

# Chapter 1815 Hospice and Nursing Home Relationships

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## Chapter 1815

# Hospice and Nursing Home Relationships

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### Overview

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Hospice care is an approach to treatment of a terminally ill patient that focuses on the relief of pain and suffering associated with a terminal illness. Although originally established for beneficiaries living at home, the Medicare hospice benefit is available to beneficiaries living in nursing homes.

Hospice care provided to nursing home residents can lead to significant anti-kickback concerns. The billing relationship between a hospice and a nursing home is complex, as Medicare and Medicaid compensate for different elements of the care provided. The resulting juxtaposition of these programs can give both hospices and nursing homes significant financial incentives to abuse the process. As a result, arrangements between hospices and nursing homes are under increasing scrutiny by the government.

This chapter describes the interrelationship between hospices and nursing homes serving Medicare and Medicaid beneficiaries.<sup>1</sup> It reviews important risk areas relating to anti-kickback provisions in the Social Security Act that address areas specific to arrangements between these facilities, as well as steps the government has taken to mitigate these risks and ensure coordination of the care received by hospice patients residing in nursing facilities. This chapter also addresses regulatory risks associated with the civil monetary penalties provisions of the Social Security Act as they relate to anti-kickback issues. Additional risk areas specific to these care facilities are covered in *Chapter 1010, Nursing Homes* and *Chapter 1020, Hospices*. For further discussion of the anti-kickback law, see *Tab Section 1400, Anti-Kickback—General Risk Areas*. For more information regarding penalties for anti-kickback violations, see *Chapter 210, Penalties*.

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## 1815.10 Law and Regulatory Summary

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### 1815.10.10 In General

#### *1815.10.10.10 The Medicare Hospice Benefit*

Hospice care, adopted by Medicare in 1983, is an approach to treatment that recognizes a patient's impending death. It represents a shift from curative to palliative care by focusing on the relief of the pain and suffering associated with a terminal illness.<sup>2</sup> Through this emphasis on palliative rather than curative services, individuals can choose alternative treatment

when conventional medical approaches might no longer be appropriate.

Hospice care is broad in scope; the benefit applies to both the patient and the patient's family. The caregiving team is made up of specially trained volunteers and representatives from the fields of medicine, nursing, social work, and spiritual counseling.<sup>3</sup>

To qualify for the hospice benefit, a patient must be eligible for Medicare and certified as terminally ill.<sup>4</sup> Terminal illness is defined as a life expectancy of six

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<sup>1</sup> While this chapter discusses the relationship between hospices and nursing homes, similar fraud and abuse issues may be implicated in arrangements between hospices and other facilities, such as assisted living facilities. The contracting standards for hospices and nursing facilities are also applicable to intermediate care facilities for the intellectually disabled. (*See* 42 C.F.R. § 418.112.) Further, in commentary to that rule, CMS declined to require hospices to institute these provisions in agreements with non-certified facilities, such as assisted living facilities, but indicated that hospices were free to do so. (*See* Medicare and Medicaid Programs: Hospice Conditions of Participation, 73 Fed. Reg. at 32152-53.)

However, it should be noted that, absent explicit approval from the applicable licensing authority, some states do not permit hospice patients to continue residing in assisted living facilities, to the extent their needs exceed those which the facility is licensed to

provide. Additional regulatory issues may be raised to the extent these facilities continue to house hospice patients and utilize hospice staff inappropriately to keep patients in the facilities longer than they would otherwise be able to. For example, the South Carolina Department of Health and Environmental Control allows community residential care facilities to request a waiver to permit up to two terminally ill patients at any given time to continue to reside in the facility, provided certain requirements are met. (Memorandum to Administrators and Licensees of Community Residential Care Facilities, from Dennis L. Gibbs, Director, Division of Health Licensing, South Carolina Department of Health and Environmental Control, Level of Care Waiver (Aug. 31, 2009)).

<sup>2</sup> Social Security Act § 1812(d) [42 U.S.C. § 1395d(d)].

<sup>3</sup> Compliance Program Guidance for Hospices, 64 Fed. Reg. 54031, 54032 fn. 2 (Oct. 5, 1999).

<sup>4</sup> 42 C.F.R. § 418.20.

months or less, assuming the terminal condition runs its normal course.<sup>5</sup>

A beneficiary who elects to enroll in a hospice program waives all rights to curative care related to the terminal illness. Medicare will continue to pay for services furnished by the patient's non-hospice attending physician and for the treatment of conditions unrelated to the terminal illness.<sup>6</sup>

Beneficiaries can revoke their hospice benefits at any time and return to curative treatment.<sup>7</sup> Likewise, a hospice agency can discharge a beneficiary if, among other reasons, it determines that the beneficiary's condition has improved or stabilized and eligibility criteria are no longer met.<sup>8</sup> The beneficiary can reinvoke the hospice benefit if he or she meets the eligibility criteria at a later time.<sup>9</sup>

A hospice program must meet stringent standards set forth in federal conditions of participation (CoPs) to qualify for reimbursement under the Medicare hospice benefit.<sup>10</sup> A qualifying hospice must establish a written plan of care encompassing all of the services that are reasonable and necessary for the palliation and management of each patient's terminal illness, including:<sup>11</sup>

- nursing care provided by or under the supervision of a registered nurse;
- physical or occupational therapy or speech-language pathology services;
- medical social services by a social worker under the direction of a physician;
- trained hospice aide services;
- homemaker services;
- medical supplies and appliances, durable medical equipment, drugs, and biologicals;
- physicians' services;
- short-term inpatient care in an appropriate inpatient facility, such as a participating hospice inpatient unit or participating hospital or nursing facility that meets hospice qualification requirements;

- counseling, including dietary counseling,<sup>12</sup> with respect to care of the terminally ill beneficiary and adjustment to the beneficiary's death, including bereavement counseling for the family; and

- any other item or service that is specified in the plan of care and for which payment otherwise may be made under Medicare.

Substantially all "core services"—which include nursing, counseling, and medical social services—must be provided directly by hospice employees.<sup>13</sup> Hospice services outside of these core services can be provided by non-hospice practitioners under contract, but only if the hospice maintains managerial control over the provision of services.<sup>14</sup>

A beneficiary is provided hospice services according to a written plan of care that is developed and monitored by an interdisciplinary team. The team must include a physician, nurse, social worker, and pastoral or other counselor.<sup>15</sup>

Hospices are reimbursed by Medicare at a fixed per diem rate, based on the geographic location of the patient and the level of care required (see *Chapter 1020, Hospices*, § 1020.10.10.40).<sup>16</sup> The hospice is responsible for providing all services necessary to conform with the patient's written plan of care.

The amount or expense of services provided by the hospice for any particular beneficiary is not considered when Medicare reimbursement is calculated. Thus, the hospice bears the financial burden for the cost of any care required by its patients. In addition, a hospice's reimbursement is subject to two caps: one on total inpatient care days for Medicare beneficiaries, which may not exceed 20 percent of the hospice's total Medicare patient care days<sup>17</sup> and one on total annual payments as determined by total Medicare patients in a year multi-

<sup>5</sup> Social Security Act § § 1814(a)(7), 1861(dd)(3)(A) [42 U.S.C. § § 1395f(a)(7), 1395x(dd)(3)(A)], 42 C.F.R. § 418.3.

<sup>6</sup> Social Security Act § 1812(d)(2)(A) [42 U.S.C. § 1395d-(d)(2)(A)]; 42 C.F.R. § 418.24(d).

<sup>7</sup> Social Security Act § 1812(d)(2)(B) [42 U.S.C. § 1395d-(d)(2)(B)]; 42 C.F.R. § 418.28.

