Palliative Care and Beyond: Key Legal Considerations for Hospices Pursuing Upstream Revenue and Service Opportunities[1]

1. Growing Opportunities for Upstream Care. Medicare, Medicaid, and commercial payors increasingly are taking a variety of innovative approaches for accomplishing the goals of the Triple Aim: improving the patient experience, improving population health, and reducing healthcare costs. Many of these approaches, from paying for new types of chronic care management services to offering more value-based reimbursement products, focus on caring for the patient at home and intervening further upstream in the patient's illness. As a result, there are opportunities, which will only continue to proliferate, for hospices to continue diversifying and expanding their services and revenue sources. Taking advantage of such opportunities may be critical for hospices in discovering their best path forward in this era of disruption and steady market consolidation.

2. Hospices Uniquely Positioned. Given their unique skills, expertise, and experience, hospices may be better positioned than many other provider types for taking advantage of these new revenue and service opportunities. Hospice was one of the first care models to receive capitated payments for providing holistic and all-inclusive patient care. Payors more and more are recognizing how the core hospice concept of the interdisciplinary team can be valuable in managing the care of clinically complex patients. Medical social services, for example, can be effective in addressing social determinants of health. Hospices also are skilled and experienced in performing roles usually reserved for payors themselves, such as retaining financial management responsibility, managing the patient's care to a budget, making coverage determinations, and contracting with other providers for coverage of the full hospice care spectrum.

3. Key Legal Considerations Related to Upstream Care Opportunities. Below, we provide an overview of some key new and emerging service and revenue opportunities for hospices to consider. Each opportunity summarized here, as well as future opportunities that may arise, should be evaluated with counsel under a variety of legal considerations. Some preliminary legal considerations include:

Licensure and Surveys

- Can I provide the new service under my existing hospice license, or do I need to obtain additional licensure as a separate provider and be separately surveyed?
- If the new opportunity involves taking on financial risk (*e.g.*, shared savings and losses), does that qualify me as an insurer under state insurance laws?

Corporate Structure, Liability, and Taxation

- Can I provide the new service under my existing corporate structure and taxpayer identification number ("TIN")?
- Does providing the new service under a new legal entity and TIN put you in a better position to protect new revenue from government recoupment efforts and general liability related to other business lines?
- Is it advantageous from a tax perspective to provide the new service under a new legal entity and TIN?
- Does the service fall within my tax exemption status (if applicable)?

Staffing

- What staff are required to provide the new service?
- What staffing model should you use to provide the new service (*e.g.*, hiring new employees, contracting with individual providers or "leasing" and assigning existing staff to the new enterprise)?
- How does the staffing model impact, if at all, compliance with the hospice core services requirement (*i.e.*, that substantially all hospice nursing services, medical social services, and counseling be provided routinely by hospice "employees")?

Healthcare Fraud and Abuse Laws

- In taking advantage of a new opportunity, are you complying with the multitude of federal and state fraud and abuse laws, including anti-kickback statutes ("AKSs") and beneficiary inducement prohibitions?
- Does the new service or arrangement fall within an AKS safe harbor (including one of the recently created safe harbors designed to protect certain patient engagement activities and encourage certain value-based payment arrangements) or within an exception to a beneficiary inducement prohibition?

