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Nursing homes and hospices: Compliance pitfalls and practical pointers

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The potential for fraud and abuse in arrangements between nursing facilities/skilled nursing facilities (nursing homes) and hospices has been an area of increasing concern since the mid-1990s for the Department of Health and Human Services Office of Inspector General (OIG). Recently, the fraud and abuse risks associated with hospice/nursing home relationships was addressed in OIG reports and draft supplemental compliance program guidance for nursing homes. The Centers for Medicare and Medicaid Services (CMS) also recently published a new Condition of Participation specific to arrangements between hospices and nursing homes. Additional federal guidance is imminent. Compliance, as a result, should be a key priority for hospices and nursing homes.

First, this article summarizes the hospice election for beneficiaries that reside in nursing homes. Then it examines compliance issues that arise in arrangements between hospices and nursing homes and offers practical solutions. The conclusion reinforces that hospices and nursing homes, in addition to reexamining their relationships to assure that they are in compliance, should stay attuned to legal and regulatory developments.

Hospice election for nursing home residents

Hospice care is an approach to caring for terminally ill individuals that centers on palliative care (i.e., pain relief, uncomfortable symptoms, and counseling) as opposed to curative care.

Medicare coverage for hospice care. Hospice care is covered for a beneficiary under Medicare Part A if:

(1) the beneficiary is eligible for Part A;
(2) the beneficiary's attending physician (if applicable) and the hospice medical director or physician member of the hospice interdisciplinary group certify that the beneficiary is terminally ill and has a life expectancy of six months or less if the terminal illness runs its normal course; and
(3) the beneficiary signs a statement choosing hospice care instead of routine Medicare covered benefits for services related to the terminal illness.[1]

By enrolling in hospice, beneficiaries waive their rights to curative care, although Medicare continues to pay for treatment of conditions unrelated to the terminal illness. The hospice election can be revoked by the beneficiary at any time, in which case the beneficiary reverts to standard Medicare Part A benefits.[2]

One goal of the Medicare hospice program is to keep beneficiaries in their homes. Home is where the beneficiary resides. When a beneficiary resides in a nursing home, the nursing home is the beneficiary's residence. Regardless of whether a beneficiary resides at a private residence or nursing home, the hospice assumes responsibility for the professional management of the beneficiary's care.

Medicare payment for hospice care. Hospices are reimbursed by Medicare according to one of four predetermined rates: (1) routine home care; (2) continuous home care; (3) respite care; or (4) general inpatient care.[3]

A hospice is paid the routine home care rate for each day a patient is not receiving one of the other three levels of care. The continuous home care rate is paid when a hospice patient is not in an inpatient facility and receives at least eight hours of direct patient care per day, consisting predominately of nursing care. Continuous home care is only furnished during brief periods of crisis and as necessary to maintain the patient at home. The respite care payment rate is paid for days on which the patient is in an approved inpatient facility and is receiving respite care on a short-term basis. Respite care is provided on an occasional basis to relieve the primary caregiver and may not be reimbursed for more than five consecutive days at a time. Payment at the general inpatient care rate is made when general inpatient care is provided. General inpatient care is appropriate when management of the terminal illness cannot be provided in other settings.

Base rates are set annually by CMS and adjusted by the wage index for the geographic location where services are provided. Hospices are reimbursed a classified daily rate, regardless of the quantity of services provided, except for continuous home care, which (when it applies) is paid in 15-minute increments, subject to a maximum daily amount. As a result, hospices have an incentive to deliver services in a cost-efficient manner.

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Nursing home room and board. When a Medicare hospice election is made by a nursing home resident, the resident, or the resident's private insurer, pays the nursing home for room and board, unless the resident is also eligible for Medicaid. For Medicare/Medicaid (dually eligible) residents, the state Medicaid agency pays the hospice for room and board. The amount paid by the Medicaid program cannot be less than 95% of the daily rate that would have been paid to the nursing home if the resident had not elected the Medicare hospice benefit.[4] The hospice in turn pays the nursing home. According to CMS, "room and board services" include personal care, assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.[5]

Relationships between nursing homes and hospices

Several compliance issues may arise in the relationships between nursing homes and hospices.