<sup>8</sup> See 42 C.F.R. § 418.26(a).

<sup>9</sup> 42 C.F.R. § 418.24(e).

<sup>10</sup> See 42 C.F.R. § 418.52, *et seq.*

<sup>11</sup> Social Security Act § 1861(dd)(1) [42 U.S.C. § 1395x(dd)(1)].

<sup>12</sup> The Centers for Medicare & Medicaid Services (CMS) is allowed to waive the requirement that all hospices provide physical and occupational therapy, speech-language pathology services, and dietary counseling. These waivers are available to an agency or organization only if it is located in an area that is not an urbanized area—as defined by the Bureau of Census—and can demonstrate to CMS that it has been unable, despite diligent efforts, to recruit appropriate personnel. Hospices will be required to submit evidence to establish that diligent efforts have been made. Social Security Act § 1861(dd)(5)(C) [42 U.S.C. § 1395x(dd)(5)(C)], 42 C.F.R. § 418.74.

<sup>13</sup> 42 C.F.R. § 418.64. There are certain exceptions to this requirement, such as unexpected high patient census, certain staffing shortages, or a patient's temporary travel away from the hospice's service area, or, as to nursing services, if CMS grants a waiver, *id.* at § 418.66.

<sup>14</sup> Social Security Act § 1861(dd)(2)(A) [42 U.S.C. § 1395x-(dd)(2)(A)]; 42 C.F.R. § 418.100(e).

<sup>15</sup> Social Security Act § 1861(dd)(2)(B) [42 U.S.C. § 1395x-(dd)(2)(B)]; 42 C.F.R. § 418.56(a)(1).

<sup>16</sup> Payment amounts are determined within each of the following categories of care days: (1) routine home care day; (2) continuous home care day, where the beneficiary receives hospice care that consists predominantly of nursing care on a continuous basis at home; (3) inpatient respite care day, where the beneficiary receives care in an approved facility on a short-term basis for respite; and (4) general inpatient care day, where the beneficiary receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings. See 42 C.F.R. § 418.302.

<sup>17</sup> See 42 C.F.R. § § 418.108(d), 418.302(f)(1).

plied by a set per-patient amount<sup>18</sup> (e.g., for fiscal year 2011 the cap was \$24,527.695<sup>19</sup>).

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#### *Hospice Care Provided in Nursing Homes*

When it was first enacted, the hospice benefit was limited to beneficiaries living at home or as inpatients at a hospice facility. In 1986, qualified individuals living in nursing homes were allowed to elect the hospice benefit as well.<sup>20</sup>

Medicare has not established a separate payment rate for hospice services provided in a nursing facility. Because hospice services typically are provided to patients in their homes, the routine home care hospice rate does not include any payment for room and board.<sup>21</sup> In fact, Medicare treats hospice beneficiaries living in nursing homes exactly the same as beneficiaries living in their own homes. It pays the same fixed per diem home care rate for each. This means that hospice patients residing in nursing homes are responsible for any room and board charges.<sup>22</sup>

However, if a patient receiving hospice benefits also is eligible for Medicaid, Medicaid is required by federal law to reimburse the hospice for the cost of room and board at a rate that is at least 95 percent of the state's daily nursing home rate. The hospice then must pay the nursing home for the beneficiary's room and board<sup>23</sup> (specific services included in the daily rate are determined by a state's Medicaid program and can vary from state to state).

The need to combine these Medicare and Medicaid benefits requires the nursing home to bill the hospice, which in turn bills each of the government programs and pays the nursing home. Specifically, billing for services to nursing home patients dually eligible for Medicare and Medicaid who elect the hospice benefit operates as follows:

- the nursing home no longer bills the state Medicaid program for the patient's long-term care;
- the nursing home bills the hospice pursuant to a written contract;
- the hospice bills the state Medicaid program for the patient's room and board;
- the hospice bills the Medicare program the daily fixed rate for the patient's hospice care; and
- the hospice then pays the nursing home for room and board and, depending on the arrangement made between the hospice and the nursing home, for other services as well.

A nursing home resident's election of the hospice benefit significantly alters the managerial rights and responsibilities of both the hospice and the nursing home. When a Medicare patient residing in a nursing home elects the hospice benefit, the hospice assumes responsibility for the professional management of the patient's medical care. The nursing home continues to provide the patient's room and board, which typically includes personal care services, daily living activity assistance, and medication administration.

Once a patient elects the hospice benefit, the nursing home is no longer in control of a hospice patient's medical care. The hospice can involve nursing home personnel in administration of prescribed medication and other therapies only to the extent that the hospice would routinely use the services of a hospice patient's family or caregiver in implementing the plan of care.<sup>24</sup> The hospice also can arrange for noncore hospice services to be provided by nursing home personnel, but the hospice must assume professional management responsibilities for these services.<sup>25</sup>

### 1815.10.20

#### **Anti-Kickback Concerns**

### 1815.10.20.10

#### *Hospice/Nursing Home Arrangements*

Hospice services can be appropriate and beneficial to terminally ill nursing home residents who wish to receive palliative care. However, arrangements between nursing homes and hospices are especially vulnerable to fraud and abuse under the anti-kickback provisions of the Social Security Act.<sup>26</sup>

Nursing home operators are in a unique position of power because they govern access to a "sizeable pool of potential hospice patients," according to the OIG.<sup>27</sup> A hospice's access to nursing home patients rests solely in the hands of the nursing home operator, who might restrict residents to one or two hospice providers. While an exclusive or semi-exclusive arrangement can promote efficiency and safety by permitting the nursing home operator to coordinate care, screen hospice caregivers, and maintain control of the premises, it also enhances the monetary value of the nursing home operator's decision. In these circumstances, an environment is created which might cause some nursing home operators or hospices to request or offer illegal inducements to influence the hospice selection.<sup>28</sup>

Not only do nursing homes house many potential hospice patients, hospice referrals for nursing home

<sup>18</sup> *Id.* at § 418.309.

<sup>19</sup> See [https://www.cms.gov/Hospice/Downloads/2011\\_Aggregate\\_Cap.pdf](https://www.cms.gov/Hospice/Downloads/2011_Aggregate_Cap.pdf).

<sup>20</sup> Pub. L. No. 99-272, § 9505(a)(2).

<sup>21</sup> OIG Special Fraud Alert: Fraud and Abuse in Nursing Home Arrangements With Hospices, 63 Fed. Reg. 20415, 20416 (April 24, 1998).

<sup>22</sup> *Id.* at 20416.

<sup>23</sup> Social Security Act § 1902(a)(13)(B) [42 U.S.C. § 1396a-(a)(13)(B)].

<sup>24</sup> 42 C.F.R. § 418.112(c)(7); Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54039.

<sup>25</sup> Social Security Act § 1861(dd)(2)(A) [42 U.S.C. § 1395x-(dd)(2)(A)]; 42 C.F.R. § 418.100(e).

<sup>26</sup> Social Security Act § 1128B(b) [42 U.S.C. § 1320a-7b(b)].

<sup>27</sup> Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54040 and fn. 89.

<sup>28</sup> *Id.*

residents can be considered more valuable than referrals for private residents, because hospice patients living in nursing homes may generate higher gross revenues per patient than those living in their own homes. Nursing home residents receiving hospice care have, on average, longer lengths of stay than hospice patients living in their homes. Often, there also is some overlap in the respective services that the nursing homes and hospices provide, allowing one or the other to reduce services and costs.<sup>29</sup>

Hospices also can save money with nursing home patients through other, less legitimate, means. Because of the standard per diem rate of reimbursement, hospices might be induced for financial reasons to reduce the number of services provided to each patient. A hospice can more easily reduce services provided to a patient living in a nursing home, who is surrounded by medical professionals, than it can to a patient living at home.

