# Nursing Homes; Assisted Living Facilities – Hospice and Nursing Homes: Risk Areas

Over the years, HOW has been very involved in structuring relationships with nursing homes that have met all of the regulatory requirements. HOW has been in the forefront nationally with regard to clarifying the coordination of the care plan and the interface of two disparate sets of regulations. We have obtained the full cooperation and collaboration of the regulators and have served as a national model. Aside from the regulatory hurdles, however, we have another issue in structuring relationships with nursing homes. This is the federal False Claims Act and particularly its anti-kickback provisions, that impact our relationships with nursing homes.

A reading of the comments submitted to the Office of the Inspector General with regard to Hospice Compliance Guidance is telling. Many of the comments focus on relationships between hospices and nursing homes. For example, the comment submitted by the Indiana Office of Medicaid Policy and Planning complains that since implementation, "Indiana Medicaid has noted that the percentage of individuals residing in a nursing facility range from 75% to 81%. Based on our dialogue with other states that also have a Medicaid hospice benefit, the number of hospice recipients residing in a nursing facility is about the same as Indiana. This raises several fraud and patient care issues ranging from the appropriateness of hospice care for that nursing facility resident to the improper coordination of services between the hospice provider and the nursing facility provider. For instance, Indiana Medicaid's Prior Authorization Unit has noted that several individuals who have elected hospice ¼ (have) hospice primary diagnoses include anorexia, debility, failure to thrive ¼ . We are aware that a recent OIG web site article has noted that 'OIG found a significant portion of Medicare hospice patients in nursing facilities were ineligible for the Medicare hospice benefit.' Specifically, 29% of sampled hospice beneficiaries in nursing facilities were found ineligible compared to only 2% of hospice beneficiaries in the private home (OEI-0493-00270). The Indiana Office of Medicaid Policy and Planning is very concerned about this since Medicaid always pays for nursing facility room and board after the 100 Medicare skilled nursing care days have been exhausted."

The Indiana letter makes a number of recommendations, including more scrutiny of the hospice physician certification. Specifically Indiana Medicaid suggests: it is

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imperative to stress that a physician has the responsibility to truly review the information on the form that states the individual is terminally ill. Currently, hospice medical directors or the physician member of an interdisciplinary team and the attending physician must certify the individual as appropriate for hospice care. If they are, in fact, fulfilling their responsibilities, then we question why are so many hospice patients in nursing facilities found to be ineligible for hospice care." The Indiana correspondence continues: "Hospices need to have checks and balances for the physician certification process to ensure the hospice medical director or the physician thoroughly review the physician certification form before providing his/her signature."

While this is not simply a nursing home issue, the recent fraud alert to physicians with regard to home health and DME sounds a warning signal: physicians, long reluctant to certify people into hospice because of the six month prognosis requirement, may feel an additional chilling effect as a result of recent fraud alerts. It is important that hospices offer assistance to physicians in sorting out hospice eligibility. A strong and compelling argument is that while inappropriate certifications into hospice are wrong, so is the unwillingness to certify those patients who are appropriate.

In addition to the question of inappropriate admissions to hospice for nursing home residents eligible for Medicaid, questions of free care and kickback are particularly troublesome in the nursing home environment. While HCFA has recently made it clear that they are not interested in pursuing hospices and nursing homes when the hospice has negotiated to pay the nursing home at 100% of the nursing home's room and board rate, there are other more troubling issues regarding overlapping responsibilities. If the hospice is obligated to pay for home health aides, consistent with the plan of care, and the nursing home under its room and board rate is likewise obligated to pay for CNAs, where is the line? These questions must be thoroughly reviewed with the nursing home and protocols established to ensure that both parties are meeting their regulatory obligations and that the hospice is not providing a service as an inducement to obtain a referral from the nursing home.

Because nursing homes are clearly an OIG target, the relationship between the hospice and the nursing home in terms of kickback must be part of every hospice's compliance plan. The following activities are particularly suspect:

1. **Provision of Free Care to Nursing Home Patients Who Have Revoked the Hospice Benefit in Order to Obtain Medicare Part A, SNF Coverage**.


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Many hospices have, over the years, provided such free care. Such free care may constitute an impermissible kickback. Any free care, but particularly free care in the nursing home, should be carefully structured to avoid scrutiny. If care is based on a sliding scale designed to assist those who do not have the ability to pay, or if the free care is clearly mission-driven without any inducement to refer into the Medicare hospice benefit, then such free care may be permissible. However, it is important to review the program very carefully to assure compliance.

2. **Payment from the Hospice to the Nursing Home for Services That the Nursing Home Is Obligated to Provide**. If the hospice is purchasing services from the nursing home, this purchase must be market driven and must not include services the nursing home is required to provide. If the hospice is paying 95% (or even 100%) of the nursing home's room and board rate for Medicaid eligible hospice patients, and is in addition paying for services provided by the nursing home, it must be ascertained that those additional services are not in fact part of the room and board rate. For example, if the hospice is purchasing or renting DME or supplies from the nursing home, the hospice should be certain that such DME/supplies are not already covered under the room and board charge.
3. **Pain Consultations to the Nursing Home**. Once again, anything of value in cash or in kind given to induce a referral is a target for anti-kickback scrutiny. If a hospice is providing pain consults in the nursing home at no charge to the nursing home, query whether these are being provided as an inducement for the nursing home to refer patients to the hospice. If on the other hand, the hospice is providing free consults on pain management throughout the entire community as part of its mission, and such consults are funded through memorials, bequests or community funding such as United Way, the analysis could be quite different.

## Conclusion

Aside from the federal and state regulatory considerations, the Federal False Claims Act requires hospices to scrutinize all of their relationships with other providers, but most importantly with nursing homes. In particular, hospices are encouraged to review, as described by Jay Mahoney, former NHO President and currently principal of Summit Business Group, the following situations where a nursing home demands or a hospice offers:

- "Goods/services free or at below fair market value in exchange for referrals.


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- To pay the nursing home for services that Medicaid considers being included in the Medicaid daily rate.
- To establish a quid pro quo process for referrals.
- To provide free or below market value care to nursing home patients for whom the nursing home is receiving another payment, e.g., Medicare skilled nursing benefit, with the expectation that when the benefit is exhausted the patient will receive hospice care under the Medicare/Medicaid Hospice Benefit.
- To provide staff at the hospice's expense to perform duties that would otherwise be performed by the nursing home."

Mr. Mahoney goes on to point out the additional problem of hospices reducing the level of services that patients in a nursing home or their families receive. HCFA data demonstrates that hospice nursing home patients have been receiving far less in services than hospice patients residing in their own homes.

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