The legal and regulatory aspects of hospice and palliative care can seem hopelessly complex, but don’t despair! In this article, and the one to follow, I’ll help you gain a powerful and clear perspective which will assist your efforts to serve your organization, patients and their families.

All hospice care is palliative care, but not all palliative care is hospice. The very word “hospice” stirs up both positive and negative thoughts. Hospice care uses an interdisciplinary approach of services provided by physicians, nurses, social workers, pastoral counselors, music and art therapists, nutritionists, physical and occupational therapy - all to provide physical and emotional comfort, pain management and symptom control for the patient. The family and caregivers also provide support in caring for the patient and they need support to prevent burnout. Later they become candidates for bereavement services. However, as a prerequisite for coverage under the Medicare hospice benefit, the patient must have a terminal illness whose prognosis is six months or less if the illness runs its normal course, and the patient must actively elect to forgo curative treatment for his terminal illness.

How does hospice treatment of the patient differ from palliative care? Essentially, there is no difference: palliative care also follows the same holistic approach of providing for the comfort, pain management and symptom control of the patient’s physical symptoms, as well as addressing the spiritual and psychological needs of the patient and providing support to the family. It has been said that “loosely defined, palliative care means making every day the best it can be. It means comfort care for pain and symptom control. It means sensitivity to the needs of the whole patient - emotional and spiritual as well as physical. It means support for the family in their care taking role, and in preparing for the changes to come. It means all that hospice has always done.” Interestingly, in Chinese the symbol for palliative care means “nurturing living.” While receiving the same care, the palliative care patient need not be terminally ill or have a life-threatening illness, and he can still pursue curative treatment while receiving palliative care. A palliative care program is a comforting first step for a patient who is facing his mortality, but who is not yet able to acknowledge his condition and elect hospice care.

Have you been frustrated in locating the state and federal regulations describing the requirements of palliative care and its reimbursement methodology? I’m not surprised: there are none. Since this is a relatively new area in medicine, the revenue streams for palliative care programs depend upon how the palliative care is provided, and require creative programs funded by current reimbursement opportunities. Thus, a palliative care consult team in a hospital with oncologists, anesthesiologists, psychiatrists, neurologists, neurosurgeons, pain management specialists, physician assistants, nurse practitioners, psychologists, and therapists will have both Medicare Part A (the appropriate DRG for the inpatient hospital care) and Part B reimbursement for professional services. On January 1, 2002, CMS issued Program Memorandum 2001-2 which adds a New Specialty Code (72) for physicians who provide pain management services. Many managed care organizations offer a palliative care program, and this may include a Medicare Part C managed-care plan. Home Health Agencies with palliative care programs can bill Medicare Part A under its prospective payment system. Private pay and third party insurance coverage may also be involved. Finally, a contractual relationship between the palliative care program and another provider also may provide a source of revenue. For example, a certified home health agency (CHHA) may contract with a hospice for use of its specially-trained nurses and social workers. The contract sets forth the payment to the hospice for use of its nurse by the home health palliative care program.
Since palliative care programs are emerging in a variety of settings, such as hospitals, nursing homes, physician practices, home health agencies, and managed care programs, there are existing complex rules which impact these programs and require legal analysis. There are rules for Medicare and Medicaid reimbursement and certification, licensing, fraud and abuse involving kickbacks, patient inducements or solicitations, self-referral and cost reporting. All should be examined as they apply to the palliative care program’s structure.

Licensing Issues of Palliative Care Programs

A good place to start is to determine if the provider’s state license permits it to offer palliative care services. For example, in New York State a hospice must be licensed by the State Department of Health and provide hospice services. Because the state license and Medicaid hospice rules mirror the federal Medicare hospice rules including eligibility and services provided, a hospice in New York could not offer nursing services as part of a palliative care program to a patient who is not terminally ill. According to the State, if a licensed hospice contracts with another provider, such as a CHHA, to lease a hospice nurse to the CHHA palliative care program, the hospice is acting as a private duty nursing service for which it is not licensed.