An OIG study published in September 1997 indicated that hospices frequently take advantage of this situation. It found that nursing home hospice patients were seen less frequently than the National Hospice Organization's (now the National Hospice and Palliative Care Organization) guidelines suggest. In fact, "[c]ompared to hospice patients living at home, nursing home hospice patients received 44 percent fewer nurse visits and 48 percent fewer aide visits." The study found that, "[d]espite providing fewer services to nursing home patients, hospices are being paid at the same level they receive for patients living at home."<sup>30</sup>

A hospice also can attempt to increase revenues by enrolling ineligible beneficiaries—that is, those with life expectancies greater than six months. These ineligible hospice beneficiaries have been found more often in a nursing home setting than in a home care setting. An Office of Evaluations and Inspections study published in April 1998 found a disproportionate number of questionable hospice enrollments among nursing home residents. Twenty-nine percent of the sampled hospice beneficiaries in nursing homes were ineligible for the benefit, while only 2 percent of the beneficiaries not living in nursing homes were ineligible.<sup>31</sup>

The monetary value of nursing home referrals, combined with a nursing home's power over hospice referrals, provides fertile ground for potential anti-kickback violations. As a 1997 OIG audit of the hospice care program concluded, "The joint funding by the Medicare

and Medicaid programs for these nursing home residents opens the possibility for abusive practices."<sup>32</sup>

A more recent OIG report, published in 2011, suggests that "high-percentage hospices"—hospices whose patient population is composed of at least two-thirds nursing home residents—have patients with a longer average hospice length of stay and less costly medical conditions, suggesting there may be additional financial incentives to caring for hospice patients who reside in nursing homes.<sup>33</sup>

### 1815.10.20.20

#### *Negative Impact of Illegal Remuneration*

Kickbacks and other illegal remuneration can distort medical decisionmaking, result in overutilization of medical services, and have an adverse effect on the quality of care patients receive.<sup>34</sup> As such, they are prohibited under federal law.<sup>35</sup>

Illegal kickback arrangements between hospices and nursing homes can have a detrimental impact on patient care and patient choice in several ways. A hospice that obtains referrals by paying more than the nursing home would otherwise receive from Medicaid has less of an incentive to compete with other hospices by providing high quality service. A resident may be deprived of his or her free choice of hospice provider if a nursing home refuses to enter into an agreement with the hospice selected by the resident because the hospice does not agree to pay more than the Medicaid room and board rate. A nursing home also might be induced to refer a patient to a hospice providing financial incentives rather than a hospice offering the best care for the patient.

Additionally, kickbacks raise the specter of overutilization of federal health care programs. Excessive use of the hospice benefit has proven to be a significant problem in the nursing home setting. In April 1998, an OEI evaluation of the hospice program determined that more nursing home beneficiaries participating in the hospice program were ineligible—that is, they were not terminally ill with a prognosis of less than six months—than those residing at home.<sup>36</sup>

The study concluded that overall the Medicare hospice program seemed to be working as intended. However, it raised questions about hospice benefits provided to nursing home residents. The OEI stated that this study added to the already growing concern about the

<sup>29</sup> *Id.*

<sup>30</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Hospice Patients in Nursing Homes* (No. OEI-05-95-00250, September 1997).

<sup>31</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Medicare Hospice Beneficiaries: Services and Eligibility* (No. OEI-04-93-00270, April 1998).

<sup>32</sup> Office of Audit Services, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments* (No. A-05-96-00023, Nov. 4, 1997).

<sup>33</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Medicare Hospices That Focus on Nursing Facility Residents* (No. OEI-02-10-00070, July 2011).

<sup>34</sup> OIG Special Fraud Alert: *Fraud and Abuse in Nursing Home Arrangements With Hospices*, 63 Fed. Reg. 20415, 20416 (April 24, 1998).

<sup>35</sup> Social Security Act § 1128B(b) [42 U.S.C. § 1320a-7b(b)].

<sup>36</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Medicare Hospice Beneficiaries: Services and Eligibility* (No. OEI-04-93-00270, April 1998).

Medicare hospice program in the nursing home setting.<sup>37</sup>

While not concluding that patients were necessarily ineligible, a subsequent OIG report concluded that 82 percent of hospice claims for nursing facility residents in 2006 did not meet Medicare coverage requirements. The OIG concluded that 33 percent of claims had either no or an inadequate eligibility statement and 4 percent had either no or an inadequate physician certification of terminal illness.<sup>38</sup>

### 1815.10.30

#### Civil Penalties and Anti-Kickback Implications

Since many of the nursing home anti-kickback concerns relate to the provision of free or below fair market value services, issues under the civil monetary penalty (CMP) provisions of the Social Security Act also can arise in hospice and nursing home relationships.

The CMP law prohibits offering or transferring remuneration to any individual eligible for benefits under Medicare or Medicaid which the person or entity “knows or should know is likely to influence” the beneficiary’s choice of provider. Substantial penalties can be imposed, but the provision, unlike the anti-kickback provisions, does not treat the conduct as a criminal offense.<sup>39</sup> For more information on the CMP provisions and their relationship to anti-kickback issues in general, see *Chapter 1405, Key Concepts and Terms*.

Under the CMP law, remuneration includes, with certain exceptions, the waiver of all or part of any applicable coinsurance or deductible and the transfer of items or services for free or for other than fair market value.<sup>40</sup> “Should know” means that the person has acted “in deliberate ignorance of the truth or falsity of the information or . . . in reckless disregard of the truth or falsity of the information.”<sup>41</sup> Thus, proof of knowledge as required to establish a violation of the CMP law is an easier evidentiary standard than proof of specific criminal intent.

The provision of free hospice services to nursing home patients to induce their election of the hospice Medicare benefit can raise anti-kickback and CMP law concerns. The opportunity for the provision of free services most often occurs while the patients are under the time-limited Medicare skilled nursing benefit.

### 1815.10.40

#### False Claims Act and Violations of the Anti-Kickback Statute

The Patient Protection and Affordable Care Act<sup>42</sup> codified what a number of courts had previously held—that violation of the anti-kickback statute is actionable under the federal False Claims Act.<sup>43</sup> Along with civil and criminal penalties and other sanctions, claims for items or services resulting from a violation of the anti-kickback statute are considered false or fraudulent claims within the meaning of the FCA.<sup>44</sup>

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## 1815.20 Industry Compliance Guidelines

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### 1815.20.10

#### Hospice Compliance Programs

The OIG has proposed that all health care providers, including hospices, implement a formal, written compliance program. If a health care provider is charged with a violation, the OIG will consider the existence of any effective compliance program that predated the governmental investigation when addressing the appropriateness of administrative sanctions.<sup>45</sup> For a discussion of general OIG guidance on compliance programs, see *Chapter 207, Compliance Program Basics*.

In October 1999, the OIG published guidelines to assist hospices in developing individual compliance programs. The guidelines suggest that hospice compliance programs set forth, in writing, specific anti-kickback risk areas to avoid.

Arrangements between hospices and nursing homes were highlighted as a potential risk. The guidelines

state that risk areas that hospices should address as parts of their compliance programs include “[h]ospice incentives to actual or potential referral sources . . . including improper arrangements with nursing homes,” as well as “[o]verlap in the services that a nursing home provides, which results in insufficient care provided by a hospice to a nursing home resident.”<sup>46</sup>

In particular, the hospice compliance program guidelines point out the inherent risk in a hospice’s overpayment of room and board fees to the nursing home in which its patient resides:

The OIG has observed instances of potential kickbacks between hospices and nursing homes to unlawfully influence the referral of patients. In general, payments by a hospice to a nursing home for “room and board” provided to a Medicaid hospice patient should not exceed what the nursing home otherwise would have received directly from Med-

<sup>37</sup> *Id.*

<sup>38</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep’t of Health & Human Servs., Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements (No. OEI-02-06-00221, September 2009).

