

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Science Board to the Food and Drug Administration.

General Function of the Committee: To provide advice and recommendations to the agency on FDA regulatory issues.

Date and Time: The meeting will be held on May 19, 1998, 9 a.m. to 3:30 p.m.

Location: Doubletree Hotel, Plaza Room, 1750 Rockville Pike, Rockville, MD.

Contact Person: Susan K. Meadows, Office of Science (HF-32), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-827-4591, or FDA Advisory Committee Information Line, 1-800-741-8138 (301-443-0572 in the Washington, DC area), code 12603. Please call the Information Line for up-to-date information on this meeting.

Agenda: Information will be presented to the board regarding: (1) FDA's research and science programs, (2) the process for peer review and findings from the Subcommittee for the Center for Biologics Evaluation and Research Review, (3) the status of the Biomaterials Forum project (a process for information exchange addressing issues in biomaterials science), (4) the activities of the Science Board Subcommittee on Toxicology, and (5) a proposed model for support for FDA Science.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person by May 1, 1998. Oral presentations from the public will be scheduled between approximately 2 p.m. and 3 p.m. Time allotted for each presentation may be limited. Those desiring to make formal oral presentations should notify the contact person before May 1, 1998, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: April 17, 1998.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 98-10970 Filed 4-23-98; 8:45 am]

BILLING CODE 4160-01-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Publication of OIG Special Fraud Alert: Fraud and Abuse in Nursing Home Arrangements With Hospices

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This **Federal Register** notice sets forth a recently issued OIG Special Fraud Alert concerning fraud and abuse practices involving nursing home arrangements with hospices. For the most part, OIG Special Fraud Alerts address national trends in health care fraud, including potential violations of the Medicare anti-kickback statute. This Special Fraud Alert, issued to the health care provider community and now being reprinted in this issue of the **Federal Register**, specifically identifies and highlights some vulnerabilities in nursing home arrangements with hospices and instances of potential kickbacks between nursing homes and hospices to influence the referral of patients.

FOR FURTHER INFORMATION CONTACT: Joel J. Schaer, Office of Counsel to the Inspector General, (202) 610-0089.

SUPPLEMENTARY INFORMATION:

I. Background

The Office of Inspector General (OIG) issues Special Fraud Alerts based on information it obtains concerning particular fraudulent and abusive practices within the health care industry. These Special Fraud Alerts provide the OIG with a means of notifying the industry that we have become aware of certain abusive practices which we plan to pursue and prosecute, or bring civil and administrative action, as appropriate. The Special Fraud Alerts also serve as an effective tool to encourage industry compliance by giving providers an opportunity to examine their own practices.

Special Fraud Alerts are intended for extensive distribution to the health care provider community, as well as those charged with administering the Medicare and Medicaid programs. To date, the OIG has published in the **Federal Register** the texts of 8 previously-issued Special Fraud Alerts (December 19, 1994, 59 FR 65372; August 10, 1995, 60 FR 40847; and June 17, 1996, 61 FR 30623), and we have indicated our intention of publishing future Special Fraud Alerts in this same

manner as a regular part of our dissemination of such information.

With regard to nursing home arrangements with hospices, this newly-issued Special Fraud Alert discusses (1) the nature of hospice care and who is eligible to receive such care; (2) the reimbursement for hospice care provided by nursing homes; (3) the vulnerabilities in nursing home arrangements with hospices; (4) several suspected kickback arrangements that are designed to induce Medicare or Medicaid referrals. A reprint of this Special Fraud Alert follows.

II. Special Fraud Alert: Fraud and Abuse in Nursing Home Arrangements With Hospices (April 1998)

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.

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.

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.

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.

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.

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:

Field offices	States served	Telephone
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	215-861-4586
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

To Report Suspected Fraud, Call or Write

1-800-HHS-TIPS (1-800-447-8477), Department of Health and Human Services, Office of Inspector General, P.O. Box 23489, L'Enfant Plaza Station, Washington, D.C. 20026-3489.

Dated: April 15, 1998.

June Gibbs Brown,

Inspector General.

[FR Doc. 98-10907 Filed 4-23-98; 8:45 am]

BILLING CODE 4150-04-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a list of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these

documents, call the SAMHSA Reports Clearance Officer on (301) 443-7978.

Substance Abuse Prevention and Treatment Block Grant Application Format: FY 1999-2001-0930-0080 (Revision)—The Public Health Service Act (42 U.S.C. 300x21-35 & 51-64) authorizes block grants to States for the purpose of providing substance abuse prevention and treatment services. Under the provisions of the law, States may receive allotments only after an application is submitted and approved by the Secretary, DHHS. For the FY 1999 Substance Abuse Prevention and Treatment (SAPT) Block Grant cycle, SAMHSA will provide States with slightly modified application forms and instructions. These changes affect the portion of the application that asks for information related to section 1926 (sales of tobacco to minors). The application no longer requires a description of sampling methodologies and procedures for identifying and selecting tobacco outlets to be sampled throughout a State, unless a change to such methodologies or procedures has occurred in the previous year. The application provides for more detailed information on the results and validity

of the random unannounced inspections, and it will request greater detail on the number and results of actual enforcement activities that a State has undertaken. At the request of the Department, SAMHSA is including an additional tobacco-related question in Attachment 6 of the application. This question requires States to briefly describe collaboration between each State's Tobacco and Health Office (ASTHO representative) and Single State Authority for Substance Abuse (NASADAD representative). Because Federal funds for tobacco prevention and control efforts are, in most cases, awarded to different State-level agencies, it is necessary for the Department and SAMHSA to verify and understand interactions at the State level on youth tobacco prevention and enforcement. SAMHSA has modified the race/ethnicity categories in Form 9 to comply with recent revisions to OMB Directive No. 15. These modifications are not expected to increase respondent burden.

The annual burden estimate for the SAPT Block Grant Application Format is shown below:

	Number of respondents	Responses per respondent	Hours per response	Total hours
1 ¹		1	530	530
59		1	563	33,217
Total				33,747

¹ Red Lake Indian Tribe (exempt from Tobacco Regulation requirements).

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to: Daniel Chenok, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, D.C. 20503.

Dated: April 17, 1998.

Richard Kopanda,

Executive Officer, SAMHSA.

[FR Doc. 98-10921 Filed 4-23-98; 8:45 am]

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DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR-4349-N-14]

Submission for OMB Review: Comment Request

AGENCY: Office of the Assistant Secretary for Administration, HUD.

ACTION: Notice.