The need to address this issue became evident when many third-party payors (such as HMOs) were approaching hospices to contract with them to provide palliative care to patients who did not meet the Medicare definition of “terminally ill” (which had been adopted by the State), or chose not to elect hospice care, or were still pursing curative care to prolong life or for recovery. The Hospice and Palliative Care Association of New York addressed the issue by proposing a new law, which was adopted on July 23, 2002. Public Health Law § 4012-b permits a hospice acting alone or under contract with a certified home health agency, a long term home health care program (NY version of PACE), a licensed home care services agency, or an AIDS home care program to provide palliative care to patients “with advanced and progressive disease and their families.” A hospice palliative care program in New York may bill third-party payors, but not Medicare or Medicaid or other government funded health plans for these palliative care services. A physician’s certification that the patient is terminally ill with a prognosis of six months or less if the illness runs its normal course is not required.

This new law in New York is consistent with a relatively recent CMS Program Memorandum (PM) A-02-102, entitled “Medicare Certified Hospices - Clarification of Acceptable Parameters for Some Contractual Arrangements”, issued October 25, 2002. The PM permits a hospice to contract with another entity for the provision of services that are not considered hospice services. The rationale for this rule is that the definition of Medicare hospice services found at § 1861(dd) of the Social Security Act requires that a hospice program be “primarily engaged” in providing hospice care and services to terminally ill patients. The loophole is that “primarily” does not mean “exclusively.” The PM gives examples of different contract relationships where another health care entity purchases some of the “highly specialized staff time or services of a hospice” for their patient needs. These services are not hospice services, but become part of the package of services of the contracting provider to offer palliative care.

A good example in the PM is a Medicare beneficiary receiving skilled services from a Medicare certified home health agency (CHHA). The beneficiary is diagnosed with a terminal illness but refuses to elect hospice care because he wants to pursue curative treatments. The patient is in pain. The CHHA purchases from the hospice “specialized pain control services” and “specialized nursing services.” The hospice bills the CHHA pursuant to the terms in its contract, and the CHHA pays the hospice directly. Neither provider bills Medicare for the contracted services. Instead, those services are reimbursed to the CHHA in its episode payment under the
Medicare prospective payment system for CHHAs. The amount of Medicare reimbursement to the CHHA depends on which Home Health Resource Group (HHRG) applies to the patient (there are 80 HHRGs). Its selection depends on how the patient scores on the OASIS evaluation. The 23 OASIS questions which assess the patient’s clinical severity domain, functional status domain (Activities of Daily Living) and service utilization domain, dictate the HHRG. Also, where the patient lives and is treated determines which Metropolitan Statistical Area (MSA) applies to the Medicare payment. Since this patient remains a CHHA patient in its palliative care program, the CHHA must maintain the patient’s medical record including documentation from the leased hospice staff.

Medicare Reimbursement Requirements In the CHHA Palliative Care Program

For the CHHA palliative care program which contracts for hospice staff services to receive any reimbursement from Medicare, the patient must be eligible for home health services under Medicare pursuant to 42 C.F.R. §409.42. He must be confined to the home, under the care of a physician, in need of skilled services on a part-time or intermittent basis pursuant to a plan of care signed by a physician, and the services must be provided by a CHHA or under arrangement.

Medicare also requires that at least one of the qualifying services be provided directly by CHHA employees. These include skilled nursing, physical, speech or occupational therapy, pursuant to 42 C.F.R. §409.44, §409.45, and §484.14(a). Therefore, the CHHA must make sure that the contracted service from the hospice for its palliative care program is not the one qualifying service. So, if nursing is the CHHA’s qualifying service, the CHHA cannot contract with the hospice for nurses, unless the CHHA decides to choose another service to be provided directly by CHHA employees.