<sup>39</sup> Social Security Act § 1128A(a)(5) [42 U.S.C. § 1320a-7a(a)(5)].

<sup>40</sup> Social Security Act § 1128A(i)(6) [42 U.S.C. § 1320a-7a(i)(6)].

<sup>41</sup> Social Security Act § 1128A(i)(7) [42 U.S.C. § 1320a-7a(i)(7)].

<sup>42</sup> Pub. L. No. 111-148, § 6402(f) (Mar. 23, 2010).

<sup>43</sup> 31 U.S.C. § 3729 *et seq.*

<sup>44</sup> 42 U.S.C. § 1320a-7b(g).

<sup>45</sup> Compliance Program Guidance for Hospices, 64 Fed. Reg. 54031, 54033 (Oct. 5, 1999).

<sup>46</sup> *Id.* at 54035-36.

icaid if the patient had not been enrolled in hospice . . .<sup>47</sup>

The OIG further noted that this risk was caused by the monetary value of hospice patients in nursing homes compared to hospice patients in private residences:

There may be some overlap in the services that the nursing homes and hospices provide, thereby providing one or the other the opportunity to reduce services and costs. 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. 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. . . . Since hospices receive a fixed daily payment regardless of the number of services provided or the location of the patient, fewer services may result in higher profits per patient.<sup>48</sup>

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#### Nursing Home Compliance Programs

The OIG identified similar concerns regarding arrangements with hospices in the 2000 compliance guidance for nursing facilities.<sup>49</sup> The OIG significantly expanded upon the hospice-specific risk areas in the supplemental guidance published in 2008.<sup>50</sup> The practices identified as suspect in the supplemental guidance are similar to those identified in the Special Fraud Alert described in greater detail in § 1815.20.60.10.

### 1815.20.30

#### Contracts Between Hospices and Nursing Homes

In response to fraud and abuse concerns raised by various governmental reports, the OIG Special Fraud Alert on fraud and abuse in nursing home/hospice arrangements,<sup>51</sup> and the results of Operation Restore Trust, CMS amended the CoPs to add requirements for hospices that care for patients residing in nursing homes.<sup>52</sup> This includes ensuring that, like all patients, patients residing in nursing homes meet hospice eligibility standards<sup>53</sup> and that the hospice recognizes its responsibility to assume professional management of all of the patient's care related to his/her terminal illness,<sup>54</sup> notwithstanding that the patient is residing in a facility that also has certain obligations to the patient.

The hospice is also required to provide training and orientation on the goals of hospice care and, among other things, the hospice's policies and procedures, to the nursing facility staff.<sup>55</sup>

The hospice and nursing home are also expected to work together in coordinating care of the patient. The hospice is required to seek the participation and input of the nursing home in developing and maintaining the hospice plan of care, update the nursing home as needed when the plan of care changes, and ensure that the plan of care delineates the specific tasks of each provider in its implementation.<sup>56</sup> Additionally, the hospice is expected to assign an individual from the interdisciplinary group to act as a liaison to the nursing home with respect to each patient to facilitate coordination of that patient's care, ensure communication between the providers, and that the nursing home receives certain hospice information and documentation, including the plan of care.<sup>57</sup>

Most notably, the CoP requires that a hospice enter into a written agreement with a nursing home that meets certain requirements before the hospice provides care at the facility.<sup>58</sup> The agreement is required to include provisions addressing the following (as more particularly described in the CoP):

- the method and documentation of communications between the providers;
- immediate notification of the hospice by the nursing home in the event of certain changes in a patient's condition;
- the hospice's responsibility to determine the course of the patient's hospice care, level of services, and any changes thereto;
- notification of the nursing home administrator by the hospice within 24 hours of any allegations of patient mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice; and
- the roles of the providers in furnishing bereavement services for nursing home staff.

Of particular significance from an anti-kickback perspective, additional requirements include:

- (4) An agreement that it is the SNF/NF . . . responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the pri-

<sup>47</sup> *Id.* at fn. 30.

<sup>48</sup> *Id.* at fn. 31.

<sup>49</sup> Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14289, 14297 (March 16, 2000).

<sup>50</sup> OIG Supplemental Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 56832, 56844-45 (Sept. 30, 2008).

<sup>51</sup> OIG Special Fraud Alert: Fraud and Abuse in Nursing Home Arrangements With Hospices, 63 Fed. Reg. 20415, 20416 (April 24, 1998).

<sup>52</sup> Medicare and Medicaid Programs: Hospice Conditions of Participation, 73 Fed. Reg. 32088, 32151 (June 5, 2008). This CoP also applies to hospice patients in intermediate care facilities for the intellectually disabled. The CoPs make binding a number of the recommendations contained in the OIG's prior Compliance Program Guidance to Hospices, 64 Fed. Reg. at 54039-54040.

<sup>53</sup> 42 C.F.R. § 418.112(a).

<sup>54</sup> *Id.* at § 418.112(b).

<sup>55</sup> *Id.* at § 418.112(f).

<sup>56</sup> *Id.* at § 418.112(d).

<sup>57</sup> *Id.* at § 418.112(e).

<sup>58</sup> *Id.* at § 418.112(c).



mary caregiver at home at the same level of care provided before hospice care was elected.

(5) An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF . . . resident were in his or her own home.

(6) A delineation of the hospice's responsibilities, which include, but are not limited to the following: Providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

(7) A provision that the hospice may use the SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/MR to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care.<sup>59</sup>

Notwithstanding CMS's clear recognition embodied in this regulation that hospices and nursing facilities need to coordinate in order to provide appropriate care to hospice patients residing in nursing homes, nothing about this rule changes the requirement that a hospice provide substantially all core services directly through hospice employees, as previously described in this chapter.

As of April 2012, there is a proposed rule that would similarly require nursing facilities to enter into a written agreement with a hospice.<sup>60</sup> Most of the proposed contractual provisions mirror those in the hospice CoP. Notably, under the proposed rule, a nursing home would also be required to ensure that hospice services were provided timely and in accordance with professional standards and principles applicable to the provision of services in the facility.

In addition to provisions addressing these requirements, the agreement should also describe the compensation arrangement between the parties, if applicable, along with any other desired terms and conditions.

Further, while most arrangements between hospices and nursing homes are compensated on a per-patient per-day rate, which is inconsistent with compliance with

the "set in advance" requirement of the personal services and management contracts safe harbor, the agreement should reflect all other required provisions of that safe harbor to the extent possible.<sup>61</sup> For further discussion of the anti-kickback statute safe harbors, see *Tab 1400, Anti-Kickback—General Risk Areas*.

#### 1815.20.40

##### Nursing Facility-Owned Hospices

Hospices increasingly are owned or operated by entities that also own or operate other health care facilities. In light of the risks associated with arrangements between hospices and nursing homes, facilities with common ownership should exercise particular care. While the concerns in this context are similar to those raised by arrangements between unrelated facilities, common ownership makes it easier in particular to utilize nursing home-hospice reimbursement mechanisms to inappropriately increase reimbursement to one or both facilities.

Further, the OIG has taken the position that separate legal entities under common ownership may still potentially violate the anti-kickback statute.<sup>62</sup> Accordingly, practices that should be particularly scrutinized from a regulatory perspective even among related entities include exclusive arrangements between the related facilities; the use of nursing home staff by the hospice and vice versa; cross-referral agreements; and the provision of free services to the nursing home by the hospice or to the hospice by the nursing home.

