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Palliative Care Legal Requirements, New State Laws, and How to Partner with ACOs and Medical Homes

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NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION

Palliative Care vs. Hospice Care

1. Both defined by Federal and State laws.
2. Hospice Eligibility requirements.
3. Hospice Election requirements.
4. Reimbursement streams for Hospice are routine, continuous, respite and inpatient Hospice care per diem rates.
   42 C.F.R. § 418.302 and § 418.306.

Palliative Care vs. Hospice Care

5. Revenue streams for Palliative Care - .
   a. Medicare Part A – Hospital, outpatient Hospital services, certified home health service
   b. Medicare Part B – physicians, physician assistants, nurse practitioners, psychologists, therapists (PT/OT), DME suppliers
   c. Medicare Part C – managed care
   d. Contract relationships between providers
   e. Private pay, and third party insurance

Federal Definitions

Hospice Care - A comprehensive set of services described in SSA §1861(dd)(1) , identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.
42 C.F.R. 418.3

Palliative Care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative Care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs to facilitate patient autonomy, access to information, and choice. 42 C.F.R. 418.3

NYS Definitions

Hospice - A coordinated program of home and inpatient care which treats the terminally ill patient and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous Hospice administration. The program provides palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness, and during dying and bereavement.
10 N.Y.C.R.R. 700.2 (a)(23)

NYS Definitions

Palliative Care means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including Hospice care. NYS Public Health Law § 2997-c(c) and 2997-d(a)

Palliative and Supportive Care shall mean services provided for the reduction and abatement of pain and other symptoms and stresses associated with terminal illness and dying. 10 N.Y.C.R.R. § 700.2 (c)(58)

A. Organization Design Options for Palliative Care Program (PCP)

I. Physician Part B Group
II. Hospice/Hospital or LTCF Contract
III. Hospice/PC Nurse Liaison in Hospital
IV. Managed Care Payment Opportunities
V. Certified Home Health Agency (CHHA)
VI. Hospice Contract for Inpatient Hospice Care 42 C.F.R. §§ 418.108, 418.110, and 418.302(a)(3) and (4)
VII. Accountable Care Organization (ACO) Provider or Medical Home Team

I. Part B Physician Practice

1. Corporate Practice of Medicine Rules Impact.
2. Create a separate entity Professional Corporation or Professional Limited Liability Company.
3. Apply for Part B "supplier" number from local Medicare fee for service contractor.
4. Medicare Applications CMS-855B, 855I, 855R, Participating Provider Agreement & Electronic Funds Transfer.

II. Hospice Contracts with Hospital or LTCF to Provide PC Specialists

1. Hospital contracts for Hospice physicians, nurses, social workers, counselors or for Palliative Care (PC) training.
2. Nurse Practitioners jointly funded.
3. Contract issues apply, *i.e.*, kickbacks, safe harbors, Stark, costs allocation on cost report.

III. Hospice/PC Nurse Liaison

1. Contract between Hospice and Hospital or LTCF for liaison nurse.
2. Rules for Intake Coordination vs. Discharge Planning (D/P) activities apply. 42 CFR § 482.43 & handout
3. Potential Kickback, Cost Report, and False Claim issues. 42 U.S.C. § 1320a-7b(b)(2). Free discharge planning services, and allocation of liaison's salary and fringe benefits on cost report.

III. Hospice/PC Nurse Liaisons (cont'd)

4. **Intake Coordination** – manage and facilitate transfer of patients from Hospital to Hospice or PCP. Occurs only after patient referred by physician to Hospice or PCP.
   a. Explain Hospice or PCP policies to patients and family after referral.
   b. Establish plan of care prior to Hospital discharge.
   c. Communicate and coordinate post-discharge care.

III. Hospice/PC Nurse Liaisons cont'd

5. **Discharge Planning** – Review Hospital files, individually or during staff discharge planning rounds, to determine level of care patient will require upon D/C. Discharge planning is hospital's responsibility Medicare conditions of participation, and part of DRG.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Discharge-Planning-Booklet-ICN908184.pdf

IV. Managed Care Payment Opportunities

Hospice contracts with managed care plans to provide comprehensive palliative care services under a capitated negotiated rate to covered patients.