Contracting With Providers or Payors

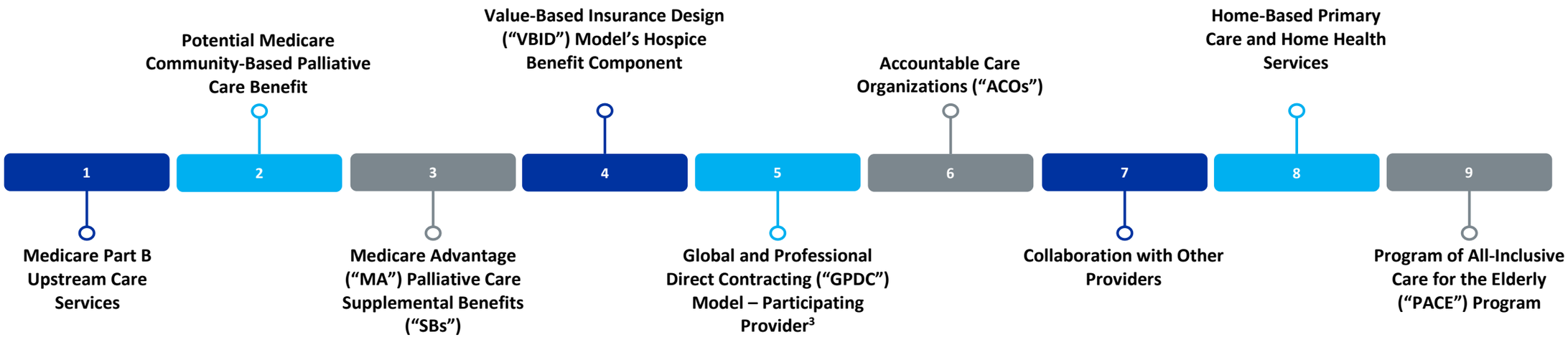
- When contracting with other providers, are you structuring the agreement so that it meets the elements of the "Professional Services and Management Contracts" federal AKS safe harbor?
- When contracting with payors, what are you focusing on in contract negotiations? Do the required services and payment terms make sense for your organization? What is the payor's ability to determine and recoup overpayments? What ability do you have to exit the arrangement if needed?

Antitrust Issues

- If the new opportunity involves affiliating or partnering with other providers, are you complying with applicable antitrust laws?

[1] Except where otherwise stated, the information provided in this handout, including the Appendix, is current as of January 1, 2022.

4. Key Upstream Care Opportunities for Hospices. Below is a summary of some key upstream service and revenue opportunities that hospices can consider pursuing or make strategic plans to implement. Taking advantage of some of these opportunities will require you to make a bigger pivot than may be needed for other opportunities. Accordingly, the key opportunities summarized below are arranged on a linear spectrum representing the relative extent of the pivot that may be required to realize the opportunity. On the left side of the spectrum, hospices may be able to use their existing license, corporate structure, and staff to provide an array of non-hospice palliative care services,[2] including new types of chronic care management services now payable under Medicare Part B. As the spectrum moves rightward, opportunities arise requiring partnerships with payors or other providers or requiring additional licensure. On the far right side of the spectrum, hospices can leverage opportunities to move closer to becoming a "payvider" (*i.e.*, an entity resembling both a healthcare provider and a payor).



[2] While "palliative care" has no single federal or state definition, it is practically defined as the scope of non-curative healthcare services a provider is licensed to furnish and can get paid for furnishing, as the provision of non-reimbursable services can raise anti-kickback and beneficiary inducement concerns. For purposes of this document, the term "palliative care" refers generally to pain and symptom management for seriously ill patients.

[3] On February 24, 2022, CMS announced that beginning January 1, 2023, the GPDC Model would be redesigned significantly and rebranded as the "Accountable Care Organization Realizing Equity, Access, and Community Health Model" or "ACO REACH Model."

Medicare Part B Upstream Care Services

1

- Numerous upstream care services currently are payable under Medicare Part B, including care management models for chronically ill patients and for patients transitioning to community settings.
- The Appendix to this handout contains a brief overview of certain of these services.
- State Medicaid programs and commercial payors may reimburse similar services.

Potential Medicare Community-Based Palliative Care Benefit

2

- Whether through Congressional action or a Centers for Medicare and Medicaid Innovation ("CMMI") demonstration, it is possible CMS may offer a new community-based palliative care benefit in the near-term future.

Medicare Advantage ("MA") Palliative Care Supplemental Benefits ("SBs")

3

- Subject to approval by CMS, MA plans may offer SBs to enrolled beneficiaries.
- SBs are "primarily health related" services not covered under traditional Medicare, and some SBs intersect with upstream care services (*e.g.*, in-home palliative care and additional in-home caregiver support).
- For CMS-approved SBs, MA plans may contract with hospices for the provision of such SBs to enrollees.