#### 1815.20.50

##### Nursing Facility-Hospice Joint Ventures to Provide Hospice or Nursing Facility Services

Joint ventures between health care providers, such as hospices and skilled nursing facilities, to provide services to patients present additional and unique regulatory concerns. The OIG has expressed concerns regarding the potential for fraud and abuse inherent in joint venture arrangements on several occasions. In particular, parties to a joint venture should ensure they are entering into an arrangement that will permit or otherwise facilitate a legitimate business venture, not with a purpose "to lock up a stream of referrals from the . . . investors and to compensate them indirectly for these referrals."<sup>63</sup> The OIG has identified a number of suspect practices to assist in distinguishing legitimate from illegitimate joint ventures, which are broken down into categories related to the selection and retention of investors, business structure of the joint venture, and its

<sup>59</sup> *Id.*

<sup>60</sup> Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities; Hospice Services, 75 Fed. Reg. 65282 (proposed Oct. 22, 2010) (proposed to be codified at 42 C.F.R. § 483.75(r)(2)).

<sup>61</sup> *Id.*

<sup>62</sup> See Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35952, 35983

(July 29, 1991); see also Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Advisory Op. No. 09-13 (Aug. 11, 2009) (subsidies paid by a hospital to an affiliated ambulance cooperative could be considered prohibited remuneration under the anti-kickback statute (AKS)).

<sup>63</sup> Special Fraud Alert: Joint Venture Arrangements, 56 Fed. Reg. 65372-74 (Dec. 19, 1994). While this quotation referred to "physician" investors, it would be applicable to other referral sources as well.

financing and methods for distributing profits.<sup>64</sup> Accordingly, joint ventures between a hospice and skilled nursing facility may be subject to significant regulatory scrutiny. In this regard, the hospice and skilled nursing facility should attempt, if possible, to structure their relationship to meet an applicable safe harbor, such as that for investment interests.<sup>65</sup> For further discussion of anti-kickback statute's application to joint venture arrangements, see *Chapter 1410, Joint Ventures and Acquisitions*.

## 1815.20.60

### Suspect Practices

#### 1815.20.60.10

##### *Special Fraud Alert*

In March 1998, the OIG released a special fraud alert that addressed arrangements between nursing homes and hospices. The alert identified several suspect arrangements that could be construed as illegal remuneration in exchange for referrals, including those where a hospice:<sup>66</sup>

- offers free goods or goods at below fair market value to induce a nursing home to refer patients to the hospice;
- pays room and board payments to the nursing home in amounts in excess of what the nursing home would have received directly from Medicaid had the patient not been enrolled in the hospice program;
- pays amounts to the nursing home for additional services that Medicaid considers to be included in its room and board payment to the hospice;
- pays above fair market value for additional non-core services that are not included in Medicaid's room and board payment to the nursing home;
- refers its patients to a nursing home to induce the nursing home to refer its patients to the hospice;
- provides free (or below fair market value) care to nursing home patients for whom the nursing home is receiving Medicare payment under the skilled nursing facility benefit, with the expectation that the patient will receive hospice services from that hospice after exhausting the skilled nursing facility benefit; or
- provides staff at its expense to the nursing home to perform duties that otherwise would be performed by the nursing home.

It is important to note that hospices that provide free or below-cost services to nursing home patients who have not elected the hospice benefit are not immune to anti-kickback liability. Anything of value can be con-

strued as remuneration under the anti-kickback statute,<sup>67</sup> and the provision of free services to non-hospice nursing home residents could be of substantial value to a nursing home.

If the free service replaces a service that nursing home personnel must ordinarily provide, the hospice's provision of that service would result in savings to the nursing home. Furthermore, even if the free service was not one that the nursing home would ordinarily provide, the hospice's provision of that service could improve the reputation and standing of the nursing home, which may also be of value.

In light of the significant power a nursing home administrator wields over a hospice's access to potential referrals, a hospice's provision of free services of any kind can be construed as illegal remuneration.

#### 1815.20.60.20

##### *Excess Room and Board Payment*

Medicaid is required to reimburse the hospice for a minimum of 95 percent of the daily rate for nursing home room and board.<sup>68</sup> Thus, any room and board payment by a hospice to a nursing home in excess of the Medicaid daily rate comes directly out of the hospice's pocket. A 1997 OIG study found that, despite this apparent loss, most hospices "pay nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice."<sup>69</sup>

The OIG concluded, "While a hospice appears to lose money by paying a nursing home more than it receives from the State, this may not always be the case." In some cases, a hospice/nursing home billing arrangement "could provide a strong incentive for nursing homes and hospices to prematurely enroll patients who do not meet the criteria for entitlement to the benefit into the hospice program." The government found that hospices that paid more than 100 percent of the Medicaid daily rate for nursing home care carried a higher percentage of patients who resided in nursing homes, indicating that the financial benefit of nursing home patients was well worth the excess room and board fees.

Benefits to the nursing home "include increasing reimbursement for Medicaid patients, receiving additional staff hours at no additional cost and reducing the supply and medication costs when the hospice provides or pays for the supplies," the OIG found. Another potential advantage for the nursing home is increasing the

<sup>64</sup> *Id.*

<sup>65</sup> See 42 C.F.R. § 1001.952(a).

<sup>66</sup> OIG Special Fraud Alert: Fraud and Abuse in Nursing Home Arrangements With Hospices, 63 Fed. Reg. 20415, 20416 (April 24, 1998).

<sup>67</sup> *Id.*

<sup>68</sup> Social Security Act § 1902(a)(13)(B) [42 U.S.C. § 1396a(a)(13)(B)].

<sup>69</sup> Of the 17 hospices reviewed, 10 paid 100 percent of Medicaid's daily rate for nursing home care; five paid 105 percent, and one paid 120 percent. Only one hospice appeared to pay 95 percent of Medicaid's daily rate. Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Hospice Patients in Nursing Homes (No. OEI-05-95-00251, September 1997).

nursing home's patient census by admitting hospice patients who were previously living at home.<sup>70</sup>

The OIG special fraud alert pertaining to nursing home/hospice arrangements specifically highlighted the hospices' practice of paying room and board fees in excess of the amount reimbursable by Medicaid. When the original request for this alert was made, it was suggested that it would be helpful to alert the hospice and nursing home industries to the fact that a hospice that pays a nursing home more than the required 95 percent of the standard Medicaid per diem reimbursement rate might violate the anti-kickback law.<sup>71</sup> However, the alert said that a hospice generally may pay a nursing facility for a hospice patient's room and board an amount equal to 100 percent of the Medicaid daily nursing facility rate for non-hospice patients without running afoul of the anti-kickback statute. The OIG adopted the following position with regard to such payments:

In general, payments by a hospice to a nursing home for "room and board" provided to a Medicaid hospice patient should not exceed what the nursing home otherwise would have received if the patient had not been enrolled in hospice. 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.<sup>72</sup>

#### **1815.20.60.30**

##### ***Contractual Language***

While hospices and nursing homes are required to memorialize their relationships in a written contract, they should be wary of using certain contractual language when drafting their agreements. In November 1997, the OIG published a study that examined contractual relationships between hospices and nursing homes.<sup>73</sup> The study found that certain hospice contracts with nursing homes contained provisions that raised questions about inappropriate patient referrals, including contracts that:

- included a clause stating, "The Home agrees to exert its best efforts to promote the use of Hospice home care services by directing the personnel of The Home to refer all terminally ill patients, subject to the informed consent of the patient and the approval of the attending, to The Hospice";
- required a nursing home to promote the concept of hospice to patients who might require hospice care; and
- specified that the hospice and the nursing home agreed to "formulate an assessment system within each

of their structures to funnel patients to the services of the other."