Fraud and Abuse Safe Harbor and Contracting Requirements In The CHHA Palliative Care Program

The hospice and CHHA may refer patients to each other. Thus, their contract must meet the safe harbor provisions for personal services and management contracts against the anti-kickback laws. The anti-kickback statute is a broad prohibition of the offer, solicitation, payment or receipt of anything of value (direct or indirect, overt or covert, in cash or in kind) which is intended to induce the referral of a patient for an item or service that is reimbursed by all federal programs, including Medicare, Medicaid, TRICARE, and programs covering veterans’ benefits. Social Security Act § 1128B, 42 U.S.C. § 1320a-7b. The federal government has authority to enforce the law through criminal prosecution and, upon conviction, impose substantial fines and forfeitures, and imprisonment for up to five years. A violation also serves as the basis for exclusion from the Medicare and Medicaid programs, as well as other federal programs; the result is no reimbursement from any government funded sources. CMS also has the authority to impose an administrative penalty of up to $50,000 for each kickback violation.

To address the problems created by the broad language of the federal anti-kickback statute, Congress added several exceptions and the Department of Health and Human Services (“HHS”) adopted implementing regulations which describe financial relationships which are a “safe harbor” to the anti-kickback law. Compliance with a “safe harbor” is a defense to an anti-kickback law prosecution by the Office of Inspector General (OIG) or the Department of Justice (“DOJ”). To qualify for safe harbor protection, all of the requirements specified in the applicable statute or regulation must be met. Note that failure to meet all of the elements of a safe harbor does not mean that the financial relationship is an automatic kickback. Whether a kickback exists depends on the intent
of the parties. It is vital that health care attorneys analyze the financial, ownership, contractual, and business relationships surrounding referral sources and the purchase, lease, order for, or arrangement of any service, item or facility for which payment may be made under Medicare, Medicaid or any other federally funded health care program.

There are safe harbors for many business relationships including investment interests; space rental; equipment rental; personal services and management contracts; sale of practice, referral services; warranties; discounts; employees; group purchasing organizations; waiver of beneficiary co-insurance and deductible; and others. The safe harbor that applies to our example, where the CHHA is leasing hospice staff to care for CHHA patients, is found at 42 C.F.R. § 1001.952(d) and is used for contracts involving personal services and management. The regulation requires the following be met for the safe harbor to apply:

As used in section 1128B of the Act, “remuneration” does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following seven standards are met -

(i) The agency agreement is set out in writing and signed by the parties;

(ii) The agency agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent;

(iii) If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals;

(iv) The term of the agent agreement is for not less than one year;

(v) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arm’s-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a state health care program;

(vi) The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law; and

(vii) The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

So, the contract between the CHHA and the hospice must contain each of the above requirements to meet the safe harbor against allegation of kickback when the CHHA contracts for hospice staff, while both providers are referring patients to each other.

Cost Report Requirements In The CHHA Palliative Care Program

Both the CHHA and hospice are required to file cost reports with their fiscal intermediary. Even though their actual reimbursement is not determined by the cost report because of PPS for CHHAs and the per-diem rate for
hospices, cost reporting regulations must be complied with. All cost reports have a signed attestation in which the provider affirms that all regulations have been met in the filing of the cost report. Therefore, in the CHHA/hospice palliative care model cost report rules relating to allocation of the salaries and associated fringe benefits which reflect the amount of time the contracted hospice staff is working for the CHHA’s palliative care program must be documented with time sheets or another methodology approved by the hospice’s fiscal intermediary. 42 C.F.R. Part 413 and Provider Reimbursement Manual HIM-15. Failure to do so may result in a reclassification of the salaries and fringe benefits of the contracted hospice staff to “non-allowable” in the hospice cost report, and ultimately impact on hospice per-diem rates because cost report data is used to determine those rates.

Conclusion

There are other types of palliative care programs. In the next article I will discuss the complex rules and issues covering inpatient hospice programs, hospital palliative care programs, managed care opportunities, the physician practice model, hospice or palliative care nurse liaison in hospital or nursing home setting, and other fraud and abuse issues.

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