In general, Davie objected the singling out of hospice-nursing home arrangements. Her letter stated that the OIG guidance "criminalizes hospices who admit SNF patients," and asked that

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the OIG remove language that refers to those arrangements as being vulnerable to fraud and abuse. ■

News From Home Care

BBA takes its toll on large agencies

It seems more than just small providers are absorbing the brunt of federal cost control initiatives aimed at reducing health care spending. Two large home care providers filed for Chapter 11 bankruptcy protection in August, while a third posted huge third-quarter losses.

Memphis, TN-based Medshares and its affiliated home care companies filed for bankruptcy after running out of cash and being cut off from additional money by its lenders. HealthCor Holdings in Dallas has filed for bankruptcy protection for similar reasons. HealthCor was removed from Nasdaq last year because it could not keep the required minimum share price and now trades over the counter.

Mariner Post-Acute Network, one of the nation's top three nursing home operators, posted a fiscal third-quarter loss of $405 million, including a charge of $351 million. The Atlanta-based company blamed changes in Medicare payments for the severe losses.

Medshares was recently forced to restructure its operations only 10 months after buying 70 home health agencies from Columbia / HCA Healthcare in Nashville, and six months after acquiring the home nursing division of Integrated Health Services in Owings Mills, MD. After the acquisitions were completed Medshares suffered a cash shortage, which was coupled by delayed federal and state reimbursement.

HealthCor has been divesting nursing and medical equipment operations in the last few months — its Texas community care services offices to Nashville, TN-based Auxi Health; all its HME operations to Lincare Holdings in Dallas; and its

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Editor: **Eric Resultan**, (770) 329-9684, (eric_resultan@email.msn.com).
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@medec.com).
Production Editor: **Nancy McCreary**.

Editorial Questions

For questions or comments, call **Lee Landenberger** at (404) 262-5483.

home care operations in League City, TX, to Unique Drawing, a subsidiary of Houston-based ComTech Consolidation Group.

Mariner has sold off some of its rehabilitation clinics and laid off thousands of workers to reduce costs. The company was formed just over a year ago when Atlanta-based Paragon Health Network and Mariner Health Group of Connecticut merged. Company officials pointed their fingers at the 1997 Balanced Budget Act for reduced payments of about $115 per patient day. ▼

HCFA sets payment limits on six DME products

The Health Care Financing Administration (HCFA) issued a proposed rule in August that creates special payment limits for five durable medical equipment items and one prosthetic device. HCFA employed a rarely used provision that allows the agency to make reductions based on inherent reasonableness.

The proposed rule would cut reimbursement for the six items between 22% to 57%. The six items included are folding walkers, wheeled walkers without seats, commode chairs with fixed arms, TENS units (2 lead), TENS units (4 lead) and vacuum erection systems. The reductions would be phased in over two years to four years.

HCFA based the revisions on a comparison of the 1998 fee schedule and what the Department of Veterans Affairs (VA) pays for those items. HCFA then marked up the 1998 VA wholesale price by 67% to come up with the new fees.

Critics in the DME industry complained that HCFA did not give any consideration to current retail prices when they came up with the payment limits. HCFA argues that the current fee schedule for the items are unreasonable because they are excessive compared to what the VA pays for the same items. "We kept hearing whispers from HCFA that this was in the works, but we did not know what items were going to be included," says **Erin Bush**, a spokeswoman for the Health Industry Distributors Association in Alexandria, VA.

HCFA, however, may not have the final word. House Ways and Means Health Subcommittee Chairman Bill Thomas (R-CA) has asked the General Accounting office to examine whether the agency overstepped its authority, and a report is expected no sooner than the fall. ■