INDIANA MEDICAID UPDATE

September 18, 1998

TO: **Indiana Medicaid Hospice Providers**
Indiana Medicaid Nursing Facility Providers

FROM: **Reimbursement and Survey Issues Related to the Hospice Benefit**

The purpose of this bulletin is to address issues/concerns that have been raised by hospice, home health, and nursing facility providers regarding the reimbursement to nursing facilities for room and board services when a nursing facility resident elects the Medicaid Hospice Benefit. This bulletin addresses the current reimbursement rate to nursing facilities for providing room and board services to hospice recipients. The nursing facilities conditions of participation for certified hospices. Finally, the bulletin addresses guidelines for the preparation of contracts between nursing facilities and hospice providers to ensure compliance with the fraud alert released by the Office of Inspector General in March of 1998.

Payment for Nursing Facility Residents

A distinction is made between **private home** and **nursing facility** level of care in the Medicaid Hospice Benefit because, for hospice residents in a Medicaid-certified nursing facility who receive routine or continuous care services, an additional payment for "room and board" services is made directly to the hospice provider. The hospice provider is then responsible for paying the nursing facility.

The room and board rate for hospice patients that reside in the nursing facility is ninety-five percent (95%) of the lowest *per diem* reimbursement rate Indiana Medicaid would have paid to the nursing facility for those dates of service on which the recipient was a resident of that facility. As you are aware, the OMPP will implement a case mix reimbursement system for nursing facilities, effective October 1, 1998. The implementation of case mix reimbursement will eliminate intermediate and skill levels of care. Beginning October 10, 1998, one reimbursement rate will be assigned per nursing facility. Therefore, the reimbursement for room and board services will be ninety-five percent (95%) of that facility's case mix rate.

As defined in 405 IAC 1-16-4, under the Medicaid Hospice Benefit, the term "room and board" includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies. Medicaid payment made directly to the nursing facility for the hospice resident is discontinued when the resident elects to receive hospice

care. The additional amount for room and board is not available for recipients receiving respite care or general inpatient care.

Reimbursement of room and board services at ninety-five percent (95%) of the lowest nursing facility rate provides the appropriate level of reimbursement necessary to meet or exceed the nursing facility's cost of providing room and board services to hospice recipients.

Hospice for Dually-Eligible Medicare/Medicaid Hospice Recipients in Nursing Facilities

Individuals eligible for both Medicare and Medicaid receive hospice services through the Medicare benefit. Medicaid does reimburse for certain services not covered under the Medicare Hospice Benefit, such as co-pays for respite care and deductibles on drugs. As a result, the Medicaid program has certain procedural requirements for hospice providers to ensure compliance with HCFA regulations and the final rule establishing the hospice benefit.

Enrollment Issues for Dually-Eligible Medicare/Medicaid Hospice Recipients in Nursing Facilities

According to HCFA regulations, Publication 21.204.2, a dually-eligible Medicare/Medicaid recipient must elect/revoke/change hospice providers and/or change address under both the Medicaid and Medicare programs at the same time. This publication further indicates that whenever Medicaid is involved, the hospice provider must send a copy of the hospice recipient's election and revocation form to the Medicaid State agency.

HCFA regulations, Publication 21, Section 2082.D further specifies that in states that offer the Medicaid Hospice Benefit and the hospice recipient is dually-eligible Medicare/Medicaid, then the hospice benefit must be elected and revoked simultaneously in both programs. This means that the hospice provider is responsible for enrolling the hospice recipient in either Medicaid and/or Medicare once that recipient becomes eligible for those programs.

> The Indiana Medicaid Hospice Benefit does accept the Medicare Hospice Benefit periods for those dually-eligible Medicare/Medicaid hospice recipients that are enrolled in the Medicaid Hospice Benefit. For example, a Medicare hospice recipient becomes Medicaid-eligible and is enrolled in the Medicaid Hospice Benefit during his/her second benefit period under the Medicare Hospice Benefit. Under this circumstance, the OMPP would consider that the dually-eligible hospice recipient is also in his/her second benefit period for the Medicaid Hospice Benefit. These policies and procedures ensure that a Medicaid hospice provider does not have to track two sets of benefit periods (one for Medicare and one for Medicaid).