Value-Based Insurance Design ("VBID") Model's Hospice Benefit Component

4

- The Hospice Benefit Component (often called the "hospice MA carve-in") is one aspect of CMMI's VBID Model, which is a demonstration to test various innovations in the design of MA plans through 2024.
- Upon approval by CMS, participating MA plans may arrange for enrollees who elect hospice to receive both traditional Medicare hospice services and also certain upstream care services, such as transitional concurrent care (*i.e.*, limited continuation of curative treatment while receiving hospice care) and MA palliative care SBs.
- MA plans may contract with hospices to furnish the Hospice Benefit Component services. Details on the provision of and payment for services, as well as other requirements, are governed by the contract and may be negotiable.

Global and Professional Direct Contracting ("GPDC") Model – Participating Provider[4]

5

- Under this CMMI demonstration that runs through 2026, CMS contracts with a Direct Contracting Entity ("DCE") to deliver value-based care to a population of Medicare beneficiaries. The DCE receives a capitated, risk-adjusted monthly payment for all traditional Medicare-covered services furnished by the DCE or by DCE-contracted providers who agree to participate in capitation, accept traditional Medicare claims reductions, and receive compensation from the DCE ("Participating Providers").
- DCEs are permitted to offer certain "benefit enhancements" not available under traditional Medicare, such as transitional concurrent care and certain care management home visits.
- DCEs can contract with hospices to furnish the hospice and upstream care services. Details on the provision of and payment for services, as well as other requirements, are governed by the contract and may be negotiable.

[4] On February 24, 2022, CMS announced that beginning January 1, 2023, the GPDC Model would be redesigned significantly and rebranded as the "Accountable Care Organization Realizing Equity, Access, and Community Health Mode," or "ACO REACH Model."

Accountable Care Organizations ("ACOs") → 6

- ACOs are groups of providers who come together to provide coordinated care to a designated group of patients.
- Since Medicare ACOs can share in any cost-savings generated from the care coordination, ACOs have an incentive to provide patients with upstream care services that are not reimbursed under traditional Medicare (*e.g.*, caregiver support and certain home-based services).
- ACOs can contract with hospices to furnish hospice and upstream care services. Details on the provision of and payment for services, as well as other requirements, are governed by the contract and may be negotiable.

Collaboration with Other Providers → 7

- Hospices can collaborate with other hospices to form an independent practice association ("IPA") to create operational efficiencies, expand geographic reach, measure quality, and enhance payor relationships.
- There are a variety of different network models that can be pursued depending on the needs of the collaborating hospices as well as antitrust and other legal considerations. These models include the messenger model, the financially or clinically integrated model, and the common ownership model.
- For additional information on this topic, consult Husch Blackwell's handout, "Success Through Collaboration: Overview of Network Models for Hospices."

Home-Based Primary Care and Home Health Services → 8

- These are different models for providing treatment and care management to home-bound or chronically ill patients in their homes.
- These models may require separate licensure and certification (*e.g.*, as a home health agency or primary care clinic).

Program of All-Inclusive Care for the Elderly ("PACE") Program → 9

- Upon approval by CMS, a provider can become a PACE organization to receive a monthly Medicare and Medicaid capitated payment for providing all covered services to enrolled Medicare and Medicaid beneficiaries.
- Enrollees must disenroll from the PACE Program to elect the hospice benefit and receive hospice services.

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Appendix: Key Medicare Part B Upstream Care Services

This Appendix highlights certain upstream care service opportunities that currently exist under Medicare Part B. For each opportunity, the Appendix describes: the service (including relevant CPT[5] codes), the health professionals who may provide the service, the manner in which the service must be provided, the current (non-adjusted) national rate for the service, and other key precursors to billing. Note that certain services described herein require a separate face-to-face ("F2F") visit by the billing Practitioner[6] if the patient has not been seen by the billing Practitioner within the past year.[7] It will be important for providers to have a detailed understanding of all documentation and billing requirements in order to determine the overall feasibility of implementing any service described herein.

