



# OFFICE OF INSPECTOR GENERAL

## SPECIAL FRAUD ALERT

### FRAUD AND ABUSE IN NURSING HOME ARRANGEMENTS WITH HOSPICES

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March 1998

The Office of Inspector General was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse and waste in the Department's programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations, and inspections.

To reduce fraud and abuse in the Federal health care programs, including Medicare and Medicaid, the OIG actively investigates fraudulent schemes to obtain money from these programs and, when appropriate, issues Special Fraud Alerts that identify segments of the health care industry that are particularly vulnerable to abuse. This Special Fraud Alert focuses on the interrelationship between the hospice and nursing home industries and describes some potentially illegal practices the OIG has identified in arrangements between these providers.

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#### **What Is Hospice Care And Who Is Eligible To Receive It**

Medicare's hospice benefit provides palliative care to individuals who are terminally ill. Palliative care focuses on pain control, symptom management, and counseling for both the patient and family. Medicare hospice payments increased from about \$958 million for Fiscal Year 1993 to over \$1.8 billion for Fiscal Year 1995. Although the hospice benefit is still a relatively small portion of total Medicare Part A expenditures (about 1.5 percent), it has grown considerably over the past several years.

In order to elect the hospice benefit, a Medicare beneficiary must be entitled to Medicare Part A services and certified as terminally ill, which is defined as a

medical prognosis of a life expectancy of 6 months or less if the illness runs its normal course. A beneficiary who elects to enroll in a hospice program waives his or her rights to all curative care related to his or her 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.

The hospice must have a written plan of care which covers physician and nursing services; physical, occupational, and speech therapy; medical social services; home health aides and homemakers; short-term inpatient care; counseling; respite care; and medical supplies, including drugs and biologicals. Certain of the hospice services ("core services") must be provided directly to the beneficiary by employees of the hospice, while other non-core hospice services may be provided in accordance with contracts with other providers. However, the hospice must retain professional management for all contracted services.

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## **Reimbursement For Hospice Care Provided In Nursing Homes**

Medicare does not have a separate payment rate for routine hospice services provided in a nursing home. Because hospice services are typically provided to patients in their homes, the routine home care hospice rate does not include any payment for room or board. For services provided to patients in nursing homes, hospices receive the Medicare routine home care rate, which is a fixed amount per day for the services provided by the hospice, regardless of the volume or intensity of the services provided. Accordingly, where the hospice patient resides in a nursing home, the patient remains responsible for payment of the nursing home's room and board charges.

If, however, a patient receiving Medicare hospice benefits in a nursing home is also eligible for Medicaid, Medicaid will pay the hospice at least 95 percent of the State's daily nursing home rate, and the hospice is then responsible for paying the nursing home for the beneficiary's room and board. The specific services included in the daily rate payment are determined by a State's Medicaid program and may vary from State to State.

In addition to the room and board payment, a hospice may contract with the nursing home for the nursing home to provide non-core hospice services (i.e., those services which the hospice is not required by law to provide itself) to its hospice patients.

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## **Vulnerabilities In Nursing Home Arrangements With Hospices**

Hospice services may be appropriate and beneficial to terminally ill nursing home residents who wish to receive palliative care. However, arrangements between nursing homes and hospices are vulnerable to fraud and abuse because nursing home operators have control over the specific hospice or hospices they will permit to provide hospice services to their residents. An exclusive or semi-exclusive arrangement with a nursing home to provide hospice services to its residents may have substantial monetary value to a hospice. In these circumstances, some nursing home operators and/or hospices may request or offer illegal remuneration to influence a nursing home's decision to do business with a particular hospice.

Hospice patients residing in nursing homes may be particularly desirable from a hospice's financial standpoint. First, a nursing home's population represents a sizeable pool of potential hospice patients. Second, nursing home hospice patients may generate higher gross revenues per patient than patients residing in their own homes because nursing home residents receiving hospice care have, on average, longer lengths of stay than hospice patients in their homes. Also, 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. A recent OIG report found that residents of certain nursing homes receive fewer services from their hospice than patients in their own homes. 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.

However, a hospice's access to nursing home patients depends on the nursing home operator. Nursing home operators may 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 value of the nursing home operator's decision. In these circumstances, some nursing home operators or hospices may request or offer illegal inducements to influence the selection of a hospice.

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## **Paying Or Receiving Kickbacks In Order To Induce Medicare Or Medicaid Referrals**

Because kickbacks can distort medical decision making, result in overutilization, and have an adverse effect on the quality of care patients receive, they are prohibited under the Federal health care programs, including Medicare and Medicaid. Under the anti-kickback statute, it is illegal to knowingly and willfully solicit, receive, offer, or pay anything of value to induce referrals of items or services payable by a Federal health care program.

The OIG has observed instances of potential kickbacks between hospices and nursing homes to 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 if the patient had not been enrolled in hospice. Any additional payment must represent the fair market value of additional services actually provided to that patient that are not included in the Medicaid daily rate.

Specific practices which are suspected kickbacks include:

- ◆ A hospice offering free goods or goods at below fair market value to induce a nursing home to refer patients to the hospice.
- ◆ A hospice paying “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 hospice.
- ◆ A hospice paying amounts to the nursing home for “additional” services that Medicaid considers to be included in its room and board payment to the hospice.
- ◆ A hospice paying above fair market value for “additional” non-core services which Medicaid does not consider to be included in its room and board payment to the nursing home.
- ◆ A hospice referring its patients to a nursing home to induce the nursing home to refer its patients to the hospice.
- ◆ A hospice providing 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 after the patient exhausts the skilled nursing facility benefit, the patient will receive hospice services from that hospice.
- ◆ A hospice providing staff at its expense to the nursing home to perform duties that otherwise would be performed by the nursing home.

Parties that violate the anti-kickback statute may be criminally prosecuted or subject to civil monetary penalties, and also may be subject to exclusion from the Federal health care programs.

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## **What To Do If You Suspect Fraud Involving Arrangements Between Nursing Homes and Hospices**

If you have information about nursing homes and hospices engaging in any of the activities described above, contact any of the regional offices of the Office of

Investigations of the Office of Inspector General, U.S. Department of Health and Human Services, at the following locations:

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<b>Field Offices</b>	<b>States Served</b>	<b>Telephone</b>
Boston	MA, VT ,NH, ME, RI, CT	617-565-2660
New York	NY, NJ, PR, VI	212-264-1691
Philadelphia	PA, MD, DE, WV, VA, DC	215-596-6796 - before 5/11/98 215-861-4586 - after 5/11/98
Atlanta	GA, KY, NC, SC, FL, TN, AL, MS	404-562-7603
Chicago	IL, MN, WI, MI, IN, OH, IA, MO	312-353-2740
Dallas	TX, NM, OK, AR, LA, CO, UT, WY, MT, ND, SD, NE, KS	214-767-8406
Los Angeles	AZ, NV, So. CA	714-246-8302
San Francisco	No. CA, AK, HI OR, ID, WA	415-437-7960