There are two different scenarios during which a dually-eligible Medicare/Medicaid hospice recipient residing in a nursing facility may elect the Medicaid Hospice Benefit.

1. The first situation involves a dually-eligible Medicare/Medicaid hospice recipient who has turned down the Medicare hospice services to choose Medicare skilled nursing facility care instead, and then exhausts his/her 100 days of nursing facility care. Then, the dually-eligible recipient elects the Medicaid Hospice Benefit. At that time, a Change of Patient Status form must be completed and sent to the EDS Prior Authorization Unit. This form indicates that the recipient is now eligible for Medicaid.

2. The second scenario involves a Medicaid-only eligible recipient residing in a nursing facility who becomes eligible for Medicare benefits midway through his/her Medicaid hospice care. This individual must enroll in the Medicare Hospice Benefit at the time of his/her Medicare eligibility. In this situation, a Change of Patient Status form is completed and sent to the EDS Prior Authorization Unit. This form indicates that the recipient is now eligible for Medicare. For such individuals, providers should anticipate these requirements prior to initiation of hospice care and should make adequate preparation.

Dually-eligible Medicare/Medicaid hospice recipients who live in a nursing home must complete hospice enrollment forms if Medicare benefits for room and board are exhausted. The OMPP prefers that the Medicaid Hospice Enrollment forms be submitted; however, the OMPP has indicated that the EDS Hospice Prior Authorization Unit will accept the Medicare Hospice Enrollment forms for the dually-eligible Medicare/Medicaid recipient. Compliance with these administrative procedures ensures that Medicare pays the hospice provider for the hospice services and Medicaid pays the hospice provider directly for room and board services.

Dually-eligible Medicare/Medicaid hospice recipients receiving Medicare hospice services in their private homes do not have to enroll in the Medicaid Hospice Benefit since Medicare is paying for the hospice services.

Medicare-Only Hospice Providers and Compliance with the 95% Rule

Hospice providers and nursing facility representatives have asked the OMPP if the reimbursement for room and board services outlined in 405 IAC 1-16-4 would apply to Medicare-only hospice providers who serve dually-eligible Medicare/Medicaid hospice recipients in nursing facilities. Since the Medicare-only hospice provider is not a Medicaid enrolled hospice provider, then there is no mechanism for the OMPP to pay the hospice provider directly the room and board *per diem* and the nursing facility receives 100% of the nursing facility Medicaid daily rate.

The OMPP requires the Medicare-only hospice provider to enroll as a Medicaid hospice provider since that is the only manner in which the OMPP can pay directly the hospice provider the room and board payment (95% of the lowest nursing facility rate) in compliance with the hospice covered services rule and the State plan. The OMPP further requires that the Medicare hospice provider not only identify the dually-eligible Medicare/Medicaid recipient, but that the Medicare hospice provider enroll these individuals in the Medicaid Hospice Benefit. The payment for room and board services directly to the hospice provider must be done in accordance with Federal and State regulations. This means that the Medicare-only hospice provider must enroll in the Indiana Medicaid Program and that those dually-eligible Medicare/Medicaid hospice recipients must be enrolled in the Indiana Medicaid Hospice Benefit.

The implementation of the Indiana Medicaid Hospice Benefit, effective July 1, 1997, changed the reimbursement for room and board services from 100% of the nursing facility Medicaid daily rate to 95% of the lowest nursing facility rate. The implementation of the Medicaid Hospice Benefit places a fiscal and program oversight responsibility on the OMPP to ensure that payment for room and board services is paid directly to the hospice provider at the rate established in the hospice covered services rule. These responsibilities exist regardless of whether the hospice and/or the nursing facility are Medicaid-enrolled providers. This issue is further clarified below:

- HCFA Regulations, Publication 21, Section 204.s regarding dually-eligible Medicare/Medicaid hospice recipients in nursing facilities indicates that whenever Medicaid is involved, the hospice provider must send a copy of the hospice recipient's election and revocation form to Medicaid. The regulations further state that in states that offer a Medicaid Hospice Benefit, the dually-eligible individual must elect under both the Medicare and the Medicaid Hospice Benefits.

