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Continuous Home Care: When Hospice Patients Reside in a Nursing Home or Assisted Living Facility

A hospice recently asked: *Is it permissible for us to promise a nursing facility or assisted living facility a certain number of continuous home care days provided to their residents? Some facilities are beginning to demand this, saying that other hospices are making such promises.*

Hospices must not promise a specific number of continuous home care days when contracting with nursing facilities or assisted living facilities. The hospice must determine level of care on a patient-by-patient basis as part of the individualized care plan developed by the hospice interdisciplinary team, the attending physician and the hospice patient and his or her family. It is impossible for the hospice to promise a specific number of continuous home care days to a nursing facility or assisted living facility, because to do so would disregard the hospice's responsibility to provide individualized care planning for its patients.

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Review of Requirements for Continuous Home Care

A hospice may provide continuous home care to patients residing in a nursing facility or assisted living facility if the hospice determines that the patient requires this level of care. However, Dr. James Cope, the Medical Director at United Government Services ("UGS"), a Medicare hospice fiscal intermediary, stated that UGS looks critically at claims submitted for continuous home care provided to residents of a nursing facility. Dr. Cope said that UGS feels that continuous home care for a nursing facility resident should be an unusual event, and that UGS sees a distinction between a hospice patient living at home and a patient living in a nursing home, which makes a certain level of care available to all of its residents. Although this represents the position of one fiscal intermediary and this distinction is not set forth in Medicare regulations or guidance, it is important to note that continuous home care claims for nursing facility residents may be more heavily scrutinized by fiscal intermediaries.

According to the Medicare hospice regulations, reimbursement at the continuous home care rate is only justified during brief periods of crisis when such care is necessary to maintain the terminally ill patient at home.[1] The regulations define "periods of crisis" as periods in which the patient requires continuous care to achieve palliation or management of acute medical symptoms.[2] Nursing care may

be covered on a continuous basis for as much as 24 hours a day during such periods of crisis, as necessary to maintain a patient at home.

To qualify for reimbursement as a continuous home care day, the hospice must provide a minimum of eight hours of care during a 24-hour day (which begins and ends at midnight) to the hospice patient, and such care must primarily be nursing care provided by either a registered nurse or licensed practical nurse. Note that beginning January 1, 2007, Medicare will require that continuous home care be billed in 15-minute increments; therefore, the hospice must provide a minimum of 32 15-minute units of care in order to qualify for a continuous home care day. Rounding up to the next whole hour will no longer be acceptable.[3] During a continuous home care day, at least half of the hours of care must be provided by an RN or LPN. Homemaker or home health aide services may be provided to supplement the nursing care, but such services must not constitute a majority of the care provided to the patient. According to the Medicare Hospice Manual, when a hospice determines that a beneficiary meets the requirements for continuous home care, it must keep appropriate documentation to support the services as reasonable and necessary and in compliance with the patient's plan of care to meet a particular crisis situation.[4] If the patient day does not qualify for continuous home care, it is reimbursed at the routine home care rate.

The Medicare Manual includes several illustrations that analyze fact patterns and determine whether they qualify for continuous home care reimbursement[5]. Below are the Medicare Manual illustrations, reproduced in their entirety for your convenience ("CHC" refers to continuous home care):

1. Frequent medication adjustment to control symptoms/collapse of family support system.
    - **Situation A:** The patient has had a central venous catheter inserted to provide access for continuous Fentanyl drip for pain control and for the administration of antiemetic medication to control continuous nausea and vomiting. The nurse spends 2 hours teaching the family members how to administer IV medications. She returns in the evening for 1 hour. The home health aide provides three hours of care. The nurse spends 2 hours phoning physicians, ordering medications, documenting and revising the plan of care. Determination: Despite 8 hours of service, this does not constitute CHC since 2 of the 8 hours were not activities related to direct patient care.

- **Situation B:** The patient experiences new onset seizures. He continues to have episodes of vomiting. The nurse remains with the patient for 4 hours (10:00 a.m. - 2:00 p.m.) until the seizures cease. During that time she provides skilled care and family teaching. The patient's wife states she is unable to provide any more care for her husband. A home health aide is assigned to the patient for monitoring for 24 hours, beginning at 2:00 p.m., with a total of 8 hours of direct care in the first day. The nurse returns intermittently for a total of an additional 4 hours to administer medications, assess the patient and to relieve the aide for breaks. The social worker provides 3 hours of services to work with the patient's wife in identifying alternative methods to care for the patient.

- **Determination:** This qualifies as a continuous home care day. This constitutes a medical crisis, including collapse of family structure. The caregiver has been providing skilled care and the change in the patient's condition requires the nurse's interventions. Since there is no overlap in nursing care, 16 hours of care would be computed as CHC. The social worker hours would not be incorporated. If the caregiver had been providing custodial care and his medical crisis resolved within a short time frame, this situation would not have qualified as CHC.

2. Symptom management/rapid deterioration/imminent death.

   - **Situation A:** A 77 year-old patient with lung cancer whose caregiver is 80 years old. The caregiver has been caring for this patient for 4 months and is now exhausted and scared. The care provided consists of assisting with bathing, assisting the patient to ambulate, preparing meals, housekeeping and administering oral medications. Since the patient is dyspneic at rest, she requires assistance in all ADLs, which equates to 9 hours of assistance within a 24-hour period.

   - **Determination:** This would not qualify as CHC since there is little nursing care that requires a nurse. The patient would however be a candidate for an inpatient respite level of care.

