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Free Care; Charity Care – Hospice and Reimbursement Issues: Is Your Corporate Compliance Program Up to Date?

Reimbursement issues may implicate the Federal False Claims Act and should be carefully reviewed as part of the hospice's compliance plan. Compliance planning is a critical part of every hospice's operations. Every hospice should have a formal compliance plan and should continue to review and update it. The consequences for non-compliance could challenge the very existence of your hospice. Recently a number of issues have been raised with regard to the hospice benefit related to reimbursement and primary and secondary payers.

The following list of frequently asked questions is provided in an effort to clarify existing laws and corporate compliance issues, as well as to assist hospices with sound business practices. As with all complex hospice questions, this information does not constitute legal advice and hospices are encouraged to contact their own legal counsel for specific assistance in establishing billing systems that meet the requirements of the law.

1. Is there a requirement that hospices bill the same rate for the same level of care regardless of payor source?

There is no absolute requirement that hospices bill the same rate for the same level of care regardless of payor source. The hospice is not prohibited from billing a private insurance company more than the Medicare rate nor less than the Medicare rate. However billing other payors less than Medicare or providing free care in the absence of a sliding scale may place the hospice at risk from a regulatory standpoint and may adversely impact reimbursement rates over the long term. If the hospice routinely waives payments to patients who are uninsured or underinsured, the hospice runs the risk of allegations of insurance fraud. Likewise, if the hospice bills private carriers less than the Medicare rate, there is a certain potential for allegations of kickback. Also, in the long run, if hospices generally reduce their fees to commercial carriers, CMS could determine that Medicare rates are too high and attempt to freeze or reduce them. Because many hospices rely heavily on charitable donations to subsidize Medicare and Medicaid fees, it is permissible to charge private carriers a fee in excess of the Medicare fee. However, all determinations of fees should be carefully reviewed

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from the standpoint of contractual obligations as well as fraud considerations.

2. Our hospice has made it a practice never to bill a patient and family. Is there anything wrong with this?

If the hospice bills private insurance, but never bills the patient or family, the hospice will have difficulty establishing that its "usual and customary" rates are what is billed to the insurance company. In essence, the insurance company may argue that its usual and customary rates are $0.00, if patients and families are never billed. The most prudent course of action, in order to avoid allegations of insurance fraud or kickback, is to charge patients and families for that amount not covered by other third party payors. However, it is permissible to establish a sliding scale system, so that charitable dollars are used to subsidize the care for those who are unable to pay for it. The hospice's mission (providing care regardless of the ability to pay) is therefore met through the allocation of community dollars.

Example 1: Big Hearted Hospice ("Big Hearted") has a standard billing rate for all routine home care days for non- Medicare/Medicaid patients of $125 per day. Reliable Insurance pays 80% of its "usual and customary" rates, which Reliable Insurance has determined is $100. Big Hearted bills Ima Patient $25 (the difference between the actual charge and the usual and customary charge) plus 20% of the usual and customary charge ($20) for a total of $45 per day. However, Ms. Patient and her family, based on the hospice's sliding scale system, are not obligated to pay for any of the care, since they fall within a financial category under which no fees are collected. In this instance, the entire $45 is billed to the hospice's uncompensated care fund.

Example 2: The facts are the same as in Example 1 except that Ms. Patient with an annual income of $200,000, based on the hospice's sliding scale system, will be billed the entire $45 per day.

It is permissible to establish sliding scale systems based on percentages.

3. Is it permissible for the hospice to enter into contracts with managed care organizations that are willing to pay only on a per visit basis (e.g., for nurses and home health aides)?

While it is not absolutely impermissible to enter into such contracts, it is important for the hospice to remember that the hospice is not permitted to unbundle the care. Therefore, the hospice must continue to provide the full range

of hospice care. If the hospice is providing free care to the patient and family or to the third party payor, there could be allegations of kickback. Most managed care contracts include clauses making it impermissible for the hospice to bill the patient and family for care that is covered by the managed care organization. It is therefore critical to review all such contracts carefully. If the managed care organization is absolutely unwilling to pay for the full range of hospice services, the hospice may have to choose either to refuse to enter into an unacceptable contract and offer to serve the patient as a private pay/sliding scale patient, or accept the contract and pay for the uncompensated care through the scarce resource of community donations.

Example: Been Burned Hospice ("Burned") has entered into a contract with a managed care organization. The contract pays $80 per visit for each nursing visit and $40 per visit for each home health aide visit up to a maximum per patient per lifetime of $2,500. The contract with the HMO prohibits Burned Hospice from billing the hospice patient and family under any circumstances, including the HMO's refusal to pay. In this instance, until the contract is terminated, Burned Hospice may not bill patients and families who are enrollees of the HMO. Funds to pay for the shortfall must come from community donations.

4. Some HMOs do not wish to purchase drugs, DME, etc. from the hospice. Is it permissible to enter into a contract whereby the hospice covers staffing, but does not pay for drugs, or DME?

It may be permissible to enter into such a contract, as long as the hospice continues to coordinate the hospice services. CMS has made a distinction between coordinating the coverage and paying for it. As long as the hospice controls the care plan with regard to all aspects of hospice care, payment for drugs, durable medical equipment and supplies may be arranged separately. As with all contract questions, such an agreement should be carefully reviewed by the hospice's legal counsel.