- According to USCA 1396a(13)(B), there will be an additional payment for the room and board services furnished by the nursing facility equal to at least 95% of the nursing facility rate that would have been paid by the State under the plan for facility services in that facility for that individual.

- 42 USCA 1396(o) states that hospice care may be provided to an individual while he/she is a resident of a nursing facility, but the only payment made under the State plan shall be for the hospice care.

- HCFA State Medicaid Section 4308.2 also addresses the payment of room and board services for the hospice recipient in the nursing home. Room and board services are defined in this section in the same manner as in the hospice rule. The rate for room and board services must equal at least 95% of the nursing facility *per diem* rate that the State would have paid to the nursing facility for that individual under the State plan.

- This section also specifies that even in those states that do NOT have a Medicaid Hospice Benefit, the State must pay the hospice provider the *per diem* for the room and board services so that the hospice may then pay the nursing facility. Medicaid payment to the nursing facility must be discontinued.

  As of July 1, 1997, Medicare-only hospice providers have the responsibility, per Federal and State regulations, to identify all dually-eligible Medicare/Medicaid hospice recipients to the OMPP. They must also enroll as Medicaid hospice providers so that the OMPP can directly pay the room and board services *per diem* at 95% of the lowest nursing facility rate to the hospice. Those Medicare-only hospice providers and the nursing facilities with which the hospices have contracted hospice services have been out of compliance with Federal and State regulations if the nursing facility has continued to bill the OMPP directly at 100% of the nursing facility Medicaid daily rate.

Guidelines for Contracts between Nursing Facilities and Hospice Providers

This section provides information regarding the Medicare guidelines for participation for certified hospices and the Medicare guidelines for contractual relationships between Medicare-certified hospice and nursing facilities.

Hospice providers and nursing facilities had expressed concerns to the OMPP regarding a recent fraud alert released by the Office of Inspector General (OIG) that focused on contracts between Medicare hospice providers and nursing facilities. The OMPP obtained clarification and direction from the OIG regarding the allowable reimbursement threshold for room and board services and guidelines for contract drafting to ensure compliance with fraud alert.

Medicare Guidelines of Participation for Hospice Care in Nursing Facilities

The Indiana Medicaid Hospice Benefit is modeled closely after the Medicare Hospice Benefit. To become a Medicaid-enrolled hospice provider in Indiana, the hospice provider must first be certified as a hospice provider in the Medicare program.

- The Medicare Hospice Benefit, as well as the Indiana Medicaid Hospice Benefit, adheres to the following general guidelines for hospice care in long term care:

- The hospice provider recognizes that terminally ill residents have the right of access to hospice services.

- The hospice provider and the nursing facility have a written agreement outlining the provision of hospice services and providing a framework for the partnership before services are initiated.

- The hospice provider and the nursing facility identify a conflict resolution mechanism to be used in the event of disputes.

- The hospice provider and the nursing facility identify the terms and procedure for formal review and renewal of the relationship on a regular basis.

- The hospice provider and the nursing facility staff develop a joint plan for continually assessing and improving patient care.

- The hospice provider must offer in-service training and education to nursing facility staff on hospice principles and practices of care.

The Medicare Hospice Benefit outlines the delivery of hospice core services for hospice recipients residing in a nursing facility as follows:

- The hospice provider assumes full responsibility for professional management of the patient's hospice care, in accordance with the hospice conditions for participation. The patient’s hospice care must relate to the terminal illness.

- The hospice provider is responsible for providing all of the core services directly by hospice employees. These core services may not be delegated to nursing facility employees. The hospice provider may not contract with the nursing facility to provide these core services. These core services include:

    - Hospice Physician Services
    - Hospice Nursing Services
    - Hospice Medical Social Work Services
    - Hospice Counseling Services (including bereavement, dietary, spiritual and other counseling that may be provided)

- The hospice provider must provide the same services offered to patients who reside in their own homes to nursing facility residents, including necessary medical services.

