Introduction

This article continues our journey analyzing the different provider settings in which palliative care services can be offered to patients. Our focus continues to examine the matrix of federal and state laws and regulations that impact reimbursement streams, and fraud and abuse concerns. The rules to comply with depend upon the provider setting in which the palliative care services are offered. State licensing requirements are the first hurdle for any provider, and were covered in the first article. Also discussed were the issues for a palliative care program ("PCP") in a home health agency. Here we now explore other settings for PCPs including physician practice, hospital, inpatient hospice program, managed care, and hospice or PCP nurse liaison in a hospital or nursing home.

Physician Practice Specializing In Palliative Care

There is recent interest by hospices and PCPs to structure contract arrangements with physician groups that specialize in palliative care. The physician group is a Part B Medicare provider. The typical arrangement is for the hospice or PCP to serve as a management service organization ("MSO") by entering into a management and administrative services contract with the physician group. Typical services provided by the MSO are staff, equipment, space and general administrative services. Administrative services may include budgeting, bookkeeping, arranging for legal and accounting services, purchasing inventory and supplies, assisting in the recruitment of practitioners, maintaining files and records, assisting in strategic planning, payroll and billing.

The health care industry has seen a large number of physician practices enter into relationships with MSOs, whereby the MSO is paid a sum of money to provide administrative “back office” services to the physician group. These contract relationships free up physician time for treating patients. Some hospices in New York are experimenting with this concept by creating a separate legal entity and applying for a license as a Diagnostic and Treatment Center, which is basically a clinic specializing in palliative care services.

This type of relationship created between the hospice or PCP and the physician group is sometimes referred to as a “captive professional corporation” because the hospice or PCP exerts some control over the physician group as a result of the contractual relationship. The relationship created should be analyzed against state corporate practice of medicine laws, fee splitting laws, federal (Stark) and state self referral laws, and safe harbors of anti kickback provisions covering the various contractual relationships, for example personal services, management, lease, and/or equipment rental.

A corporate practice of medicine prohibition prevents a business corporation or lay person from controlling the medical decisions of a physician and his or her professional staff. As a result, a business corporation may not employ and may be limited in contracting opportunities to hire licensed professionals to provide medical services. With the rise of the physician practice management companies over the last decade, many physician practices have ceded aspects of their control of the day-to-day business affairs to business corporations. The corporate practice of medicine prohibition is implicated to the extent that the management company exercises any control over the medical judgment or professional decision-making of a licensed practitioner. Therefore, it is imperative, particularly in states with broad corporate practice restrictions, such as New York, that a management services contract expressly avoids restricting the licensed practitioner’s professional judgment. A physician’s
participation in such an arrangement may be viewed by the state as “unprofessional medical conduct” and subject the physician to sanction under the professional conduct rules of the state.

If the hospice or PCP seeks to establish a medical professional corporation, a health care attorney should review the proposed organizational documents, for example the articles of incorporation and bylaws, to ensure that the physician has sufficient control. It could be problematic if the bylaws sought to limit the ability of the physician shareholders to receive distribution from the professional corporation. Similarly, a health care attorney should review bylaws and stock transfer agreement provisions that seek to force the sale of the physician’s shares upon certain triggering events, or prohibiting the physician from voting on specified matters.

With respect to the MSO, both parties should evaluate the degree to which the hospice or PCP controls the money flow to the physician group. The more control exercised by the non-physician entity, for example through budgetary constraints, the more likely the arrangement will be problematic and a possible violation of any state corporate practice of medicine laws.

A successful example of the contractual relationship between a hospice and a palliative care physician group is the Palliative Care Center of the Bluegrass (“the Center”). Created “to advance the concept of palliative care and reach a broader population not yet appropriate for hospice care, the Hospice of the Bluegrass established an outpatient palliative care service as a separately incorporated non profit medical practice in January 1999. The practice is certified for Medicare Part B provider billing and meets licensing and tax requirements ....” The Center operates an outpatient clinic in rented space on the campus of their local hospital. It also is “a base” for the local hospital’s palliative care consulting services. The physician group includes the Medical Director of the Hospice of the Bluegrass, the local hospital’s advanced practice palliative care nurse, a licensed clinical social worker and a part-time administrator of the physician group. The Center’s mission is to serve patients with “incurable diseases” and “limited life expectancies.” Patients are referred to the Center for pain and symptom management. Palliative care services are offered, along with regular treatment. The Center may offer physician consultation services, primary physician services, and home physician consultation visits for a local managed care plan.¹

**Hospital Palliative Care Teams**

A hospital may have a palliative care consulting team consisting of a physician pain specialist or oncologist, nurse practitioner, social worker, and pastoral counselor. These teams assist with discharge planning. Members of the team are hospital employees and physicians. Reimbursement for members of the palliative care team in a hospital setting include the appropriate DRG (pain management, radiation and related patient diagnoses) for the hospital; the physician bills Medicare Part B, Medicaid and other insurance; and the nurse practitioner bills Part B for services or insurance, if appropriate. However, there is no reimbursement stream for some of the team’s services such as counseling. Private fund-raising may pay for these services.