V. CHHA Palliative Care Program

1. CHHA contracts with Hospice for nurses and social workers for PC team. Negotiated rate per visit.
2. Kickback Safe Harbor for personal services. 42 C.F.R. § 1001.952(d)
3. PPS – Home Health Resource Groups (HHRGs). OASIS- clinical & functional status (ADLs), service utilization (PT, OT, Speech), and Metropolitan Statistical Area.

4. .

V. CHHA Palliative Care Program cont'd

4. Medicare eligible: home-bound, skilled services on part-time or intermittent basis, plan of care signed by physician. 42 C.F.R. § 409.42.
5. Medicare requires one qualifying service (skilled nursing, PT, ST, OT, or home health aide) be provided directly by CHHA employees. 42 C.F.R. § 409.44 & § 484.14(a) .

VI. Inpatient Hospice Unit

1. Hospital or NH contracts with Hospice to provide inpatient Hospice care. Collaborative plan of care. GIP unit may be part of the Hospital's PCP.
2. Admission is for pain control, acute management of symptoms that cannot be managed elsewhere, or Respite Care.
3. Hospice pays Hospital negotiated per diem rate. Safe harbor personal services against kick-backs.
4. 24-hour nursing required for GIP, not Respite.

VII. Goal of Affordable Care Act (ACA)

- *"Value-Based Purchasing is a concept that links payment directly to the quality of care provided and is a strategy that can help transform the current payment system by rewarding providers for delivering high quality, efficient clinical care."*
- Three Goals: 1) better care for individuals; 2) better health for populations; 3) lower growth in Medicare Part A & B expenditures

76 Federal Register 67802 (November 2, 2011) **http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf**

VII. ACA – Different Models to Improve Extended Community Based Services

SSA § 1899 Accountable Care Organizations, part of the Medicare Shared Savings Program. Effective Jan. 1, 2012. 42 C.F.R. Part 425.

Contract with ACOs to provide services and become an ACO provider. Contract should comply with safe harbor against Kickbacks for personal services.

http://oig.hhs.gov/compliance/accountable-care-organizations/index.asp

VII. Shared Savings Program a/k/a ACO's Goals

1. Accountability and better health care for a patient population.
2. Better individual care by coordinating services and items under Medicare Part A & B.
3. Encourage investment in infrastructure, *i.e.,* electronic medical records.
4. Redesign Care Processes for high quality and efficient service delivery, thus lowering growth in expenditures.

VII. So What do ACO & Medical Homes Have In Common With PCP and Hospices?

- ★ Better care for individuals
- ★ Better health for populations
- ★ Lower growth in expenditures

These goals are same as ACO. PCPs and Hospices employ interdisciplinary approach to care, which engages the patient and family, and the receipt of capitated payments in Hospice encourages efficiency, while maintaining quality care.

VII. ACO Definitions 42 C.F.R. § 425.20

Accountable Care Organization is a legal entity authorized under State, Federal or Tribal law , identified by a Tax Identification Number (TIN), and comprised of Medicare eligible providers and suppliers that work together as an ACO to manage and coordinate care for Medicare fee-for-service beneficiaries (Part A & B).

ACO Participants are providers and supplies who establish a mechanism for shared governance whereby each ACO Participant has a proportionate control over ACO's decision-making process, management, clinical and administrative systems.

VII. Requirements of ACO-SSA § 1899 & 42 C.F.R. Part 425

1. ACO Participants are accountable for quality, cost, and overall care of beneficiaries. § 425.100
2. ACO Participants must have a TIN and National Provider Identifier (NPI), and provide CMS with identifiers to:
   a. support retroactive assignment of Medicare beneficiaries to an ACO;
   b. for quality and reporting requirements;
   c. receive and distribute shared saving;
   d. repay shared losses due CMS.

VII. Requirements of ACO-SSA § 1899 & 42 C.F.R. Part 425

3. Three-Year Contract between ACO and CMS to become accountable for quality, cost and overall care of at least 5,000 Medicare fee-for-services beneficiaries. § 425.110
4. CMS assignment of beneficiary to ACO:

   If primary care physician associated with ACO is responsible for more allowed charges for primary care services provided to a beneficiary than any other provider or supplier during the performance year, then the beneficiary is assigned to that ACO for the purpose of calculating any shared savings. §§ 425.400 – 425.404

VII. Requirements of ACO-SSA § 1899 & 42 C.F.R. § 425.112

5. **Evidence-Based Medicine** is "generally defined as the application of the best available evidence gained from the scientific method to clinical decision making." 76 FR 67827
   a. ACO must describe how it will define, establish, implement and periodically update processes to promote evidence based medicine applicable to diagnoses found in their beneficiary population.
   b. Goal is to improve quality, reduce costs, and address a patient's individual needs.
   c. Electronic Health Records (EHR), to report on quality and cost measures.

