Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HOSPICE AND NURSING HOME CONTRACTUAL RELATIONSHIPS

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1997
OEI-05-95-00251

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EXECUTIVE SUMMARY

PURPOSE

To examine the contractual relationships between hospices and nursing homes.

BACKGROUND

Hospice care is an approach to treatment that recognizes that the impending death of an individual may warrant a change in focus from curative to palliative care. Hospice helps patients face death while minimizing pain and disruption of normal activities. The Medicare hospice benefit was established in 1983. In 1986, Congress allowed States to add a hospice benefit to their State Medicaid plans.

For nursing home patients who are dually entitled to Medicare and Medicaid and who choose the hospice benefit, Medicaid pays the hospice for the patient's room and board, (no less than 95 percent of the Medicaid daily rate), and Medicare pays the hospice for the hospice benefit. The hospice then pays the nursing home for daily care, and, depending on the arrangement made between the hospice and the nursing home, for other services as well.

Based on evaluations, audits, anecdotal evidence and a review of statutory provisions, we decided to examine whether contractual arrangements between hospices and nursing homes present vulnerabilities for inappropriate or excessive Medicare and Medicaid payments being made to hospice or nursing homes.

From a stratified random sample of 36 hospices, we reviewed the contracts and financial records of 22 hospices who had patients residing in nursing homes. We did not attempt to project these findings to the universe of hospices.

FINDINGS

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

Of the 22 hospice contracts reviewed, 17 had sufficient information to determine the hospice payment to the nursing home for room and board. Of the 17 hospices, 10 pay 100 percent of Medicaid's daily rate for nursing home care; 5 pay 105 percent, and 1 pays 120 percent of Medicaid's daily rate. Only one hospice pays less than 100 percent of Medicaid's daily nursing home rate.

The six hospices paying more than 100 percent of the Medicaid daily rate for nursing home care have a higher percentage of patients in nursing homes.

The hospices that paid over 100 percent of the Medicaid daily rate had, on average, 49 percent of their Medicare patients living in nursing homes. Two of these six hospices had close to 100 percent of their patients living in nursing homes. The 11 remaining hospices had, on average, 24 percent of their Medicare patients living in nursing homes.

Both the hospice and the nursing home can benefit financially by enrolling patients in hospice.

In one instance we found additional hospice income generated because Medicaid payments to hospice for room and board exceeded what the hospice paid the nursing home for room and board. By enrolling nursing home patients hospices also benefit financially from increases in the average length of stay and increasing the efficient utilization of staff. The advantages for the nursing homes are: increasing reimbursement for Medicaid patients, receiving additional staff hours at no additional cost, increased patient census and reducing supply and medication costs when the hospice provides them.

Some hospice contracts with nursing homes contain provisions that raise questions about inappropriate patient referrals between hospices and nursing homes.

Language from contracts in 3 of 22 hospices we reviewed raises the possibility that some nursing homes and hospices are inappropriately referring patients to each other. Another potential abuse was in the provision of free care in return for patient referrals. These arrangements potentially implicate the Medicare-Medicaid anti-kickback statute.

RECOMMENDATIONS

Given the above information, and information in our companion report entitled "Hospice Patients in Nursing Homes", we are concerned that some decisions about patient care can be potentially influenced by financial rather than clinical factors. Financial incentives between hospices and nursing homes that induce referrals may implicate the Medicare anti-kickback statute. Any contracts with potentially troublesome language will be reviewed further by appropriate components of the Office of Inspector General. These offices may take additional action as necessary.

We recommend that the Health Care Financing Administration (HCFA) work with the hospice associations to educate the hospice and nursing home communities to help them avoid potentially fraudulent and abusive activities that might influence decisions on patient benefit choices and care.

In addition, we recommend that HCFA work with the States to develop regulations

defining what is included in their nursing home room and board payment.

AGENCY COMMENTS

We received comments from HCFA and they concur with both of our recommendations. They state that HCFA staff and the regional home health intermediaries are in constant touch with the national and local hospice associations and are working to educate them regarding potentially fraudulent and abusive practices. Also, HCFA is currently developing technical regulations for Medicaid hospice care that will discuss the issue of what constitutes room and board for nursing home patients electing hospice care.

The HCFA suggested that the OIG issue guidance to the hospice and nursing home industries and the Medicare intermediaries about the problems we identified in our report. We agree and plan to do so. In addition we hope to make our report widely available for this purpose, both by sending it to the affected industry organizations and intermediaries and making it available on the internet. We will discuss our plans with HCFA to ensure adequate dissemination of these results.

