

# Hospice ‘Bridge’ Programs: Pitfalls and Possibilities

By Mary Michal, J.D. and Dorothy Clark, J.D.

Many hospices have considered implementing bridge programs, through which the hospice provides transitional services to patients who, for a variety of reasons, are not ready for hospice. These patients often have life-threatening diseases that are expected to be terminal, but they are not emotionally ready for hospice, do not fit strict hospice eligibility criteria (as imposed by the Medicare program or other third-party payors), or else are not ready to give up curative treatment. The goals for bridge programs are to create a safe place for patients to explore life-transition issues, provide an additional viewpoint in considering treatment decisions and get patients and families more comfortable with hospice philosophy and hospice personnel. The need for such a service has been recognized by others in the larger end-of-life field, some of whom are trying to create alternatives to hospice in order to meet these needs.

By definition, bridge services do not qualify as hospice services, because, for a variety of reasons, the patient has not elected the hospice benefit. Some hospices that are not additionally certified as home health agencies may provide bridge services free of charge, because patients are unable or unwilling to pay for them. Other hospices, which also hold home health agency certification, attempt to provide such services under the home health benefit. However, this approach has its limitations, due to the differing threshold requirements and other regulatory requirements.

Bridge programs in many ways represent the future direction of end-of-life care as a continuum of services and levels of care. Unfortunately, they are problematic under current Medicare hospice regulations and under fraud-and-abuse laws, despite the very worthy goals of helping patients to better understand hospice and the palliative approach and explore life-transition issues prior to hospice enrollment, as well as easing or facilitating referral to hospice.

This article sets out the primary regulatory impediments for Medicare-certified hospices wanting to offer these kind of bridge services, and then discusses some approaches that have been taken in providing such care and

recommendations for minimizing the risks involved.

## Legal Impediments

(1) Medicare certification and state licensing concerns: The Medicare statute 42U.S.C. § 1395x(dd)2. and the hospice regulations 42 C.F.R. § 418.50, require that a Medicare-certified hospice be “primarily engaged in providing the care and services” defined as hospice care. Hospice care is a comprehensive “bundle” of services. Breaking out particular services to be provided to patients under a bridge program, even without charging for them, or mirroring hospice for those not eligible for or enrolled in a hospice, is legally inconsistent with this definition of hospice care. “Bridge” services are not hospice services, and should not be referred to as hospice services. IN addition, because Medicare requires certified hospices to be “primarily engaged in” providing hospice care, the extent to which a hospice provides unbundled services to non-hospice patients needs to be relatively small.

State licensure for hospice often requires that the full range of hospice services be made available to every hospice patient, who must meet certain eligibility criteria. Therefore, bridge services for patients not meeting all eligibility requirements for Medicare and/or state hospice licensure cannot be provided by a hospice for its hospice patients. Because of these limitations, most bridge programs are conducted under the auspices of a related certified, licensed home health agency.

(2) Anti-kickback violation: The provision of free care as remuneration for a referral: Medicare fraud-and-abuse laws provide criminal penalties for individuals and entities that knowingly and willfully offer, pay, solicit or receive any remuneration in order to induce referrals of business reimbursed under Medicare or Medicaid. The types of remuneration covered include any kickback, bribe or rebate, made directly or indirectly, overtly or covertly, in cash or in kind. The statute covers both remuneration intended to induce referrals of patients and remuneration intended to induce the purchasing, leasing, ordering, arranging or recommending of any good, facility, service or item for which payment may

be made in whole or in part by Medicare or Medicaid. This very broad provision in federal law can be violated even when only purpose of a payment is to induce future referrals. An offense of the statute is classified as a felony and is punishable by up to five years in jail, fines up to \$25,000, and exclusion from participation in the Medicare and Medicaid programs.

Under the anti-kickback provisions of the Medicare fraud-and-abuse laws, if a hospice provides bridge services to a patient free of charge, with the hope or intent that the patient will eventually enroll in hospice, such care could be seen as prohibited “remuneration” in exchange for a referral (42U.S.C. § 1328a-7b(b)). The fact that the free care is provided directly to a patient does not remove the anti-kickback liability, as such patients are considered a source of referrals: a patient can refer him or herself to the hospice program. Scenarios where the hospice provides free bridge services to patients receiving care from another provider, such as a nursing home, hospital or home health agency, are in some ways more problematic, because they could be seen as evidence of a more systematic attempt to obtain referrals.

For example, by providing bridge services to nursing home patients, the hospice also provides a very tangible benefit to the nursing home, because the nursing home is already required to provide most of the same kind of services to the resident. The nursing home is in a unique position to influence which particular hospice program a patient may choose, since there must be a contractual agreement between the nursing home and a certified hospice in order to provide covered services to the nursing home’s residents (42 C.F.R. § 418.56). Because of the complex coordination that is required when a nursing home resident elects hospice, a nursing home has an incentive to limit the number of hospices with which it has relationships. This limitation makes the nursing home’s choice of a particular hospice all the more valuable to the hospice that is chosen. If a hospice provides free services in an attempt to influence the nursing home’s referrals of residents in need of hospice care, it would violate the anti-kickback statute.

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Similarly, a hospice nurse who goes on rounds of a hospital, providing pain management consultations free of charge, could be seen as providing an inducement not only to the particular patient, but also to the hospital itself. The hospital is responsible for managing its patients’ pain, so the hospice is providing the hospital with something for which it normally would have to expend resources. The inference could thus be made that in exchange for the free services, the hospital would recommend the hospice once the patient is ready to elect the hospice benefit. Such an exchange would violate the anti-kickback statute, because at least a part of the intent would be to induce the referral of a patient whose care is paid for by Medicare.