VII. Requirements of ACO-SSA § 1899 & 42 C.F.R. § 425.112

6. **Patient-Centeredness Criteria – ACO must engage patients through:**
   a. patient surveys;
   b. coordination of care;
   c. patient involvement in ACO governance;
   d. use of individualized care plans that improve outcomes, and identify high risk patients;
   e. use of materials to communicate clinical information in an understandable manner to beneficiaries;
   f. process for evaluating health needs of ACO assigned population;
   g. patient access to medical records & communications.

VII. Requirements of ACO-SSA § 1899 & 42 C.F.R. §§ 425.600 - 425.608

7. Two ACO Payment Models:
   a. One-sided model – ACO shares savings for 3 years and losses only in third year.
   b. Two-sided model – ACO shares savings and losses for all 3 years. Increase in amount and share of savings to encourage this model.

8. ACO is paid shared savings if it meets:
   a. minimum quality performance standards;
   b. exceeds minimum savings rate compared to a per capita expenditure benchmark; and
   c. maintains eligibility to be an ACO.

VII. Payment & Treatment of Savings 42 C.F.R. § 425

9. CMS will evaluate ACO on five "domains":
   a. patient/caregiver experience
   b. care coordination
   c. patient safety
   d. preventative health
   e. at-risk population/frail elderly health

- CMS will audit to ensure ACOs do not avoid high-risk Medicare beneficiaries.

VII. CMS Innovative Center - Demonstration Models ACA § 3021, SSA § 1115A

CMS has demonstration projects underway whereby they are testing models of care delivery for "defined populations for which there are deficits in care leading to poor clinical outcomes or potential avoidable expenditures." Focus on models to reduce costs, while enhancing quality of care. **http://dhhs.nv.gov/HealthCare/Docs/reimbursement/ACA3021InnovationCenter.pdf**

PCP should explore opportunities to collaborate in demonstration projects.

VII. Various Demonstration Models ACA § 3021, SSA § 1115A

Patient Centered Medical Homes - a health care setting that facilitates partnerships between individual patients and their personal physicians, and if appropriate, patient's family. Care is enhanced by information technology, and other means. Demonstration project is being conducted in 8 states including urban, rural and underserved areas over a 3 year period.

B. Complex Rules Require Expert Legal Analysis

I. State License Laws
II. State Corporate Practice of Medicine Laws
III. Anti-Kickback – Federal and State Laws
IV. Physician Self Referral – Federal (Stark) and State
V. Patient Inducement or Solicitation Laws
VI. Fee-Splitting Rules – State
VII. Cost Reporting Rules – Medicare and Medicaid
VIII. Complex Medicare/Medicaid Reimbursement Rules

C. NYS Hospice & Palliative Care Laws

I. Family Health Care Decisions Act
II. Palliative Care Information Act (PHL 2997-c)
III. Medicaid Redesign Team (MRT) Initiative 109 to expand access to Palliative Care
IV. Palliative Care Access Act (PHL 2997-d)

C. NYS Hospice & Palliative Care Laws

V. Medicaid Redesign Team Initiative #209 to expand access to Hospice
VI. Hospice Modernization Act (A7650)
VII. Pediatric Palliative Care – Care at Home I & II
VIII. Concurrent Care for Children (Federal ACA)

C. NYS Hospice & Palliative Care Laws

IX. Hospice and Managed Care

- Hospice Concurrent with Managed Long Term Care Program (MLTCP)
- Hospice Carved Into Medicaid Mainstream Managed Care (10-01-13)

I. Family Health Care Decisions Act

- FHCDA effective March 2010 (after 17 years!).
- Surrogate decision-making for patients without capacity who do not have a health care proxy.
- Changes processes for withholding & withdrawing life-sustaining therapies including intubation and mechanical ventilation, artificial nutrition & hydration.
- FHCDA Improvement Act, effective July 2011, includes the decision to elect Hospice and consent to the Hospice plan of care, regardless of where the decision is made or where the care is provided.