Written agreements. CMS issues Conditions of Participation (CoPs) that hospices must meet as Medicare participating providers. In June of this year, CMS published new hospice CoPs that hospices must comply with by December 2, 2008,[6] including a new CoP specific to hospices that provide care to nursing home residents. This new hospice CoP addresses mandatory terms that must be included in the agreement between a hospice and a nursing home.[7] The written agreement must, for example, require the nursing home to immediately notify the hospice if there is a significant change in the resident's physical, mental, social, or emotional status. Hospices should carefully review this new hospice CoP to ensure that all written agreements with nursing homes are compliant by December 2, 2008.

In addition to CMS, states often have a similar nursing home written agreement requirement for hospices that participate in the state Medicaid program. For this reason, hospices should also be familiar with their specific state's requirements applicable to arrangements between hospices and nursing homes.

Billing the appropriate Medicare rate. Based on recent indications, ensuring the correct Medicare rate is billed for hospice services is high on the agendas of the OIG and CMS. Compliance areas of focus for hospices should include ensuring that the continuous home care and respite care levels are only billed when appropriate.

Continuous home care. For fiscal year 2008, the difference between the routine home care and continuous home care rates can be significant. For example, the unadjusted routine home care rate is $135.11 per diem. In contrast, the maximum amount per day that a hospice could receive under the unadjusted continuous home care rate is $788.55 ($32.86 per hour). This rate differential could create a financial incentive in favor of hospices providing continuous home care. As a result, hospices should use caution when billing a continuous home care rate to ensure that all requirements are satisfied to bill at this level. Hospices should not render continuous home care when routine home care is appropriate under the medical circumstances.

Hospices must ensure that the required number of hours as well as the required level of care is provided when billing a continuous home care rate for services provided to a nursing home resident. Continuous home care requires that the hospice provide direct patient care services for at least eight hours per 24-hour period, which begins and ends at midnight. At least half of the direct patient care services must be provided by a registered nurse or licensed practical nurse. Homemaker or home health aide services may be provided to supplement nursing services. If fewer than eight hours of care is provided, the services are properly billed as routine home care rather than continuous home care.[8]

Respite care. Another example of incorrect billing was recently reinforced by the OIG in a memorandum to CMS. The OIG stated that it is "contrary to Federal requirements" for hospice beneficiaries residing in nursing homes to receive respite care.[9]

This conclusion only makes sense when considering the purpose of respite care, which is to provide short-term relief to the primary caregiver (i.e., the patient's family, etc.). Medicare pays for respite care that is provided in a nursing home that meets hospice CoP requirements if the patient maintains a private residence, such as an apartment. However, Medicare does not pay for respite care when the patient's residence is the nursing home.

Improper incentives to induce referrals. An area of fraud and abuse concern is financial incentives between a hospice and a nursing home to influence patient referrals. The Federal Anti-kickback Statute (AKS) makes it illegal to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program. For purposes of the AKS, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. Remuneration can include, for example, the transfer of items or services for free or for other than fair market value.

Situations that can pose fraud and abuse risks for hospices and nursing homes include:

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- **Payment for room and board.** As discussed earlier, when a dually eligible hospice beneficiary resides in a nursing home, Medicare pays the hospice benefit and the state Medicaid agency pays the hospice for room and board charges. A state's payment to the hospice cannot be less than 95% of the state's Medicaid daily nursing facility rate. The hospice pays the nursing home a negotiated rate for room and board. OIG has indicated that payments by a hospice to a nursing home at 100% of the Medicaid daily nursing facility rate are unlikely to pose significant legal risk under the AKS.[10] In contrast, OIG has made clear on multiple occasions that room and board payments exceeding 100% of the Medicaid daily nursing facility rate pose a great risk of fraud and abuse under the AKS.[11] OIG characterizes room and board payments to nursing homes in amounts exceeding what the nursing homes would have received directly from Medicaid had their patients not been enrolled in hospice as a suspect practice under the AKS.[12]

- **Additional payment for supplies and services.** Another related area of potential AKS risk is when a hospice pays a nursing home not only for room and board, but also for separate services and supplies provided by the nursing home. For example, a hospice might pay a nursing home 100% of the Medicaid daily nursing facility rate for dually eligible residents and also pay the nursing home for supplies the hospice is required to provide under the Medicare hospice benefit. From a business perspective, if the nursing home keeps such supplies at its facility, a hospice may find it easier to purchase these supplies directly from the nursing home instead of another third party.