The report said another potential abuse of the system was the provision of free care in return for patient referrals. It quoted a hospice contract that raised questions about the appropriateness of hospice care as well as Medicare's skilled nursing facility benefit. The contract stated that:

for residents who are eligible for Medicare skilled nursing home room and board reimbursement, Hospice will provide its core services without charge until nursing home Medicare reimbursable days expire before the patient elects the Medicare Hospice Benefit.<sup>74</sup>

This conduct also might raise compliance risk issues under the CMP law (see *Civil Penalties and Anti-Kickback*, § 1815.10.30).

#### **1815.20.60.40**

##### ***Community Service Programs***

Though an advisory opinion, the OIG has given direct guidance on free care offered as part of a community service program sponsored by a nonprofit hospice to patients residing at home or in a nursing home.<sup>75</sup> The OIG determined that, based on the program described, the hospice would not be subject to sanctions under the anti-kickback or CMP statutes.

Under the described program, a nursing home volunteer would be sent to a terminally ill nursing home patient (with a prognosis of one year or less to live) to provide, without charge, certain services, including friendship and visitation, transportation, and assistance with writing and reading correspondence. A home service volunteer would be sent to a terminally ill patient residing at his/her home to provide errand runs, food preparation, and respite breaks for the patient's family or caregiver. Under either setting, the patient would be informed of the various community organizations that provide continuing care services, including the hospice sponsor of the program.

In evaluating whether the program violated the anti-kickback or CMP laws, the OIG looked at:

- whether the sponsor knew or should have known that the free services would likely influence the patients' choice of hospice provider;
- whether the sponsor intended in part to induce patients to use the sponsor's hospice services; and
- whether providing the free services to nursing home hospice residents would be remuneration to the nursing homes for allowing the sponsor access to the residents.

<sup>70</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Hospice Patients in Nursing Homes* (No. OEI-05-95-00251, September 1997).

<sup>71</sup> Letter from William J. Young, Missouri Assistant Attorney General, to the Office of Inspector Gen., U.S. Dep't of Health & Human Servs. (Feb. 28, 1997).

<sup>72</sup> OIG Special Fraud Alert: *Fraud and Abuse in Nursing Home Arrangements With Hospices*, 63 Fed. Reg. 20416.

<sup>73</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Hospice and Nursing Home Contractual Relationships* (No. OEI-05-95-00251, September 1997).

<sup>74</sup> *Id.*

<sup>75</sup> Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Advisory Op. No. 00-03* (April 7, 2000).

The OIG found that despite the fact that some of the free services had value and constituted unlawful remuneration within the meaning of both statutes and that it was likely that the benefits were provided in part to induce the patients to use the sponsor's hospice services, the program was not subject to sanctions because of the combination of the following four safeguards:

- the services were provided by unpaid volunteers;
- the benefits of the program were primarily intangible and psychic in nature—that is, designed to assist the patients and their loved ones to cope with daily life activities of the patients;
- the program provided a substantial benefit to a vulnerable patient group; and
- the election of hospice care entailed overcoming substantial barriers, such as the requirement that the Medicare beneficiary renounce coverage for curative medical treatment for the terminal condition.

With respect to this last point, the OIG limited the scope of this safeguard by stating that those “substantial barriers” are sufficient to protect against overutilization, as intended by these federal statutes, only where the services are of relatively small monetary value and are provided by unpaid volunteers. Consequently, a hospice cannot offer other inducements where such protections against overutilization are not present.

The OIG also focused on the fact that the free services did not overlap with services that the nursing home was required to provide under federal health care programs and that the services were carefully delineated. Moreover, a majority of the volunteers were not health care professionals or workers, thereby making it unlikely that the program would be acting as a substitute provider of nursing home services. Accordingly, the OIG found that it was the patient, not the nursing home, who was receiving free services from the program. Notwithstanding its approval of the program, the OIG cautioned against the provision of free or below market value goods to actual or potential referral sources.

#### 1815.20.60.50

##### ***Excess Pharmacy Benefit***

A suspect practice similar to paying a nursing home more than the Medicaid daily rate for room and board (see *Excess Room and Board Payment*, §1815.20.60.20) is paying a nursing home for medications related to a beneficiary's terminal condition.

If a Medicare beneficiary lives in a nursing facility, he or she is responsible for paying the nursing facility's room and board charges. (Medicare has no long term custodial nursing facility benefit, but reimburses the patient's hospice a fixed per diem for hospice services, including hospice-related pharmacy services.)<sup>76</sup> Some Medicare patients of limited means also are eligible for

Medicaid, which has a nursing facility benefit. If a patient who elects hospice is dually eligible for both Medicare and Medicaid benefits, Medicare pays its regular hospice benefit, and the state Medicaid program covers the room and board charges. However, instead of paying the nursing facility for the room and board, as is done for non-hospice patients, the state Medicaid program pays the hospice, which, in turn, pays the nursing facility a negotiated rate.

In Advisory Opinion No. 01-20,<sup>77</sup> the OIG reviewed an arrangement under which a New York hospice paid nursing facilities the full Medicaid nursing facility per diem rate for non-hospice patients, which covers pharmacy services, plus a separate payment for drugs used for their terminal illnesses by patients dually eligible for both Medicare and Medicaid.

Citing its March 1998 Special Fraud Alert, the OIG said that, without running afoul of the anti-kickback statute, a hospice generally may pay a nursing facility for a hospice patient's room and board an amount equal to 100 percent of the Medicaid daily nursing facility rate for non-hospice patients. The arrangement under review, however, with its separate payments for drugs (including drugs that may be covered by the Medicaid daily nursing facility rate), posed “a more difficult question.”

Separate payment for pharmaceutical services already covered by the Medicaid daily nursing facility rate may implicate the anti-kickback statute if the payments are intended to induce or reward referrals, the OIG said. When a nursing facility collects an amount equal to the full per diem payment without providing the full panoply of services typically covered by that payment, the facility is no longer providing the same services for its residents who have elected hospice as it furnishes to its residents who have not elected hospice, it observed.

However, the OIG said, palliative drugs are an essential component of the hospice benefit and are necessary to the provision of effective hospice services. In some situations, therefore, separate payments for drugs may be appropriate. For example, 1) drugs used for hospice patients may not be included in the state's Medicaid daily nursing facility rate, or 2) certain outlier drugs may be included in the state's Medicaid daily nursing facility rate for non-hospice patients, but present little risk of program abuse. If a separate payment is appropriate, it should reflect fair market value in an arms-length transaction and, if the nursing facility purchases the drug from a pharmacy or other supplier, the nursing facility should not mark up its charge to the hospice, the OIG said.

In the case of the arrangement under review, however, the OIG said that the hospice requesting the opinion provided insufficient facts to enable the OIG to

<sup>76</sup> 42 C.F.R. § 418.202(f).

<sup>77</sup> Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Advisory Op. No. 01-20 (Nov. 14, 2001).

evaluate the risk of fraud and abuse. In particular, the hospice failed to provide an adequate accounting of the drugs for which separate payments were made, the OIG said. The opinion therefore found the arrangement

could involve prohibited remuneration under the anti-kickback statute and that the OIG could potentially impose administrative sanctions.

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## 1815.30 Enforcement

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### 1815.30.10

#### OIG Reports

Reports published by the OIG serve to highlight hospice/nursing home arrangements that the OIG views as problematic and seeks to redress. In 1997, the OIG conducted two studies that focused on the relationship between hospices and nursing homes. The report, *Hospice Patients in Nursing Homes*, investigated the quality and quantity of treatment hospice patients receive in nursing homes. The report made the following findings:<sup>78</sup>

- *Lower Frequency of Services.* Hospice beneficiaries in nursing homes were provided less frequent services than those who were not in nursing homes: Nursing home residents received fewer nurse visits and fewer aide visits despite the hospice's being paid the same fees as for patients living at home, according to the report. Nursing home administrators contacted by the study acknowledged that patients in their facilities "may not be getting the services hospices said they would provide." Hospices promise additional support for nursing home staff, post-death bereavement, family support, and pain management. However, 10 out of the 79 nursing homes contacted claimed that, in all too many cases, hospices were not providing these services.