We appreciate the work that HCFA is dong in this area. The full text of their comments can be found in Appendix A.

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INTRODUCTION

PURPOSE

To examine the contractual relationships between hospices and nursing homes.

BACKGROUND

Hospice Care

Hospice care is an approach to treatment that recognizes that the impending death of an individual may warrant a change in focus from curative to palliative care. Hospice helps patients face death while minimizing pain and disruption of normal activities. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in a home environment.

The Medicare hospice benefit was established in 1983. To be eligible for Medicare's hospice benefit, a patient has to be diagnosed with a terminal condition with a life expectancy of 6 months or less if the illness runs its normal course. The benefit was initially comprised of four levels of care, with three benefit periods and a limit of 210 days of coverage.

In 1990, Medicare's hospice benefit was expanded by adding a fourth benefit period that was unlimited in duration. Before the addition of this period, patients who lived beyond 210 days and still required hospice care were provided care by the hospice without charge to Medicare or the patient.

Medicare patients enrolled in the hospice program waive coverage of all medical services related to the treatment of their terminal illness. The hospice assumes responsibility for all of the patient's medical needs related to their terminal illness. However, 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.

Medicaid's Hospice Benefit

In 1986, Congress allowed States to add a hospice benefit to their State Medicaid plans. The original legislation adding the optional hospice benefit specifically mentioned that "hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility" (P.L. 99-272, Sec.9505(a)(2)). To be eligible for hospice care under Medicaid, patients have to meet the same requirements defined by Medicare. For nursing home hospice patients

who are dually entitled to Medicare and Medicaid, Medicaid pays an additional amount to cover the patient's room and board[1].

Room and board can include the following:

- assistance in activities of daily living,
- socializing activities,
- administration of medication,
- maintaining the cleanliness of a resident's room,
- supervising and assisting in the use of durable medical equipment and prescribed therapies, and
- personal care services.

When a dually entitled patient elects hospice, Medicaid pays the hospice for the patient's room and board instead of paying the nursing home. The hospice then pays the nursing home. Initially, Congress only required that States "take into account the room and board furnished by such facility" in determining the room and board payment. In 1990, Congress required States to pay "at least 95 percent of the rate that would have been paid by the State...." There is nothing in this section of the law that explicitly prohibits a hospice from paying all or more than the 95 percent they receive from the State to a nursing home for room and board.

OIG Studies

Recently, the Office of Inspector General (OIG) conducted a number of different audits, inspections and investigations examining Medicare's hospice benefit. Previously, OIG conducted a number of Hospice audits in Puerto Rico. Other OIG reports include individual hospice audits as well as "Enhanced Controls are Needed to Insure Validity of Medicare Hospice Enrollments" (A-05-96-00023).

This report is a companion to an earlier report entitled "Hospice Patients and Nursing Homes" (OEI-05-95-00250). In that report, we found that a lower frequency of service for nursing home patients, overlap of services, and questionable enrollment in hospice by nursing home patients suggests that current payment levels for care in nursing homes may be excessive.

METHODOLOGY

For our inspection entitled "Hospice Patients and Nursing Homes" (OEI-05-95-00250), we selected a stratified random sample of 36 hospices, 6 hospices each from

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[1] In this report "room and board" is used to describe the payments made by hospices to nursing homes once a patient elects hospice. "Nursing home care" is used to describe those payments that the State Medicaid agency would have made if the patient did not elect hospice care.

California, Florida, Illinois, New York and Texas and 6 hospices from the remaining States. From these sampled hospices, we requested the hospice's Medicare census for December 1995. We received responses from 31 of the 36 hospices.

In the patient census, we asked the hospice to identify whether the patient was a resident of a nursing home and receiving hospice services and whether the patient was entitled to Medicaid. Twenty-two of the 31 hospices had patients who were residents of a nursing home while receiving hospice services. We requested from the hospices the complete medical and financial record for these patients. The complete financial record included the written agreement between the hospice and the nursing home and copies of receipts and distributions for the patient's care. In addition, we requested from the nursing homes identified as the patient's residence copies of their complete medical and financial records.

Based on our sample, 51 percent of Medicare hospice patients living in a nursing home were also entitled to Medicaid. For these residents, we requested from the State Medicaid agencies, the patient's complete 1995 claims history. We received responses from each State. We also obtained from the Health Care Financing Administration claims history for each patient in our sample. Medical review was conducted on 208 nursing home hospice patients.