I. Family Health Care Decisions Act cont'd

FHCDA Surrogates

- Patient's guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81

- Patient's spouse, if not legally separated from the patient, or the domestic partner
- Patient's son or daughter, age 18 or older
- Patient's parent
- Patient's brother or sister, age 18 or older
- Patient's actively involved close friend, age 18 or older

I. Family Health Care Decisions Act cont'd

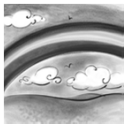
- FHCDA surrogates may make any health care decision for patients in hospitals or LTCFs who:
  - lack medical decision-making capacity, and
  - do not have a health care agent
- FHCDA surrogates may make DNR/DNI decisions for patients in the community, who lack medical decision-making capacity and do not have a health care agent.
- Outstanding issue – the Isolated Patient

II. Palliative Care Information Act (PCIA)

- Effective February 2011.
- Requires physicians and nurse practitioners with primary responsibility to offer information, and counseling about Palliative Care to patients with terminal illnesses.
- Information and counseling to be offered:
  - Range of options appropriate to the patient;
  - Prognosis;
  - Risks and benefits of various options; and
  - Patient's *"legal rights to comprehensive pain and symptom management at the end of life."*
- May be provided orally or in writing.
- If patient lacks capacity, information and counseling is to be provided to the health care decision-maker.

II. Palliative Care Information Act cont'd

- The Palliative Care Information Act was amended in August 2012:
  - Requiring that physicians and NPs offer information regarding other treatment options should the patient wish to initiate or continue treatment.



Where health care practitioner does not feel qualified to provide info/counseling, he/she may arrange for another physician or NP to do so.

II. Palliative Care Information Act cont'd

- *"Palliative Care":* Health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including Hospice care.
- *"Terminal Illness or Condition*": Reasonably expected to cause death within 6 months.
- *"Appropriate":* Consistent with applicable legal, health and professional standards; the patient's clinical and other circumstances; and the patient's reasonably known wishes and beliefs.

II. Palliative Care Information Act cont'd

- "*Attending health care practitioner*": A physician or nurse practitioner who has primary responsibility for the care and treatment of the patient. Where more than one physician or nurse practitioner share that responsibility, each of them has responsibility to offer information and counseling, unless they agree to assign that responsibility to one of them.
- Which clinicians are covered:
  - Physicians and nurse practitioners with "primary responsibility"
  - If physician assistant is treating the patient, the supervising physician is required to comply

II. Palliative Care Information Act cont'd

- DOH Staff and Palliative Care Education and Training Council developed FAQs to assist with implementation. Available at: **https://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/2011-12-14_questions_and_answers.htm**
- HPCANYS developed "PCIA/PCAA Resource Center"
  - Available to HPCANYS members at: http://hpcanys.org/member_access.asp
  - Available to non-HPCANYS members at: www.hpcanys.org

III. Medicaid Redesign Team –(MRT) #109 Facilitate Access to Palliative Care

- **Palliative Care Access Act** PHL 2997-d - effective September 27, 2011.
- Expands on Palliative Care Information Act.
- Applies to hospitals, LTCFs, home care agencies, and enhanced and special needs assisted living residences.
- Applies to patients with *"advanced, life-limiting illnesses or conditions."*

IV. Palliative Care Access Act – PHL2997-d

What entities must provide:

Facilitate access to appropriate Palliative Care consultations and services, including associated pain management, including but not limited to, referrals consistent with patient needs and preferences.

Policies and Procedures:

- Must address how to identify the appropriate patient who will benefit from Palliative Care; and
- Must contain provisions which allow persons who are legally authorized to make medical decisions on behalf of patients who lack capacity so that such information and counseling is provided.

IV. Palliative Care Access Act – PHL2997-d

Penalties for Failure to Comply with NY Public Health Law are punishable by

- a civil penalty of up to $2,000 to $5,000 for repeat violations within 12 months that were a serious threat to health and safety;
- willful violation punishable by imprisonment of up to 1 year and/or a fine of up to $10,000, and a medical misconduct action.