- *Overlap of Services.* Hospices failed to provide hospice nursing services to their patients residing in nursing homes. "Three out of four nursing home hospice patients received only basic nursing and aide visits. Many of these services were provided by nursing home staff as part of room and board when hospice staff were not present." The report noted that, in many cases, "the nature of services provided by hospice staff, while appropriate and efficacious, appeared to differ little from services a nursing home would have provided if the patient was not enrolled in a hospice."

- *Questionable Enrollments.* Ineligible beneficiaries were more likely to be enrolled in hospice if they were living in nursing homes. The questionable enrollment of patients in hospice care occurs largely among patients already living in a nursing home before their hospice election. The enrollments of only 4 percent of patients who entered a nursing home after hospice election were questionable. However, OIG reviewers questioned 21 percent of hospice admissions where the en-

rollee had already been living in the nursing home. The average length of stay for patients with a questionable enrollment was significantly longer than for patients the OIG found were clearly eligible for hospice care.

The second report, *Hospice and Nursing Home Contractual Arrangements*, investigated the contractual relationships between hospices and nursing homes. The following findings were published:<sup>79</sup>

- Almost all hospices reviewed by the OIG paid nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice.

- The six hospices reviewed that paid more than 100 percent of the Medicaid daily rate for nursing home care had a higher percentage of patients in nursing homes.

- Both the hospice and the nursing home could benefit financially by enrolling patients in hospices.

- Some hospice contracts with nursing home contained provisions that raised questions about inappropriate patient referrals between hospices and nursing homes.

More recently, the OIG has increasingly turned its attention toward understanding the characteristics of hospices that serve nursing home residents. The OIG has published several reports that analyze differences between Medicare hospice patients in nursing homes and the hospices that serve them, along with identifying potential risk areas associated with such differences.

A December 2007 report, *Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings*, compared characteristics of hospice patients residing in nursing homes with those who resided at home. The following findings were reported:<sup>80</sup>

- *Longer Length of Stay.* Medicare hospice patients who resided in nursing homes in 2005 received, on average, more days of hospice care than those who resided at home, and hospices who served them received an average of \$2,000 in additional Medicare payments annually per beneficiary.

- *Differences in Terminal Condition.* Almost half of nursing home residents receiving hospice services had terminal diagnoses of (1) an ill-defined nature, such

<sup>78</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Hospice Patients in Nursing Homes* (No. OEI-05-95-00250, September 1997).

<sup>79</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Hospice and Nursing*

*Home Contractual Relationships* (No. OEI-05-95-00251, September 1997).

<sup>80</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., *Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings* (No. OEI-02-06-00220, December 2007).

as adult failure to thrive, debility, or senility, (2) mental disorders, or (3) Alzheimer's disease, as opposed to cancer, which was the most prevalent diagnosis of hospice patients residing at home.

A March 2008 memorandum report, *Hospice Beneficiaries' Use of Respite Care*,<sup>81</sup> described previous findings from the December 2007 report that hospices may have inappropriately received Medicare respite care payments for patients who resided in nursing homes in 2005. Two percent of all hospice patients in 2005 received respite care, including 62 beneficiaries residing in nursing homes. The OIG indicated it would provide additional information to CMS regarding these "potentially inappropriate cases."

In September 2009, the OIG published the report, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements*, that investigated whether hospice claims for nursing home residents met applicable Medicare coverage requirements.<sup>82</sup> According to the report, more than 80 percent of hospice claims paid in 2006 did not comply with at least one Medicare coverage requirement (e.g., incomplete or inadequate eligibility statements, plans of care, or physician certifications), and in 31 percent of claims, services were provided less frequently than required by the patient's plan of care or not at all. CMS's response to the report indicated that it would "instruct Medicare contractors to consider the issues in this report when prioritizing its medical review strategies or other interventions" and would "share this report and relevant claim information from OIG with the Recovery Audit Contractors," (RACs, now known as Recovery Auditors).

The OIG's July 2011 report, *Medicare Hospices That Focus on Nursing Facility Residents*, reviewed characteristics of hospices that have a high percentage of patients residing in nursing homes.<sup>83</sup> The report, reviewing hospice claims paid between 2005 and 2009, showed a 69 percent increase in Medicare payments for hospice services provided to nursing facility residents and a 40 percent increase in the number of hospice patients residing in nursing homes. During this period, the number of Medicare hospices increased 17 percent.

This report identified for the first time so-called "high-percentage hospices," those where more than

two-thirds of patients resided in nursing homes in 2009. Patients of these hospices had an average hospice length of stay that was 21 days longer than other hospice patients, resulting in nearly \$3,200 in additional Medicare reimbursement per hospice patient.

As a result of these findings, the OIG recommended that CMS pay "special attention . . . to hospices that depend heavily on nursing facility residents," and that CMS consider reducing hospice payments for nursing facility residents. In response, CMS indicated it would "share the information in [the] report with . . . RACs and [Medicare Administrative Contractors (MACs)]" and further, that it would "continue to emphasize to the MACs the importance of this issue when prioritizing medical review strategies or other interventions." Regarding the payment recommendation, CMS indicated it was in the "early stages" of hospice payment reforms, which are mandated by the health care reform legislation to be implemented no earlier than Oct. 1, 2013,<sup>84</sup> but "agreed that incentives to seek out beneficiaries in nursing facilities may exist in the current payment structure."

The OIG Fiscal Year 2012 Work Plan indicated OIG's intention to continue focusing on the relationship between hospices and nursing homes, including a review of the marketing practices of hospices, with a particular focus on high-percentage hospices.<sup>85</sup>

### 1815.30.20

#### Operation Restore Trust

In 1995, a joint initiative—Operation Restore Trust—was established between the OIG, CMS, (then the Health Care Financing Administration or HCFA), and the Administration on Aging. The initiative sought to identify vulnerabilities in the Medicare program and develop solutions that would reduce Medicare's exposure to fraud, abuse, and waste.

Operation Restore Trust targeted five states—California, Florida, Illinois, New York, and Texas—which accounted for approximately 40 percent of Medicare expenditures and beneficiaries. The initiative focused on

<sup>81</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Memorandum Report: Hospice Beneficiaries' Use of Respite Care (No. OEI-02-06-00222, March 31, 2008).

<sup>82</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements (No. OEI-02-06-00221, September 2009).

<sup>83</sup> Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Medicare Hospices That Focus on Nursing Facility Residents (No. OEI-02-10-00070, July 2011).

<sup>84</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3132(a), 3401(g) (Mar. 23, 2010). This statutory

change requires the Secretary of Health and Human Services to collect data and information appropriate to implement hospice payment revisions. Whether or not such revisions are based on this data and information, the Secretary is instructed to "implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care," as deemed appropriate. "Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care." The revisions are required to be budget neutral and the Secretary must consult with the Medicare Payment Advisory Committee and hospice programs regarding the data collection and payment reforms.

<sup>85</sup> Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Fiscal Year 2012 Work Plan at 12.

Medicare's provision of home health care, nursing home care, durable medical equipment, and hospice care.<sup>86</sup>

In November 1997, Operation Restore Trust published the results of its ongoing audit of Medicare hospice services. The primary concern identified in the audit was the number of ineligible beneficiaries—that is, individuals with a life expectancy of greater than six months—who were enrolled in hospice care.