   - **Situation B:** The patient's condition deteriorates. The patient now has circumoral cyanosis, respiratory rate of 44 and labored with intermittent episodes of apnea. The nurse performs a complete assessment and teaches the caregiver on methods to make the patient comfortable. The nurse returns twice within the 24-hour period to assess the patient. She

revises the plan of care after conferring with the patient's attending physician and with the hospice physician. The homemaker and home health aide are sent to assist the caregiver. Within the 24-hour period, the direct care provided by the nurse equates to 3 hours, homemaker with 2 hours, and home health aide of 6 hours.

- **Determination:** Since only 3 of the 11 hours were skilled care requiring the services of a nurse, this would not constitute CHC. In this situation, the care required is not predominantly nursing but are comprised of services provided by a home health aide. In addition, it would not be correct to discount any portion of the home health aide's hours or to provide these services gratis in order to qualify for the CHC benefit.

- **Situation C:** The next day, the patient's condition deteriorates further. She has increased periods of apnea and air hunger. In addition she is experiencing continuous vomiting and increasing pain. Her blood pressure is beginning to decrease and her respirations are increasing. The nurse remains at the patient's bedside for 4 hours while attempting to control her pain and symptoms. The home health aide provides care during one hour of this period. The nurse leaves and the home health aide remains at the bedside for 3 hours. The social worker comes and talks with the caregiver and remains for 1 hour. The nurse returns while the aide leaves. The nurse remains with the patient for 2 hours until she dies. The social worker returns and stays with the caregiver for 1 hour until the mortuary arrives.

- **Determination:** The nurse provided 6 hours of direct skilled nursing care; the aide provided 4 hours of direct care resulting in a total of 10 hours of registered nurse and home health aide care. Since at least 6 of the 10 hours were direct nursing care, and since nursing care was the predominant service provided during the 10 hours, the care meets the criteria for CHC. In addition, since the nurse and the aide provided direct care for the patient simultaneously, it would be appropriate to bill for each resulting in total of 10 billable hours. The patient received 12 hours of care. The 2 hours for the social worker are not counted towards the CHC hours. These illustrations emphasize the fact-specific nature of continuous home care determinations. It is important to note that even in situations of imminent death, continuous home care is not always justified. Continuous home care must be analyzed on a patient-by-patient basis to determine whether circumstances warrant that level of care.

Fraud and Abuse Concerns

Because of the individualized nature of hospice care, it is impossible for a hospice to credibly guarantee a nursing facility or assisted living facility a certain number of continuous home care days when contracting with the facility. A hospice making such a promise, and then billing Medicare for that promised number of continuous home care days (or providing remuneration to the nursing facility or assisted living facility in the event of a shortfall), is exposing itself to scrutiny not only by the Medicare fiscal intermediary processing the hospice claims but also by government fraud and abuse investigators.

The Department of Health and Human Services, Office of Inspector General ("OIG") is responsible for identifying and eliminating fraud and abuse in the Medicare system. The OIG has identified arrangements between hospices and nursing homes as vulnerable to fraud and abuse because of the substantial potential hospice population residing in nursing homes and the desirability of nursing home patients from the hospice's perspective. In 1998, the OIG released a Special Fraud Alert titled "Fraud and Abuse in Nursing Home Arrangements With Hospices." The OIG also included improper arrangements with nursing facilities and hospice incentives to actual or potential referral sources as two "risk areas" in its 1999 Compliance Program Guidance for Hospices.[6] As a result, hospices and nursing or assisted living facilities should proceed with extreme caution when entering into arrangements with each other, particularly if the hospice intends to offer any incentives to the facility.

The practice of a hospice offering a nursing facility or assisted living facility a guaranteed number of continuous home care days could be a violation of the Federal Anti-Kickback Statute, exposing both the hospice and the facility to potential liability under that statute. The Anti-Kickback Statute imposes criminal and civil penalties for, among other things, offering, paying, soliciting or receiving any remuneration for the referral of patients for items or services reimbursed by federal health care programs (*e.g.*, Medicare, Medicaid). The Anti-Kickback Statute is an intent-based statute. Courts have found that if one purpose of a payment is to induce referrals, there is a violation of the Anti-Kickback Statute. An arrangement in which a hospice guarantees a nursing facility or assisted living facility a certain number of continuous home care days would certainly attract the attention of the OIG as a potential Anti- Kickback Statute violation if the facility also refers residents to the hospice.[7] If one purpose of the hospice's offer to guarantee a number of continuous home care days was to solicit referrals of

patients from the facility, a court could reasonably find that an Anti-Kickback Statute violation had occurred.

In conclusion, because each hospice patient's plan of care must be individualized, and because a hospice has no way of predicting the number of continuous home care days it will provide to hospice patients residing in the nursing facility or assisted living facility, a hospice may not guarantee a nursing facility or assisted living facility a certain number of continuous home care days provided to hospice patients. In addition to the absence of individualized hospice care planning under such an arrangement (which would be a violation of the Medicare hospice conditions of participation) a hospice and facility may subject themselves to government scrutiny for an Anti- Kickback Statute violation if the OIG became aware of this arrangement.

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[1] *See* 42 C.F.R. § 418.302(b)(2).
[2] *See* 42 C.F.R. § 418.204(a).
[3] *See* CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 1101, Change Request 5245 (July 28, 2006).
[4] *See* CMS Manual System, Pub. 100-02, Chapter 9, § 40.2.1.
[5] *Id*.
[6] 64 Fed. Reg. 54031 (October 5, 1999).
[7] A violation of the Anti-Kickback Statute is a felony which is punishable by imprisonment of up to five years and a fine of up to $25,000. In addition, individuals and entities found to have violated the Anti-Kickback Statute are subject to civil monetary penalties of up to $50,000, assessments of up to three times the amounts claimed for, and potential exclusion from the Medicare program or any state health care program.