A hospital’s PCP could also contract with a hospice to provide trained nurses, social workers, counselors, therapists, or palliative care training. Similar issues discussed in the first article such as state licensing, kickbacks safe harbors, and cost allocation on cost reports apply.

¹ The source of the quotations is the National Hospice and Palliative Care Organization publication entitled “Hospital – Hospice Partnerships In Palliative Care: Creating a Continuum of Service” at page 21.
Hospice and Hospital or Nursing Home Contracts For Inpatient Hospice Care Units

An inpatient hospice unit in a hospital or skilled nursing home is created by a contract with a hospice for short-term admission of hospice patients for pain control, symptom management or respite purposes that cannot be managed in other settings. Hospice is still involved in providing services required in the hospice plan of care. Hospice pays the hospital or nursing home a per diem rate negotiated between the parties as stated in their contract.

These contracts are strictly governed by federal regulations and rules found at 42 C.F.R. §§ 418.98, 418.302(a)(4), 418.56(e) and State Operations Manual, Pub. 7. Requirements include that the hospital or nursing home meet the requirements of § 418.98, including 24-hour nursing services and patient areas. Pursuant to 42 C.F.R. 418.56(e), the contract must at a minimum state:

1. That the hospice furnishes to the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;
2. That the inpatient provider has established policies consistent with those of the hospice and agrees to abide by the patient care protocols established by the hospice for its patients;
3. That the medical record includes a record of all inpatient services and events, and that a copy of the discharge summary and, if requested, a copy of the medical record are provided to the hospice;
4. The party responsible for the implementation of the provisions of the agreement; and
5. That the hospice retains responsibility for appropriate hospice care and training of the personnel who provide the care under the agreement.

My sample hospice/hospital contract for inpatient hospice services are found at the websites for [www.arentfox.com](http://www.arentfox.com) and [www.capemssm.org](http://www.capemssm.org).

Managed Care Reimbursement Opportunities For PCP

Palliative care providers and hospices may contract with hospitals and other providers, who have contracts with managed care plans to provide comprehensive palliative care services under a capitated rate. With approval from the managed care organization (“MCO”), the hospital could subcontract or “carve out” with the PCP or hospice to provide such services at a negotiated rate. Another possibility is for a PCP or hospice to contract directly with the MCO to provide all palliative care services of covered patients. An example, is the Support Blue Program of Blue Cross/Blue Shield of Western New York which is a palliative care HMO program.

Hospice Or Palliative Care Nurse Liaison In A Hospital Or Nursing Home

The reason for placing a hospice or PCP liaison nurse in a hospital or nursing home may be two-fold: for intake coordination and/or discharge planning activities. Intake coordination is the management of the transfer of the patient from the hospital to the hospice or PCP. This occurs only after the patient’s physician has referred the patient to hospice or the PCP. Coordination activities include: (1) explaining the hospice or PCP’s policies to patients and family; (2) creating the plan of care after discharge; (3) assuring that the hospice or PCP is ready
to meet the patient’s needs at the time of discharge; and (4) communicating and coordinating the post-discharge care.

Discharge planning includes review of hospital records, and assessing the patient for the purpose of determining the level of care a patient will require upon discharge. Discharge planning is the hospital’s responsibility pursuant to the Medicare conditions of participation for hospitals. See 42 C.F.R. § 482.43. Discharge planning functions are not properly reimbursable to a hospice or PCP because reimbursement for this activity is included in the hospital’s DRG rates.

The second problem is a cost report issue for the hospice because the hospital’s discharge planning activities are not costs related to the care of a hospice patient. The same theory applies for a PCP if it is an entity that files a cost report with Medicare. Including all of the nurse liaison’s salary and related expenses on the hospice cost report could be a false claim or false statement violation. See 31 U.S.C. § 3729 et seq.; 18 U.S.C. § 1001.

These issues need to be examined by health care counsel who may be able to construct the relationship so that a safe harbor to the kickback laws applies. For example, the hospice or PCP employee could be leased to the hospital to provide discharge planning services. The contract should be in writing, specify the services, a schedule on which they are provided, for a term of a year or more, for fair market value, and without consideration of the value or volume of referrals from the hospital. The services contracted for must not promote or counsel a business arrangement or activity that violates any Federal or state law. Finally, the services contracted for must be reasonably necessary to accomplish the commercially reasonable business purpose of the services. This contract would meet the Personal Services and Management Contract safe harbor under the kickback law. 42 C.F.R. § 1001.952(d).

The cost report issue is addressed by the nurse liaison keeping time records to indicate time spent on discharge planning activities versus intake activities. This information is needed to allocate the costs of the hospice or PCP liaison on the cost report between allowable and non-allowable costs for the hospice or PCP. The fiscal intermediary must approve the cost allocation methodology prior to its implementation. The Provider Reimbursement Review Manual - Pub. 15, § 2113 et al. address the rules relating to education and intake activities versus discharge planning activities. These rules are summarized in a compliance tool on the subject appearing at the website of www.arentfox.com.

**Conclusion:**

This article raises issues for you to think about as a provider of palliative care. An exhaustive discussion of all of the issues and possible solutions is not possible. However, you should now have some guidance in figuring out what issues need to be addressed by health care counsel in creating the provider setting for your palliative care program.

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