We reviewed a sample of financial records from each hospice to examine the financial relationship between the hospice and the nursing home. A total of 22 hospices were reviewed although 3 hospices served no Medicaid patients during our sample period. No payments for room and board were made to nursing homes by these three hospices. Despite the absence of Medicaid patients, we reviewed the contract language since the contracts contained information pertaining to room and board payments for patients who might be entitled to Medicaid. National projections regarding our findings were not made.

This inspection was conducted in accordance with Quality Standards for Inspections as developed by the President's Council on Integrity and Efficiency.

FINDINGS

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

We reviewed the contracts of 22 hospices of which 17 had sufficient information to determine the hospice payment to the nursing home for room and board. A hospice and a nursing home must have a signed agreement detailing the responsibilities of each entity. Of the 17 hospices, 10 pay 100 percent of Medicaid's daily rate for nursing home care; 5 hospices pay 105 percent and one hospice pays 120 percent. Only one hospice appears to pay 95 percent of Medicaid's daily rate.

In almost all of the contracts we reviewed, hospices pay nursing homes either a flat daily rate to cover all the patient's room and board expenses or a rate that covers room and board and an additional amount to cover supplies and services. Currently, there are no regulations defining what is included in a room and board payment for hospice patients. When the contract states that payment will be a flat rate for room and board and an additional amount for supplies, the language is typically stated as follows:

> *For Hospice Medicare and Medicaid patients, Hospice will pay the Facility 95% of the existing Medicaid Nursing Facility Rate for the patient, plus an additional 5% for services purchased by Hospice from the Facility.*

According to many of the contracts, the additional 5 percent payment covers routine supplies such as incontinent pads, ostomy supplies and other care items generally provided by the nursing home. Many of these supplies and items are not ordered by the hospice, rather these supplies appear to be part of the routine care provided by the nursing home that would normally be reimbursed in the Medicaid daily rate.

Beyond these routine services and supplies, almost all of the contracts allow nursing homes to bill the hospice in addition to the 5 percent for additional supplies and services ordered by the hospice when related to the terminal illness. Examples of these items include speech therapy, drugs, or other services not normally covered in the Medicaid daily rate.

Almost all the contracts state that the hospice expects the nursing home to provide the same level of services and care to hospice patients that would have been provided had the patient not elected hospice. A typical example of language found in most contracts:

> *The Home shall furnish to the individual who is both a resident of The Home and a Hospice patient all of those services which The Home normally would have*

provided in the absence of The Hospice program, as provided for in The Home's policies, procedures, protocols, and agreements with the resident and the resident's family.

The six hospices paying more than 100 percent of the Medicaid daily rate for nursing home care have a higher percentage of patients in nursing homes.

Our analysis indicates that hospices that pay more than 100 percent of the Medicaid daily rate for nursing home care have a higher percentage of patients in nursing homes. The six hospices that paid over 100 percent of the Medicaid daily rate had, on average, 49 percent of their Medicare patients living in nursing homes. Two of these six hospices had close to 100 percent of their patients living in nursing homes. The 11 remaining hospices had, on average, 24 percent of their Medicare patients living in nursing homes.

If the purpose of the additional payment to the nursing home is to induce the referral of patients, the hospice and nursing home are potentially in violation of 42 U.S.C. section 1320a-7b(b). This statute makes it illegal to offer or solicit anything of value to induce the referral of a patient to a person for furnishing or arranging a service for which payment may be made under Federal health care programs (including Medicare or Medicaid). This statutory prohibition is generally referred to as the Medicare anti-kickback law.

However, if the nursing home provides legitimate services for hospice patients beyond those routine services normally provided to nursing home patients and covered by the daily rate, it would be appropriate for the hospice to reimburse the nursing facility for those services.

Based on a review of patient's financial and medical records, it is unclear whether payments made by hospices for additional services provided by the nursing home warrant payment in excess of 100 percent of the Medicaid daily rate for nursing home care. We believe that payments that exceed 100 percent may implicate the Medicare anti-kickback statute.

Both the hospice and the nursing home can benefit financially by enrolling patients in hospice.

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 one example, both the hospice and the nursing home appear to profit from their arrangements.