Opportunity	Brief Description	Who Provides the Service?	How Is the Service Provided?	What Is the Reimbursement?	Other Key Billing Requirements
Chronic Care Management ("CCM")	Care management services for chronically ill patient, such as: - Communication with patient, family, or caretaker - Assessment and support for treatment regimen adherence and medication management Comprehensive care plan must be established, implemented, revised, or monitored Services need not be provided F2F *CPT codes 99490, 99439, 99491, 99437*	*99490 and 99439* Clinical Staff[8] (general supervision)	*99490* First 20 minutes per month *99439* Each additional 20 minutes per month (up to twice per month)	*99490* Monthly management fee of $64.02 (non-facility) or $51.56 (facility) *99439* $48.45 (non-facility) or $36.34 (facility)	Patient must have at least 2 chronic health conditions that (i) are expected to last at least 12 months or until death and (ii) place patient at significant risk of death, acute exacerbation, or functional decline CCM codes cannot be reported in the same calendar month as Complex CCM or PCM codes
		99491 and 99437 Practitioner	*99491* First 30 minutes per month *99437* Each additional 30 minutes per month	*99491* Monthly management fee of $86.17 (non-facility) or $77.52 (facility) *99437* $61.25 (non-facility) or $52.26 (facility)	

[5] CPT codes, descriptions, and other data are protected by American Medical Association ("AMA") copyright. CPT is a registered trademark of the AMA. All rights reserved.
[6] As used herein, "Practitioner" means a physician, nurse practitioner ("NP"), physician assistant ("PA"), certified nurse midwife, or clinical nurse specialist.
[7] For certain services, CMS may have issued a waiver for this requirement for an established patient relationship during the COVID-19 public health emergency.
[8] As used herein, "Clinical Staff" means a health professional working under the direction of the billing Practitioner and as an integral part of the services provided by the billing Practitioner. The level of supervision (*i.e.*, whether direct or general) that the billing Practitioner is required to exercise over Clinical Staff varies depending on the service in question.

Opportunity	Brief Description	Who Provides the Service?	How Is the Service Provided?	What Is the Reimbursement?	Other Key Billing Requirements
Complex CCM	Advanced care management services for chronically ill patient Includes criteria for 99490 and 99491 (described above) and: - Establishment of or substantial revision to care plan - Higher complexity of medical decisions Services need not be provided F2F *CPT codes 99487, 99489*	*99487* Clinical Staff (general supervision)	*99487* 60 minutes per month	*99487* Monthly management fee of $134.27 (non-facility) or $92.75 (facility)	Same as for CCM codes Complex CCM codes cannot be reported in the same calendar month as CCM or PCM codes
		99489 Clinical Staff (general supervision)	*99489* Each additional 30 minutes per month	*99489* $70.60 (non-facility) or $51.22 (facility)	
Principal Care Management ("PCM")	Advanced care management services for *single* high-risk disease that requires frequent medication adjustment or is unusually complex to manage due to comorbidities Services require: - Development, monitoring, or revisions to disease-specific care plan - Ongoing communication and care coordination between practitioners furnishing care Services need not be provided F2F *CPT codes 99424, 99425, 99426, 99427*	*99424 and 99425* Practitioner	*99424* First 30 minutes per month *99425* Each additional 30 minutes per month	*99424* Monthly management fee of $83.40 (non-facility) or $75.44 (facility) *99425* $60.22 (non-facility) or $52.60 (facility)	Patient must have 1 complex chronic condition that (i) is expected to last at least 3 months and (ii) places patient at significant risk of death, hospitalization, acute exacerbation, or functional decline PCM codes cannot be reported in the same calendar month as CCM or Complex CCM codes
		99426 and 99427 Clinical Staff (general supervision)	*99426* First 30 minutes per month *99427* Each additional 30 minutes per month (up to twice per month)	*99426* Monthly management fee of $63.33 (non-facility) or $50.53 (facility) *99427* $48.45 (non-facility) or $35.64 (facility)	