- The hospice provider must provide medications, durable medical equipment and medical supplies related to care of the terminal illness and related conditions. Medications must be furnished in accordance with accepted professional standards of practice (42 CFR 418.96).

- Hospice transitions the focus of the patient's care from rehabilitative and/or curative measures to palliative care. The expected outcomes of care include patient and family input and control over end-of-life care, safe and comfortable dying, and support for effective grieving.

Finally, the hospice provider and the nursing facility should follow these guidelines established by the Medicare Hospice Benefit about how to jointly prepare a plan of care for the hospice recipient who resides in a nursing facility setting:

- The hospice provider and the nursing facility must communicate, establish, and agree upon a coordinated plan of care. Providers may continue to use their own forms as long as the plan of care is compatible.

- The care plan must reflect hospice philosophy of care and is based on patient/family needs.

- The coordinated plan of care must specifically identify the respective care and services, which the nursing facility and the hospice provider will provide.

- The hospice provider and the nursing facility must be responsible for performing the respective functions as mutually agreed upon in the plan of care.

- All changes in the plan of care must be immediately communicated to the other provider.

- The hospice provider must ensure that hospice services are always provided in accordance with the plan of care in all settings.

- Documentation in the hospice and nursing facility records must reflect the current condition and care of the patient.

The following cites from the Indiana Medicaid Hospice Reimbursement Rule provide information to supplement the Medicare guidelines previously outlined in this section:

Cite	Topic
405 IAC 1-16-4	Additional amount for nursing facility residents
405 IAC 5-34-2	Provider Enrollment (addresses the interdisciplinary group and parameters for discharge from hospice services)
405 IAC 5-34-7	Plan of Care
405 IAC 5-34-8	Covered Services

A copy of the hospice covered services rule may be obtained by contacting Carolyn Rader of Myers and Stouffer, LC (OMPP's rate-setting contractor) at (317) 846-9521.

Clarification from Office of Inspector General regarding Contracts between Nursing Facilities and Hospice Providers

The Office of Inspector General (OIG) released a fraud alert on March of 1998 regarding fraud and abuse noted in the contractual relationships between nursing facilities and hospices. The nursing facility, hospice and home health providers raised concerns to the OMPP regarding the OIG fraud alert, specifically requesting clarification about contracting guidelines. As a result, the OMPP has made extensive efforts to clarify these concerns regarding the reimbursement for room and board services and the additional non-core hospice services (i.e. those services that the hospice is not required by law to provide itself) when nursing facilities and hospices negotiate a contract.

In the State of Indiana, the maximum reimbursement under the Medicaid Hospice Benefit for room and board services provided by a nursing facility to a hospice recipient is 95% of the lowest nursing facility rate (or 95% of the case mix rate, effective October 1, 1998). The OMPP pays the hospice provider the additional amount for room and board services and then the hospice provider must reimburse the nursing facility. Both hospice providers and nursing facility representatives questioned whether it is permissible for a hospice provider to pay a nursing facility 100% of the nursing facility Medicaid daily rate without raising compliance concerns with the OIG.

The OIG fraud alert states that, in general, payments by a hospice to a nursing home for room and board services provided to a hospice patient should not exceed what the nursing home otherwise would have received if the patient had not been enrolled in hospice.

The OIG clarified to the OMPP that the payments for room and board services may not exceed the Medicaid daily rate that the nursing facility would have received if that resident had not elected hospice. For example, the nursing facility's Medicaid daily rate is $100.00 for caring for that resident. Once that individual elects the hospice benefit, the nursing facility should not receive more than $100.00 from the hospice provider for providing room and board services.

The OIG further clarified that the OMPP can only pay the hospice provider 95% of the lowest nursing facility rate for room and board services per your rule. However, the hospice may pay the nursing facility anywhere from 95% to 100% of the Medicaid daily rate for room and board services without raising concerns about kickbacks or fraud. Payment exceeding 100% of the nursing facility's Medicaid daily rate raises the scrutiny for kickbacks and/or fraud.

Finally, the OMPP then sought clarification from the OIG about how a hospice and nursing facility should document the contract when a hospice would like to pay the nursing facility an additional amount for non-core hospice services and a *per diem* amount for room and board services. Basically, the concern centers around how the two parties document the services and rates in the contract to avoid compliance problems with the fraud alert.