The following example, illustrated on page 7, shows how at least one hospice and nursing home benefitted financially from their arrangement. In this example, the nursing home's Medicaid rate was $80.88 per day. The patient's share of their nursing home cost was $497.00 per month. Under current Medicaid regulations, individuals living in nursing homes must have a post-eligibility determination made to apply some

of their income to the costs of nursing home care. This patient's share also applies when a nursing home patient elects hospice care.

If the patient had not elected hospice care, the total amount that would have been paid by Medicaid for nursing home care in December 1995 would have been $2,507.28 minus the patient's $497.00 for a total Medicaid reimbursement of $2,010.28. However, the patient did elect hospice care. The hospice and nursing home negotiated a rate for room and board of $85.00 per day or 105 percent of Medicaid's per day rate. The total amount that the nursing home billed the hospice was $2,635.00. Again the total patient's share of cost was $497.00 which was deducted from the $2,635.00. The total amount paid by the hospice was $2,138.00. This exceeded the $2,010.28 that the nursing home would have been paid by Medicaid by $127.72.

The hospice then bills the State Medicaid agency for the patient's room and board. The average daily rate paid by the State for room and board for hospice patients was $75.73 per day. This amount is slightly less than 95 percent of the Medicaid daily rate. This may represent a partial adjustment for the patient's share of cost. The total amount paid by the State for this patient's room and board for December 1995 was $2,347.60 which exceeded the $2,138.00 paid by the hospice to the nursing home by $209.60. In addition to the Medicaid and hospice payments for room and board for the hospice patient, Medicare paid the hospice $3,342.00 for hospice care or $107.80 per day.

This situation 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. Other advantages for hospices include increasing the average length-of-stay, (as noted in hospice industry presentations) and increasing the efficient utilization of human resources.

The advantages for the nursing homes 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. Another potential advantage for the nursing home is increasing the nursing home's patient census by admitting hospice patients who were previously living "at home."

Nursing Home - A Daily Rate for Nursing Home Care $80.88			
Patient - A		Patient - A (Hypothetical)	
Patient Elects Hospice Nursing Home Stay 12/1/95 - 12/31/95		Patient Does Not Elect Hospice Nursing Home Stay 12/1/95 - 12/31/95	
Nursing Home Bills Hospice at 105 % of Medicaid Daily Rate		Nursing home bills Medicaid at its daily rate	
Service	Charge	Service	Charge
31 Days @ $85.00 per day	$2,635.00	31 days @ $80.88 per day	$2,507.28
Patient's Share of Cost	-$497.00	Patient's Share of Cost	-$497.00
Total	$2,138.00	Total	$2,010.28
Hospice Paid Nursing Home	$2,138.00	Medicaid Paid Nursing Home	$2,010.28
	Difference between hospice payment and Medicaid payment		**$127.72**
Hospice bills Medicaid for room and board			
Service	Charge		
31 Days @ $75.73 per day	$2,347.60		
Medicaid paid hospice	$2,347.60		
Hospice paid nursing home	$2,138.00		
Difference between hospice payment and Medicaid payment	**$209.60**		
Medicare payment to Hospice for Hospice Care	**$3,342.00**		

Some hospice contracts with nursing homes contain provisions that raise questions about inappropriate patient referrals between hospices and nursing homes.

Language in three hospice nursing home contracts raises the possibility that nursing homes and hospices are inappropriately referring patients to each other, potentially violating the Medicare anti-kickback statute. This statute makes it illegal to offer or

solicit anything of value to induce the referral of a patient to a person for furnishing or arranging a service for which payment may be made under Federal health care programs (including Medicare or Medicaid). Below is an example of language pertaining to patient referrals found in a hospice's contract with a nursing home.

> *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.*

In another contract from the same hospice but with a different nursing home the language regarding referral asks that the nursing home promote the concept of hospice to patients who may require hospice care.

In another hospice's contract, the hospice and nursing home agree to

> *formulate an assessment system within each of their structures to funnel patients to the services of the other.*

Another potential abuse of the current system is providing free care in return for patient referrals. One hospice's contract raises questions both about the appropriateness of hospice care as well as Medicare's Skilled Nursing Facility benefit. The contract states 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.*

This language, along with examples of patients moving between the hospice benefit and regular Medicare benefits, raises questions as to whether the hospices and nursing homes are placing patients for reimbursement reasons rather than patient needs.