Opportunity	Brief Description	Who Provides the Service?	How Is the Service Provided?	What Is the Reimbursement?	Other Key Billing Requirements
Transitional Care Management	Care management and transitional care services (*e.g.*, reviewing discharge information and the need for follow-up tests and treatments) during inpatient-to-community transitions of care Requires patient communication within 2 days of discharge, F2F visit within specified number of days of discharge, and medication reconciliation and management *CPT codes 99495, 99496*	*99495* Certain services must be provided by a Practitioner Clinical Staff may provide certain other services under varying levels of supervision	*99495* Visit must be provided F2F (in-person or via telehealth) Other services need not be provided F2F	*99495* One-time fee of $209.02 (non-facility) or $144.65 (facility), billable within 30 days of discharge	Patient must be transitioning from (i) an inpatient hospital setting, (ii) hospital observation status, or (iii) a nursing facility setting
		99496 Same as for 99495	*99496* Same as for 99495, except higher complexity of medical decisions and shorter time period for providing some services	*99496* One-time fee of $281.69 (non-facility) or $195.87 (facility), billable within 30 days of discharge	
Chronic Care Remote Physiologic Monitoring	Treatment management services for remote monitoring of patient's physiologic parameters (*e.g.*, weight, blood pressure, pulse oximetry, and respiratory flow rate)[9] Services need not be provided F2F, but codes require interactive communication with the patient or caregiver during the month *CPT codes 99457, 99458*	Practitioner or Clinical Staff (direct supervision)	*99457* First 20 minutes per month	*99457* Monthly management fee of $50.18 (non-facility) or $31.15 (facility)	The device used by the patient must be a medical device as defined by the FDA
			99458 Each additional 20 minutes per month	*99458* $40.84 (non-facility) $31.15 (facility)	

[9] In addition to paying for remote patient monitoring, CMS also pays for the initial work associated with onboarding a new patient, setting up the monitoring equipment, and educating the patient on the use of the equipment. *See* CPT 99453 and 99454.

Opportunity	Brief Description	Who Provides the Service?	How Is the Service Provided?	What Is the Reimbursement?	Other Key Billing Requirements
General Behavioral Health Integration ("BHI") Services	Primary care team-based model for treating a behavioral health condition[10] that requires: - Initial assessment or follow-up monitoring - Care planning - Facilitating and coordinating treatment of the condition - Continuity of care with designated care team member[11] Services need not be provided F2F *CPT code 99484*	Clinical Staff (general supervision)	20 minutes per month	Monthly management fee of $44.64 (non-facility) or $30.45 (facility)	Patient must have a behavior health condition being treated by the billing Practitioner
Advance Care Planning	A F2F visit with patient, family, or surrogate to discuss advance care planning, including advance directives *CPT codes 99497, 99498*	*99497* Practitioner	*99497* First 30 minutes Visit must be provided F2F (in-person or via telehealth)	*99497* Fee of $85.48 (non-facility) or $77.86 (facility)	
		99498 Practitioner	*99498* Each additional 30 minutes Visit must be provided F2F (in-person or via telehealth)	*99498* Fee of $74.06 (non-facility) or $73.36 (facility)	
Traditional Evaluation & Management ("E/M") Services	Medically necessary patient visits (*e.g.*, history and examination), with reimbursement varying by location of patient, time spent with patient, and complexity of medical decisions *CPT codes 99201-99359*[12]	Practitioner[13]	F2F visit (in-person or telehealth, depending on the specific CPT code)	Varies by CPT code	

[10] CMS specifies that conditions that may be eligible for BHI services broadly include any mental, behavioral, or psychiatric condition, including substance use disorder.
[11] The Psychiatric Collaborative Care ("CoCM") Model is an enhanced version of the BHI services model and additionally requires case management by a behavioral health care manager and psychiatric consultation. *See* CPT 99492, 99493, and 99494. CMS provides greater reimbursement for this CoCM Model under Medicare Part B.
[12] Note that CPT codes 99441, 99442, and 99443 codes, describing certain E/M services provided via telephone (including an audio-only telephone), also are payable under Medicare Part B if they were provided during the COVID-19 public health emergency.
[13] In certain circumstances, licensed and qualified clinical social workers may bill Medicare for certain E/M services to diagnose and treat mental illnesses.