IV. Palliative Care Access Act – PHL2997-d cont'd

- DOH Staff and Palliative Care Education and Training Council have developed FAQs for providers and consumers that are available on the DOH Website at:
- **https://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/2011-12-14_questions_and_answers.htm**
- Palliative Care NYS DOH Web Page:
- **hhtp://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/**

V. Medicaid Redesign Team 209: Expand Hospice

- Expand Definition of terminal illness 12 months. Passed in Hospice Modernization Bill
- Expand concurrent Hospice and curative care to Medicaid adults.
- Integrate Hospice into Medical Home and ACO projects through regulations.
- Concurrent care for adults would require a change in Social Security Act (unlikely), or a Medicaid waiver (more feasible).

VI. Hospice Modernization Act

- Effective August 2011.
- Implements 12-month terminal prognosis component of MRT #209.
- Currently applies only to private pay/private insurance.
- NYS DOH has submitted a State Plan Amendment to CMS requesting that the 12-month terminal prognosis apply to Medicaid. (accepted Feb. 2014)
- Requires change in Medicare statute to apply to Medicare patients.

VI. Hospice Modernization Act

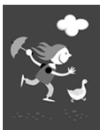
- Allows Hospices to employ/contract with health care professionals for the provision of Palliative Care. *"Dear Administrator"* Letter (DAL) from DOH at:
- **http://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/2011-12-14_dear_ceo_palliative_care_access_act.htm**
- Caution NYD Education Law

VII. Pediatric Palliative Care – Care At Home I/II

- **Care at Home (CAH) Medicaid Waiver Programs** (CAH I/II)
  - Existing Medicaid programs for families who would not otherwise be eligible for NYS Medicaid.
  - Provides medical and related services not covered under insurance to families who want to bring their physically disabled child home from a Hospital or LTCF.
  - Children must be unmarried, under 18 years of age, disabled by SSI criteria and require SNF or Hospital level of care.

VII. Pediatric Palliative Care –Care At Home I/II cont'd.

- Medical Care Services
- Home and Vehicle modifications
- Case Management
- Respite Care
- Pediatric Palliative Care Services
  - Family Palliative Care Education Training
  - Pain and Symptom Management
  - Bereavement Services for family
  - Expressive Therapies (art, music, play) for patient and siblings
  - Massage Therapy



VII. Pediatric Palliative Care – Care At Home I/II cont'd

- Provided by Certified Home Health Agency (CHHA) or Hospice
- Providers must demonstrate ongoing proficiency in the principles of end of life care, through annual participation and successful completion of pediatric Palliative Care education and training.
- HPCANY offers Interdisciplinary Pediatric Palliative Care training and a train-the-trainer program.

VIII. Federal & State Palliative Care Initiatives

Affordable Care Act § 2302 - Concurrent Care for Children – Allows children on Child Health Plus, Family Health Plus, and Medicaid Managed Care to receive "*curative treatment*" and Hospice concurrently

- NYS Implementation in Process
- NYS Health Website rolled out 10/1/13
- Hospice with 210 days limitation included in Essential Benefits package

IX. Hospice and Managed Care

- Hospice Concurrent with Managed Long Term Care Program (MLTCP)
  - Included in 2013 Budget Bill
  - Individuals enrolled in MLTCP can elect their hospice benefit without disenrolling from MLTCP
  - Challenges - care coordination

IX. Hospice and Managed Care, cont'd

- Hospice Carved Into Medicaid Mainstream Managed Care
  - Implemented 10-01-13
  - Hospice as defined in NYS statute (cannot be "unbundled")
  - First year (until 10-01-14) MCOs reimburse hospice at established per diem rates
  - Challenges – education & communication

IX. Hospice and Managed Care, cont'd

- HPCANYS' Proactive Approach
  - Innovations/Managed Care TF
  - Hospice/PC/Managed Care tool kits
  - Return on Investment template
  - Navigation tool
  - Collaborate with Health Care Plans Assoc. & Managed Care consortiums
  - Resource to NYS DOH

Final Thoughts

- ❖ Think outside the box.
- ❖ Use Current Reimbursement Streams to fund Your Palliative Care Programs.
- ❖ Change comes through challenge.
- ❖ Complex Federal and State laws require analysis by Healthcare Attorney.
- ❖ Articles: www.arentfox.com.

Questions?

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