RECOMMENDATIONS

Given the above information, and information in our companion report entitled "Hospice Patients in Nursing Homes", we are concerned that some decisions about patient care can be potentially influenced by financial rather than clinical factors. Financial incentives between hospices and nursing homes that induce referrals may implicate the Medicare anti-kickback statute.

Any contracts with potentially troublesome language will be reviewed further by appropriate components of the Office of Inspector General. These offices may take additional action as necessary.

We recommend that the Health Care Financing Administration (HCFA) work with the hospice associations to educate the hospice and nursing home communities to help them avoid potentially fraudulent and abusive activities that might influence decisions on patient benefit choices and care.

In addition, we recommend that HCFA work with the States to develop regulations defining what is included in their nursing home room and board payment.

AGENCY COMMENTS

We received comments from HCFA and they concur with both of our recommendations. They state that HCFA staff and the regional home health intermediaries are in constant touch with the national and local hospice associations and are working to educate them regarding potentially fraudulent and abusive practices. Also, HCFA is currently developing technical regulations for Medicaid hospice care that will discuss the issue of what constitutes room and board for nursing home patients electing hospice care.

The HCFA suggested that the OIG issue guidance to the hospice and nursing home industries and the Medicare intermediaries about the problems we identified in our report. In addition we hope to make our report widely available for this purpose, both by sending it to the affected industry organizations and intermediaries and making it available on the internet. We will discuss our plans with HCFA to ensure adequate dissemination of these results.

We appreciate the work that HCFA is dong in this area. The full text of their comments can be found in Appendix A.

APPENDIX A

AGENCY COMMENTS

DATE: SEP 2 [illegible]97

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle NMD
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Hospice and Nursing Home Contractual Relationships," (OEI-05-95-00251)

We reviewed the above-referenced report that examines contractual relationships between hospices and nursing homes.

Hospice care is an approach to treatment that recognizes the impending death of an individual may warrant a change in focus from curative to palliative care. Hospice helps patients face death while minimizing pain and disruption of normal activities. The Medicare hospice benefit was established in 1983. In 1986, Congress allowed states to add a hospice benefit to their state Medicaid plans.

For nursing home patients who are dually entitled to Medicare and Medicaid and who choose the hospice benefit, Medicaid pays the hospice for the patient's room and board (no less than 95 percent of the Medicaid daily rate), and Medicare pays the hospice for the hospice benefit. The hospice then pays the nursing home for daily care and, depending on the arrangement made between the hospice and the nursing home, for other services as well.

Based on evaluations, audits, anecdotal evidence, and a review of statutory provisions, OIG decided to examine whether contractual arrangements between hospices and nursing homes present vulnerabilities for inappropriate or excessive Medicare and Medicaid payments being made to hospices or nursing homes.

The Health Care Financing Administration (HCFA) concurs with all of OIG's recommendations. Our detailed comments are as follows:

OIG Recommendation 1

HCFA should work with the hospice associations to educate the hospice and nursing home communities to help them avoid potentially fraudulent and abusive activities that might influence decisions on patient benefit choices and care.

HCFA Response

We concur. It is important to note that both HCFA staff and our contractors, the regional home health intermediaries (RHHIs), are in regular contact with the national and local hospice associations, and are working to educate them regarding potentially fraudulent and abusive activities. The RHHIs have been instructed to conduct educational seminars for providers, physicians, and/or consumers when there is a general misunderstanding of coverage, widespread overutilization in areas, or issues all parties may not be aware of that might impact utilization of services. We will encourage the RHHIs to re-emphasize this aspect of potentially fraudulent and abusive activities in their continuing educational efforts.

OIG Recommendation 2

HCFA should work with the states to develop regulations defining what is included in their nursing home room and board payment.

HCFA Response

We concur. HCFA is currently developing technical regulations for Medicaid hospice care. It should be noted that the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) included a definition for nursing home room and board. However, before this provision could be incorporated into the Medicaid regulations, the statute was repealed with OBRA 1990. As a technical regulation, we are implementing the requirements of section 1905(o) of the Social Security Act. In the preamble, there will be a discussion of nursing home room and board for those individuals who elected hospice care. We expect this information will clarify some of the confusion surrounding this issue and may negate the need for a separate regulation. However, we will include in the preamble a request for comment from the public on the need to develop separate regulations for room and board.

Additional Comments

We agree the hospice associations should be informed of situations considered to be potentially fraudulent and abusive. It would be helpful if OIG prepared a document/alert that outlines potential anti-kickback violations so that HCFA could work with the associations and the RHHIs.