The provision of free care to home health patients is probably the most common scenario in bridge programs. If the home health agency is part of the same corporate system as the hospice, surveyors and the OIG may allege fraud and abuse if they believe that the provider has received undue Medicare or Medicaid payments (e.g., by keeping an expensive hospice-eligible patient in home health care). If the home health agency is not part of the same corporate system as the hospice, the free services provided could result in anti-kickback scrutiny.

## Possible Methods for Providing Bridge Services

The anti-kickback statute and state and federal regulatory requirements thus combine to create serious impediments to fulfilling the genuine need for transitional or bridge services. Some hospices that are also home health agencies have attempted to overcome these impediments by providing hospice-oriented home health services to “pre-hospice” patients. However, this strategy is limited by the requirement that beneficiaries receiving home health agency services must be homebound and in need of skilled nursing care, among other regulatory requirements.

Also, fraud investigators and surveyors are instructed to look closely at the admission and discharge patterns between agencies that are certified for home health and hospice care. The OIG

has identified abusive practices under which hospices transfer patients to home health agencies (and vice versa) based on maximizing reimbursement rates. In addition, to the extent that services covered under the home health benefit differ from the bridge services provided to the patient, the problem remains that the provision of free (uncovered) services could be seen as an inducement to the current home health patient to choose the hospice when the time comes to elect the hospice benefit.

For hospices that choose to take on the risks involved in providing bridge services through their home health agency, it will be very important to ensure that the bridge patient’s medical record clearly documents the process of choosing home health care instead of hospice. If the patient is clearly not eligible for hospice, but is eligible for home health, there would be less concern. However, where the patient is eligible for both, that patient’s record should provide detailed documentation supporting why the patient chose home health over hospice.

Assuming it is not forbidden by state hospice regulations, a hospice attached to a home health agency. Or even one entering into some type of joint venture relationship with an unaffiliated home health agency, could set up a separate bridge program using funds raised specifically for this purpose. Because of the anti-kickback concerns discussed above, it would be important to provide the bridge services to patients who are not eligible for hospice, regardless of their insurance or Medicare coverage and regardless of the potential for referrals. There should be no linkage to how many of the bridge patients chose the hospice subsequent to receiving its bridge services, or evaluation of the program’s success on that basis.

Still assuming that the unbundling of hospice services is permitted under state regulations, another possible way of providing bridge services, other than to provide them free of charge, would be to charge patients for them, using a sliding scale payment rate. Before initiating such a program, the hospice should set up a policy and method for determining financial need.

If the hospice provides bridge services to meet an unmet community need as part of its mission, either free of charge or based on a sliding scale (perhaps through a foundation, a planned effort to use its memorials and bequests and other charitable funds or a grant from United Way or other funding source), that underlying motivation should be clear and consistent. Because the anti-kickback statute prohibits the provision of free or reduced fee services intended to induce referrals into hospice, it is vitally important that referrals into hospice be neither sought nor expected as a result of the bridge program. Also, of course, regulators are particularly concerned about reimbursement-driven admission decisions between a home health agency and its affiliated hospice.

Unfortunately, at this time there is no clear line delineating which bridge services or programs will pass muster with fraud investigators or with hospice surveyors. Determinations of anti-kickback violations are very fact specific, and hinge on in tent Hospices that initiate bridge programs with the intent of fulfilling a genuine need, while also hoping to obtain more referrals, run a risk of prosecution for fraud.

Practically speaking, it would be difficult to design a bridge program that removes any possible inference that obtaining referrals was part of the program’s purpose. Possible examples of such programs might include special demonstration programs such as MediCaring, where the federal government has granted all necessary waivers in order to study a certain concept, or a bridge program created by a home health agency and a hospice that are part of the same organization and that can clearly demonstrate that admission decisions are carefully made on the basis of clinical protocols and documented, informed patient choice. The very concept of a bridge program is to identify individuals who may become hospice patients, educate them about hospice and provide hospice-like services in the transitional period. Therefore, with these two exceptions, provider participants in bridge programs must be prepared to defend their program as unrelated to and completely unconcerned with referrals into hospice.

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The chief dangers for hospices in providing bridge services lie in citations from surveyors for exceeding the scope of their licensure, and in being charged with criminal or civil violations of the anti-kickback statute. (Plus, as mentioned above, there is some potential that organizations providing both home health and hospice care might face other fraud-and-abuse scrutiny if it appears that care decisions and patient admissions are driven by reimbursement.) The fines associated with such citations and charges are prohibitively high, and could lead to the closure of a hospice.

Unfortunately, there are no easy answers to these legal and regulatory issues. As the National Hospice Organization continues its advocacy addressing hospice Medicare reimbursement and eligibility criteria, hospices are advised to approach bridge programs with caution. It is recommended that:

Hospices run bridge programs only through a licensed provider organization, usually a home health agency.

If the home health agency is part of the hospice organization, there should be clear protocol for admissions to the bridge program, and the patient should either be ineligible for hospice or have clearly chosen home health care over hospice

In all bridge programs, be certain that there is no motivation to induce referrals into hospice

*Mary Michal and Dorothy Clark practice health law in the Madison WI office of the Reinhart Boerner law firm, which also has offices in Milwaukee, Denver and Washington, DC. They have extensive experience in hospice representation and can be reached at 800/728-6239 or [www.reinhartlaw.com](http://www.reinhartlaw.com)*

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