The OIG advised that the additional non-core services must not be services that Medicaid considers to be included in the Medicaid nursing facility daily rate. The contract should separately identify the room and board services from any other additional non-core service and the individual rates for each

service noted in the contract, however; it is not required that the hospice provider have two contracts. It would be prudent that the contracts meet the safe harbor requirements to immunize the providers from the fraud alert. The safe harbor regulations are outlined at 42 CFR 1001.952 in the most current CFR, revised as of October 1, 1997. Also, the anti-kickback statute lists some exceptions at 42 USC 1320a-7(b)[SSA sec. 1128b].

The Indiana nursing facility Medicaid daily rate includes the services outlined in the Medicaid covered services rule. According to the OIG's response in the previous paragraph, the services included in the Medicaid daily rate cannot be considered as additional non-core services in contracts between nursing facilities and hospice providers since these services are part of the nursing facility Medicaid daily rate. The following paragraphs clarify those services included in the nursing facility *per diem*:

- According to 405 IAC 5-31-4, the *per diem* rate for nursing facilities include the following services:
    - Room and board (room accommodations, all dietary services, and laundry services. The *per diem* rate includes accommodations for semi-private rooms). Medicaid reimbursement is available for medically necessary private rooms. Private rooms will be considered medically necessary only under (1) or both of the following circumstances:
        - The recipient's condition requires isolation for health reasons, such as communicable disease.
        - The recipient exhibits behavior that is or may be physically harmful to self or others in the facility.
    - Nursing Care
    - The cost of all medical supplies and equipment, which includes those items generally required to assure adequate medical care and personal hygiene of patients.
    - Durable medical equipment (DME), and associated repair costs, routinely required for the care of patients, including, but not limited to, ice bags, bed rails, canes, walkers, crutches, standard wheelchairs, and traction equipment may not be billed to Medicaid by the facility, an outside pharmacy or any other provider. The DME provider must bill nonstandard items of DME, and associated repair costs, that have received prior authorization directly to Medicaid. Facilities may not require recipients to purchase or rent such equipment with their personal funds. DME purchased with Medicaid funds becomes the property of the Office of Medicaid Policy and Planning. The county office of family and children must be notified when the recipient no longer needs the equipment.
- According to 405 IAC 5-22-10 (6), respiratory therapy services.
- According to 405 IAC 5-22-11(7), occupational therapy services.
- According to 405 IAC 5-22-8, physical therapy services.

- According to 405 IAC 5-22-9, speech therapy services.

The information outlined in this section addresses all contract-related concerns raised by nursing facility, hospice and home health providers since the release of the March, 1998 OIG Fraud Alert. Any further case-specific issues arising from contract negotiations between a nursing facility and a hospice provider must be resolved between these two entities (and their respective legal staff) since they are the two parties to the contract. Finally, hospice/home health/nursing facility providers may submit further case specific questions regarding this fraud alert directly to the OIG for an advisory opinion. The following website (http://www.hhs.gov/progorg/oig/advopn/advopn.html) offers a preliminary checklist for advisory opinion requests. The OIG also has a regional field office in Chicago, Illinois that providers may contact at (312) 353-2740.

As all questions raised by providers regarding these unique contract-related concerns have been answered, the nursing facilities and hospice providers should direct any further case by case contract issues related to the hospice benefit to their respective attorneys for legal research and resolution. As the OMPP is not a party to these agreements between the nursing facilities and hospice providers, our involvement in the legal research and resolution of any future contract negotiation issues would not be appropriate.

State Department of Health Surveying Procedures of Nursing Homes with Hospice Recipients

Nursing facility representatives have raised concerns regarding the policies and procedures of the State Department of Health (SDOH) for surveying nursing facilities that have residents that receive contracted hospice services after electing the Medicaid Hospice Benefit. Specifically, nursing facility representatives expressed concerns about the conflict between the OBRA standard of highest practicable level of functioning and the hospice philosophy of palliative care. The OMPP obtained the following clarification from SDOH regarding surveying policies and procedures.