  It is important that a hospice pay a nursing home only for additional supplies or services related to the palliation and management of the terminal illness of a specific hospice patient. Paying a nursing home for supplies or services, when use of the supply or provision of the service is unrelated to the terminal illness of a specific patient, undoubtedly raises fraud and abuse concerns. In addition, a hospice should pay the fair market value for additional services or supplies. Paying above fair market value will raise fraud and abuse concerns, regardless of whether use of the supply or provision of the service is related to the palliation and management of the resident's terminal illness.

  In determining whether making an additional payment to a nursing home for supplies or services is likely to impose a risk under the AKS, the hospice must also consider whether the cost of the supplies or services is already included in the Medicaid daily nursing facility rate for the applicable state. If the cost of the supply or service is included in the daily rate, concerns may arise as to whether the nursing home is being paid twice by the hospice for the same supply or service—once in the form of the room and board payment and once via the additional payment made by the hospice. Such a "double dip" could be viewed as payment by the hospice to the nursing home to induce the nursing home to refer patients to the hospice, in violation of the AKS.

- **Free staffing.** An area of growing concern is the provision of free staffing by a hospice to a nursing home. It is inappropriate for a hospice nurse or other hospice professional to provide any free or below-market services to a non-hospice nursing home resident. For example, it would raise serious fraud and abuse concerns if a hospice nurse provided free care to non-hospice residents of a nursing home as a "favor" to the nursing home. The OIG recognizes this potential for abuse. To be sure, in recent draft supplemental compliance program guidance for nursing homes, the OIG identified a "hospice providing staff at its expense to the nursing home" as a suspect practice under the AKS.

Conclusion

Hospices and nursing homes must ensure arrangements are set forth in a written agreement that meets CMS and state Medicaid agency requirements. In addition, hospices should have well-developed payment policies and internal checks in place to ensure that Medicare is billed according to the appropriate classification of the services provided on a particular day. A well-developed policy would address, for example, the prohibition on billing for respite care provided to a hospice patient who is a nursing home resident and the eight-hour requirement when billing for continuous home care.

Hospices and nursing homes should also have policies and procedures to minimize fraud and abuse risks. Procedures should ensure that payments made by a hospice to a nursing home are well documented and consistent with legal requirements. A well-developed policy would, for example, identify the provision of free or below fair market value services, of any kind, to nursing homes by hospices as a suspect practice to avoid. In addition, hospice staff who are responsible for invoicing should be trained on when it is appropriate to reimburse a nursing home for room and board, supplies, services, or other costs.

Changes in and, hopefully, more specific guidance on the permissible legal parameters that govern relationships between nursing homes and hospices are on the horizon. OIG released a study in December 2007 that analyzed the care of hospice beneficiaries in nurs-

ing homes. A companion study is expected to be released shortly to assess the appropriateness of payments for hospice care beneficiaries in nursing homes. Draft supplemental compliance program guidance for nursing homes, released in April 2008, addresses the fraud and abuse potential in the hospice/nursing home relationship. New CoPs for hospices were published in June 2008. Administrators, legal counsel, and compliance officers for hospices and nursing homes should stay aware of these developments when reviewing and structuring arrangements between hospices and nursing homes. ■

This article is intended to provide information regarding compliance issues in relationships between nursing homes and hospices. However, the information contained in this article is of a general nature and should not be considered legal advice as to any specific matter, organization, or medical provider.

1 42 C.F.R. §§ 418.20, 418.22 and 418.24.
2 42 C.F.R. § 418.28.
3 42 C.F.R. § 418.302; see Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 11, § 30.1.
4 42 U.S.C. § 1396a(a)(13)(B).
5 Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 9, § 20.3.
6 The new hospice COPs are available at http://www.cms.hhs.gov/CFCsAndCoPs/05_Hospice.asp.
7 This new hospice COP specific to nursing homes will be located at 42 C.F.R. § 418.112.
8 Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 9, § 40.2.1.
9 Memorandum Report: "Hospice Beneficiaries' Use of Respite Care," OEI-02-06-00222, March 31, 2008.
10 See, e.g., OIG Advisory Opinion No. 01-20.
11 See, e.g., Hospice and Nursing Home Contractual Relationships, OEI-05-95-00251, November 1997; Fraud and Abuse in Nursing Home Arrangements with Hospices, OIG Special Fraud Alert, March 1998; OIG Advisory Opinion No. 01-20.
12 Draft OIG Supplemental Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 20680, 20692.

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