5. When a Medicare hospice patient also has private insurance with a drug benefit, is the hospice permitted to bill the insurance company for the medications related to the terminal illness?

Assuming that Medicare is the primary payer and that the Medigap policy is secondary (which is nearly always the case), the hospice must pay for all of the drugs that are part of the care plan and connected with the terminal illness. This question raises the potential for a fraud investigation both by the Medicare

program and by the private insurer. The only exceptions might be in the case of a drug that is not included under the hospice protocol or not part of the care plan. In these cases, it is recommended that the hospice discuss the matter with the insurance company, explaining coverage under the Hospice Medicare benefit and why the medication is not covered by the hospice. If full disclosure is made to the insurance company regarding the reasons why the insurer may be billed, then it may be possible to continue to bill the insurer. However, such cases should be infrequent and should be carefully reviewed before the private insurer is billed.

6. The patient does not qualify for either Medicare or Medicaid. Coverage is through the patient's HMO, which negotiated a per diem arrangement with the hospice. Under this agreement, the HMO continues to pay for drugs, DME and supplies. The per diem arrangement between the hospice and the HMO is for IDG team care and bereavement. May the hospice be paid the full per diem rate when services and care related to the terminal illness are unbundled in this way?

See the National Hospice and Palliative Care Organization Managed Care Contracting Standards for Hospice. See also the answer to number 3., above. In the case of a negotiated fee, there is no prohibition against charging more for commercial patients than the Medicare rate, or for allowing the commercial insurer or HMO to pay for drugs, DME, etc. as long as the hospice has the ability to ensure that the patient will have access to covered services identified in the plan of care. Under Medicare COP 418.56, the IDG must be in charge of the creation and execution of the patient and family's plan of care. However, as long as this occurs and the services and supplies are provided, the HMO or commercial insurer may pay for them apart from the contracted per diem. (See number 4., above.)

7. When a Medicaid patient has other coverage, may the hospice accept the full Medicaid reimbursement if part of the interventions related to the terminal illness are paid for by another payer? For example, in the case of a child on a ventilator, what if the insurer is willing to pay for the ventilator?

In the case of children, hospices often have difficulty determining the appropriateness of the hospice benefit. What might not normally be considered appropriate hospice care (*e.g.*, ventilator and tube feedings) may in fact be appropriate in the case of a child, given the needs of the family. The hospice may be faced with the difficult situation of whether to admit the patient who is still receiving certain treatments. Assuming that the child is in fact eligible, and

assuming that the hospice is appropriately billing the Medicaid program for the appropriate levels of care, it may be possible to negotiate with the insurance company to provide coverage for items and services that are not part of the Medicaid hospice benefit. Specific fact situations such as this one should be carefully reviewed to ensure that the hospice does not increase its risk of regulatory or reimbursement scrutiny. If the documentation in the care plan is appropriate, regulatory requirements are met and the insurance company understands its obligations and what is covered under the Medicaid Hospice benefit, there should be no absolute bar to billing the insurance company for care that is not covered under the benefit. Once again, these types of issues should be carefully scrutinized in light of the hospice's corporate compliance plan and the specific facts involved.

8. How should the hospice develop a standard system for billing and collecting?

In devising a standard system for billing and collecting from insurers and managed care organizations, it is important to be aware of the National Hospice and Palliative Care Organization's Managed Care Contracting Standards for Hospices. The Standards require that the hospice maintain professional management of the patient, consistent with Medicare COP 418.56. This means that hospice services may not be "unbundled," as many insurers would prefer. Also, the Standards include a warning to hospices who do not make reasonable attempts to bill insurers and patients who are not covered by Medicare/Medicaid. The Standards, as well as additional information on managed care contracts are found at NHPCO's website.

In the event that the hospice decides to implement a sliding scale system, so that only those patients who are able to afford the cost of their care are billed the entire amount, the hospice is advised to establish a separate fund. This fund could apply donations from memorials and bequests, for example, to compensate care for those who are not able to afford to pay for such care. Utilizing this fund, each non-Medicare/Medicaid patient will be billed the same amount, but the funds will come from a variety of sources, including insurers, self-pay and the hospice's own uncompensated care fund.

When billing insurers, including HMOs and other managed care plans, as well as billing patients and families, it is important to remember that if the hospice is billing less than its true costs, the community is subsidizing the care, over and above the subsidy the community is already providing to Medicare/ Medicaid

patients. In order to ensure the financial stability of the hospice, it is important to implement a billing system that adequately compensates the hospice for the care it is providing. When patients and families cannot afford to pay for the full cost of care, community dollars are a useful and important source of revenue. Ultimately, if the hospice is not billing its true costs, the cost reports may lead to decreases in government reimbursement as well as an unwillingness on the part of private payors to pay the full cost of hospice care.

This article does not constitute nor replace legal advice. The issue of reimbursement under Medicare, Medicaid and private insurance is an extremely complex one that implicates the Federal False Claims Act, Compliance Guidance for Hospices and the program integrity units of most private insurance companies. It is important for all hospices to implement and maintain workable corporate compliance programs that include a careful review of reimbursement practices. Once those programs are in place, individual circumstances can be more easily evaluated."