According to the State Department of Health, nursing facilities are liable and responsible for providing the care that meets State operations regulations. If an individual care plan identifies a patient who has elected the hospice benefit, the requirement of the care plan goal that respects the hospice philosophy supersedes the requirement of a care plan goal that respects the need for the highest optimum outcome.

The SDOH must survey the nursing facility and the hospice provider to ensure that both providers meet the standards of the respective nursing facility and hospice guidelines. The long term care surveyor from SDOH must evaluate the nursing facility to ensure that the nursing facility is complying with the long term care regulations to meet the needs of the nursing home residents. The hospice surveyor from SDOH must evaluate the nursing facility to ensure that the nursing facility is complying with the hospice regulations to meet the needs of the resident. The hospice surveyor's review is more focused and would also include a review of the hospice provider's plan of care. The SDOH must survey both providers to ensure compliance with all regulations regarding the resident's care.

The SDOH expects the hospice provider and the nursing facility to coordinate the care of the resident so that the resident needs are met. The nursing facility and the hospice provider should use the plan of care that they jointly develop to specify each provider's individual service delivery obligations that are meant to ensure that they jointly address and meet all the hospice resident's care needs. As long as the hospice resident's overall care needs are met, there should be no compliance concerns.

Clarification from HCFA and the State Department of Health regarding Hospice Recipients in Nursing Facilities

The nursing facility representatives have raised concerns surrounding the obligations of the nursing facilities to provide contracted hospice services when a nursing home resident elects the Medicaid Hospice Benefit. The OMPP obtained clarification from the Health Care Financing Administration (HCFA) and SDOH surrounding these specific concerns.

Specifically, the concerns raised by nursing facility representatives and HCFA and/or SDOH's responses are:

- A concern as to whether the hospice benefit as a contracted service in nursing facilities is similar to other contracted services in a nursing facility, such as dialysis.

  HCFA and SDOH indicated that a nursing home resident's election of the hospice benefit is an independent choice. The nursing facility (NF) is not obligated to offer hospice services if hospice is not a standard contracted service. However if a nursing facility resident elects the hospice benefit and the facility does not provide contracted hospice services, then the nursing facility must make a good faith* effort to locate a nursing facility that does provide contracted hospice services and then assist the resident in transferring to that facility.

  *The OMPP was asked by hospice providers to define the legal term good faith. The following two paragraphs provide definitions of good faith and bad faith according to Black's Law Dictionary, Sixth Edition, Centennial Edition (1891-1991):

  Good Faith: Good Faith is an intangible and abstract quality with no technical meaning or statutory definition, and it encompasses, among other things, an honest belief, the absence of malice and the absence of design to defraud and seek an unconscionable advantage, and an individual's good faith is a concept of his own mind and inner spirit, and, therefore, may not conclusively be determined by his protestations alone. Doyle v. Gordon, 158 N.Y.S.2d 248,259,260. Honesty of intention, and freedom for knowledge of circumstances, which ought to put the holder upon inquiry. An honest intention to abstain from taking any unconscious advantage of another, even through technicalities of law, together with absence of all information, notice or benefit or belief of facts which render transaction unconscious. In common usage, this term is ordinarily used to describe that state of mind denoting honesty of purpose, freedom from intention to defraud, and, generally speaking, means being faithful to one's duty or obligation. Efron B. Kalmanovitz, 249 Cal. App. 187, 57, Cal.Rptr. 248,251.

  Bad Faith: The opposite of good faith, generally implying or involving actual or constructive fraud, or a design to mislead or deceive another, or a neglect or refusal to fulfill some duty or contractual obligation, not prompted by an

honest mistake as to one's rights or duties, but by some interested or sinister motive. The term bad faith is not simply bad judgement or negligence, but rather it implies the conscious doing of a wrong because of dishonest purpose or moral obliquity; it is different from the negative idea of negligence in that it contemplates a state of mind affirmatively operating with furtive design or ill will. Stath v. Williams, Ind. App. 367 N.E.2d 1120,1124. An intentional tort that results from breach of duty imposed as consequence of a relationship established by contract. Davis v. Allstate Ins. Co., 101 Wis.2d 1, 303 N.W.2d 596,599.