The initiative identified several underlying factors contributing to the problems found in the hospices audits. Two of these related to arrangements between hospices and nursing homes:<sup>87</sup>

*Ineligible Hospice Beneficiaries.* “There has been less rigorous enforcement of the six-month prognosis requirement by the hospice industry, especially for various non-cancer diagnosed patients. This softening is most apparent in the enrollment of nursing facility residents that have chronic medical problems common to an elderly population. About 60 percent of the 1,373 ineligible beneficiaries identified during our reviews were nursing facility patients.”

*Medicare/Medicaid Billing Dichotomy.* “Hospice regulations applicable to nursing home residents are complex. The regulations prohibit Medicare payments for hospice care on behalf of beneficiaries receiving Medicare funded services in skilled nursing facilities. Paradoxically, Medicare payments for hospice care are permissible when the beneficiary is receiving Medicaid funded services in a nursing facility. The joint funding by the Medicare and Medicaid programs for these nursing home residents opens the possibility for abusive practices.”

<sup>86</sup> Press Release, U.S. Dep't of Health & Human Servs., Operation Restore Trust, May 3, 1995. The HHS announced that the initiative would include: financial audits by the OIG and CMS; criminal investigations and referrals by the OIG to appropriate law enforcement officials; civil and administrative sanctions and recovery actions by the OIG and other appropriate law enforcement officials; surveys and inspections of long-term care facilities by CMS and state officials; studies and recommendations by the OIG and CMS for program adjustments to prevent fraud and abuse; special fraud alerts to notify the public and health care community about schemes in the provision of home health services, nursing care, and medical equipment and supplies; a voluntary disclosure program; and a fraud and waste report hotline.

<sup>87</sup> Office of Audit Services, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Enhanced Controls Needed to Assure

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#### Enforcement Actions

In light of a renewed focus on fraud and abuse enforcement in PPACA, enforcement actions in the health care sector in general are increasing with higher likelihood of specific actions in the hospice-nursing home context.

In 1998, an osteopath who owned several nursing homes pled guilty to a number of criminal charges, including one count of accepting over \$25,000 in illegal kickbacks from a hospice to promote the hospice to the staff of his nursing homes.<sup>88</sup>

In 2009, the Department of Justice intervened in a qui tam action against a hospice that billed for general inpatient care provided to hospice patients pursuant to a contract with a nursing home when such patients allegedly did not always meet the requirements for the general inpatient level of care.<sup>89</sup> In December, 2011, the hospice agreed to pay \$2.7 million to settle the charges.<sup>90</sup>

In December 2011, the Department of Justice intervened in a qui tam action against a hospice that was affiliated through common ownership with long term care facilities. The Department of Justice's Complaint in Intervention alleged that the hospice routinely billed for hospice services for patients that did not meet Medicare hospice eligibility criteria.<sup>91</sup> The qui tam relators' 2009 complaint alleged this scheme to falsely enroll Medicare beneficiaries for hospice services was part of a larger corporate policy designed to maximize skilled nursing facility and hospice reimbursement through certifying and decertifying patients for hospice eligibility in a manner tied to skilled nursing benefit exhaustion and/or designed to utilize skilled nursing facility patients to reduce the hospice's per patient payment under the hospice cap.<sup>92</sup>

Validity of Medicare Hospice Enrollments (No. A-05-96-00023, Nov. 4, 1997).

<sup>88</sup> U.S. Dep't of Justice, Health Care Fraud Report Fiscal Year 1998

<sup>89</sup> Press Release, U.S. Dep't of Justice, U.S. Att'y E.D. Ark., Department of Justice to Intervene in Whistleblower Case (May 20, 2009).

<sup>90</sup> Press Release, U.S. Dep't of Justice, U.S. Att'y E.D. Ark., Hospice Home Care to Pay \$2,700,000 Settlement in Medicare Fraud Case (May 20, 2009).

<sup>91</sup> United States Complaint in Intervention, *United States ex rel. Richardson v. Golden Gate Ancillary LLC*, No. 09-CV-00627-AKK (N.D. Ala. filed Dec. 6, 2011).

<sup>92</sup> *Qui Tam* Complaint, *Richardson ex rel. United States v. Golden Gate Nat'l Senior Care LLC*, No. 2:09-CV-00627 (N.D. Ala. filed Mar. 31, 2009).





## Chapter 1815—Exhibit 1

### Hospice and Nursing Home Compliance Checklist

*The following lists reflect—from the perspective of what is needed in a compliance program—key requirements established by the federal anti-kickback statute and regulatory safe harbors, compliance guidance and fraud alerts issued by the Office of Inspector General, and judicial opinions interpreting the statute.*

#### General Checklist

- Basic Concepts and Rules.** Include in the provider’s written compliance materials for business personnel a plain-English explanation of the reasons why relationships between hospices and nursing homes implicate the anti-kickback statute. Convey the basic rule that financial relationships between hospices and nursing homes must be for fair market value and must not be tied directly or indirectly to referrals for items or services reimbursed under a federal health care program. Cross-reference the compliance materials’ treatment of the Civil Monetary Penalty law related to the provision of free services to nursing home providers and patients.
- Safe Harbors.** Include in the provider’s written compliance materials for business personnel a plain-English explanation of the role of safe harbors, and the general thrust of the personal services contract safe harbor.
- Referral Potential.** Train relevant business personnel to recognize when nursing homes might be in a position to refer to, or otherwise generate business for, a hospice.
- Problem Areas.** Train relevant business personnel to recognize financial and contractual arrangements that might raise kickback problems.
- Review of Agreements.** Require that all proposed nursing home-hospice agreements be reviewed by legal counsel.
- Written Agreements.** Require all agreements to be in writing, and warn against the making of unwritten promises or providing services outside the scope of the written contract.
- Audits.** Referring to a detailed checklist of safe harbor elements and problem areas, examine existing agreements as part of the provider’s regular, periodic compliance audit of operations.
- Disclosure to Patients.** Develop and use a plain-English disclosure informing patients of their right to choose the nursing home or hospice, as the case may be, when such services are required.

#### Problem Areas—Hospice-Nursing Home Relationships

*The following questions, if answered yes, can signal safe harbor noncompliance or a violation of the anti-kickback statute, and should prompt immediate review by legal counsel. With slight changes in phrasing, the questions will apply to assessment of a proposed contract arrangement or review of an existing one.*

- Does the hospice’s contract with the nursing home include a term of less than one year?
- Does the contract fail to clearly delineate the services to be provided by each provider and the hospice’s ultimate assumption for the professional management of the patient’s medical care for the terminal condition?
- Does the contract or do the parties contemplate that nursing home personnel will assist in the provision of services in implementing the plan of care to an extent greater than would be required of a family member if the patient were living at home?
- Does the contract require the nursing home to provide noncore hospice services?
- Does the hospice’s room and board payment to the nursing home for a Medicaid hospice patient exceed what the nursing home otherwise would have received if the patient had not been enrolled in hospice?
- Would payment otherwise be viewed as being above fair market value?
- If additional services are purchased from the nursing home, are these services being paid for by the hospice at greater than fair market value?

- Are these additional services covered by the Medicaid room and board payment?
- Does the hospice have an exclusive or semiexclusive right to provide hospice services to this nursing home?
- Does the hospice-nursing home contract fail to clearly define the hospice's sole responsibilities for billing the Medicaid program?
- Does the contract fail to include requirements that will help minimize double billing opportunities and that permit an audit of records to monitor compliance?
- Is the hospice offering free or below market price goods, services, or staff to the nursing home?
- If so, are these services of more than nominal value to residents or the nursing home?