Standards for Hospice Managed Care

I have had the privilege to serve on NHPCO's Managed Care Task Force this year. Members of the Task Force include hospice executives from around the country, as well as managed care consultants. The Standards we developed were approved by the NHPCO Board of Directors in October of this year. Even if managed care represents only a small fraction of a hospice's patient census, I cannot overstate the importance of these standards, as they touch the very heart of the hospice philosophy of care: **Unbundled care is not hospice care!** Managed care organizations wishing to purchase only nursing and home health aide services should understand the licensing requirements for hospices in Wisconsin. The following Standards provide helpful guidance.

THE NATIONAL HOSPICE AND PALLATIVE CARE ORGANIZATION (NHPCO)
Managed Care Contracting Standards for Hospice
Developed by the NHPCO Managed Care Task Force
Approved by the NHPCO Board of Directors - October 2000

Standard: Compliance with State Hospital Licensure Laws

In states where hospice licensure laws currently exist all NHPCO members in those states will abide by such licensure laws in any and all contracts that the NHPCO member enters into with entities including but not limited to individuals, managed care organizations, employers, indemnity insurance companies and other payors.

Standard: Compliance with the Medicare Conditions of Participation

All Medicare certified NHPCO members will abide by The Medicare Conditions of Participation for all patients for whom they provide hospice care. Specifically, NHPCO Medicare certified hospices will only enter into contracts with managed care organizations and other payors that specify the provision of hospice care if such care is defined as no less than consistent with The Medicare Conditions of Participation. The reimbursement structure need not mimic the Medicare Hospice Benefit's reimbursement structure as long as the resulting hospice practice is consistent with the obligations imposed upon the hospice under the Medicare

POSTED:

Mar 14, 2001

RELATED PRACTICES:

Health Care
https://www.reinhartlaw.com/practices/health-care

RELATED SERVICES:

Hospice and Palliative Care
https://www.reinhartlaw.com/services/hospice-and-palliative-care

Conditions of Participation.

Particular Issues May Include:

1. **Professional Management of the Patient**; the hospice must retain professional management of the patient (Medicare COP 418.56 - see excerpts from the COPs at the end of this document). The hospice interdisciplinary team, which includes (at least) a registered nurse, the hospice medical director, a social worker, and a pastoral or other counselor, must be in charge of the creation and execution of the patient and family's plan of care (Medicare COP 418.58 and 418.68). While the managed care plan may dictate the subcontractors the hospice will work with (contracted services in areas such as pharmacy, laboratory, home medical equipment, oxygen, etc.), the hospice must have the ability to ensure that the patient will have access to everything identified in the plan of care.

2. **Inpatient Hospice Care** (Medicare (COP 418.98): hospice includes the availability of inpatient hospice care.

3. **Payment**: while most hospices provide care to all patients who wish it and whose medical condition qualifies them for it, hospices are not obligated to provide services without a reasonable attempt to bill for such services. In fact, in most managed care situations the provision of any "free care" raises potential inducement issues. As a result, if managed care organizations wish hospices to provide care to individuals that do not have hospice benefits or who pay only for RN and home health aides or whose benefits have capped, the hospice must make reasonable attempts to bill the patient/family. A sliding scale billing system based on ability to pay is consistent with such reasonable attempts, but the uncompensated care should then be billed to a separate fund set up by the hospice for such purpose. Most hospices pay for such care through memorials, bequests or other community donations. In addition, hospices should contact employers to inform them of situations where the managed care organization is asking for "free care."

4. **Bereavement Care** is part of hospice care plan (COP 418.88)

5. **The Patient And Family Are The Unit Of Care** (COP 418.88)

Reinhart

Fraud and Abuse Issues Related to Managed Care Contracting for Hospices Services

Issues for hospices to be aware of when contracting and conducting business with managed care organizations:

1. **Commercial Pricing as an Inducement for Medicare Risk Plan Referrals or Medicare Referrals**: if a hospice is contracting with a managed care organization that has both commercial and Medicare risk enrollees, or if the managed care organization is owned by physicians who refer Medicare patients to the hospice, the hospice should be very cautious about being sure that its pricing on the commercial business could not be seen as an "inducement" for referrals from the Medicare business. In other words, be sure you can defend all of your contract pricing as consistent based upon volume, business requirements, payment terms and other reasonable business variables. If any purpose is to induce referrals to the hospice under Medicare, Medicaid or other government programs, the hospice may be in violation of anti-kickback prohibitions under the federal False Claims Act.

2. **Any Free Care**: while most hospices have mission and values statements that direct them toward providing care and/or services for all appropriate patients there are potential fraud and abuse issues to consider:

    1. "Free" assessments: is there any way that some special relationship with a managed care organizations could be construed as an inducement? One easy benchmark is whether a hospice provides a "free" service to any and all parties or only select parties.

    2. "Pre-hospice care": same as above.