The measure of good faith and/or bad faith with regards to the discharge and transfer of a hospice recipient by a nursing facility is case-specific and should be evaluated by the nursing facility and, if necessary, the facility's legal staff. The general information/guidelines provided in this bulletin should not supplant a provider seeking legal advice from his/her attorney on case-specific situations.

- A concern that centers on the nursing facility's obligations when a nursing facility resident elects the Medicaid Hospice Benefit and has a preferred hospice provider that does not have a contract with the nursing facility.

  HCFA and SDOH indicated that the nursing facility should inform the nursing facility resident that the nursing facility does not have a contract with his/her preferred hospice provider and then advise the resident of his/her options. The first option is for the nursing facility resident to obtain hospice services from any of the hospice providers that are on contract with the nursing facility. The second option is for the nursing facility to make a good faith* effort to locate a nursing facility that has a contract with the resident's preferred hospice provider and then assist in the transfer of the nursing home resident to that other facility. However if the nursing facility has made an extensive effort and cannot find another facility that has a contract with the nursing home resident's preferred hospice provider, then the responsibility falls back to the nursing home resident and his/her family. Finally, a third option noted by hospice providers is for the nursing facility and the hospice provider to enter into a one-patient contract.

  In conclusion, neither the nursing facility and/or the hospice provider are under an obligation to enter into a contract with each other. This general rule includes, but is not limited to:

- Hospice is not a standard contracted service of the nursing facility.

- The nursing facility resident's preferred hospice provider does not have a contract with the nursing facility.

- The nursing facility resident's preferred hospice provider proposes to the nursing facility a one-patient contract.

- The nursing facility resident's preferred hospice provider proposes to the nursing facility to enter into a contract that specifies the same services and reimbursement as the nursing facility's current contracted hospice providers.

- A concern regarding clarification about the circumstances under which a nursing facility may discharge a hospice recipient. A nursing facility may discharge a recipient based on one of the six reasons listed in the federal regulations (42 CFR Section 483.12(2)(i)-(vi) or in Indiana regulations (410 IAC 16.2-2-3(I)(4)(A)-(F). The six reasons for discharge are:

  1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

  2. The transfer or discharge is necessary because the resident's health has improved sufficient so the resident no longer needs the services provided by the facility.

  3. The safety of the individuals in the facility is endangered.

  4. The health of the individuals in the facility would otherwise be endangered.

  5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to the facility, the facility may charge a resident only allowable charges under Medicaid.

  6. The facility ceases to operate.

  For more case-specific hospice situations, the nursing facility should request the assistance of the State Long Term Care Ombudsman.

- A concern regarding the advice of the SDOH to the OMPP that a hospice provider is required to provide a minimum service to hospice recipients. The Certification Process, Section 2080 of the State Operations Manual (SOM) outlines the service and items that hospices must provide. The hospice selection should be viewed as services above and beyond the services provided by the long term care facility.

- A concern regarding the advice of the SDOH to the OMPP as to which situations the acute care/NF complaint process applies. The divisions of Acute Care and Long Term Care share a common complaint intake service. This program is staffed with professional intake staff. The complaint program staff will elicit enough information to determine the entity to which the complaint is targeted. If during an investigation it is determined that a concern exists in the entity not under investigation, a referral will be made to the appropriate program.

In conclusion, SDOH has indicated that inappropriate care for residents will be cited by ISDH. State Operations Manual/Transmittal #274 outlines the survey evaluation process for a resident receiving hospice care in a long term care facility. A copy of this document may be obtained directly from the Long Term Care Division of State Department of Health by calling (317) 233-7442.

Conclusion

The OMPP has obtained extensive legal and policy clarification about surveying and contract-related issues raised by hospice, home health, and nursing facility representatives. Specifically, extensive research has been dedicated to the reimbursement of room and board services at 95% of the lowest nursing facility rate and other contract-related matters. The formal responses from HCFA, OIG, and SDOH are outlined in this comprehensive bulletin.

Further inquiries regarding the hospice benefit may be directed to the EDS Provider Assistance Unit at 1-800-577-3278.