Post-Acute Care Discharge Planning

BARNES & THORNBURG LLP

LeadingAge Indiana

INALA Indiana Assisted Living Association

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LeadingAge Indiana

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INALA Indiana Assisted Living Association

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Our Backgrounds and Perspectives

Jason Schultz, JD | Partner
Barnes & Thornburg LLP

- 2007-2011
  - –Private Practice Law Firm
- 2011-2020
  - –General Counsel, Saint Joseph Health System
- 2020-2022
  - –Vice President of Strategy, Saint Joseph Health System
- 2022-Current
  - –Attorney, Barnes & Thornburg

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Our Backgrounds and Perspectives

Joel Benson, JD, MHA | Attorney
Barnes & Thornburg LLP

- 2016-2019
  - –JD/MHA, Indiana University
  - –Intern/Externships
    - IU Health
    - Simon Cancer Center (IUSM)
    - American Health Network (Optum)
- 2019-2023
  - –Attorney, Global Law Firm
- 2023-Current
  - –Attorney, Barnes &

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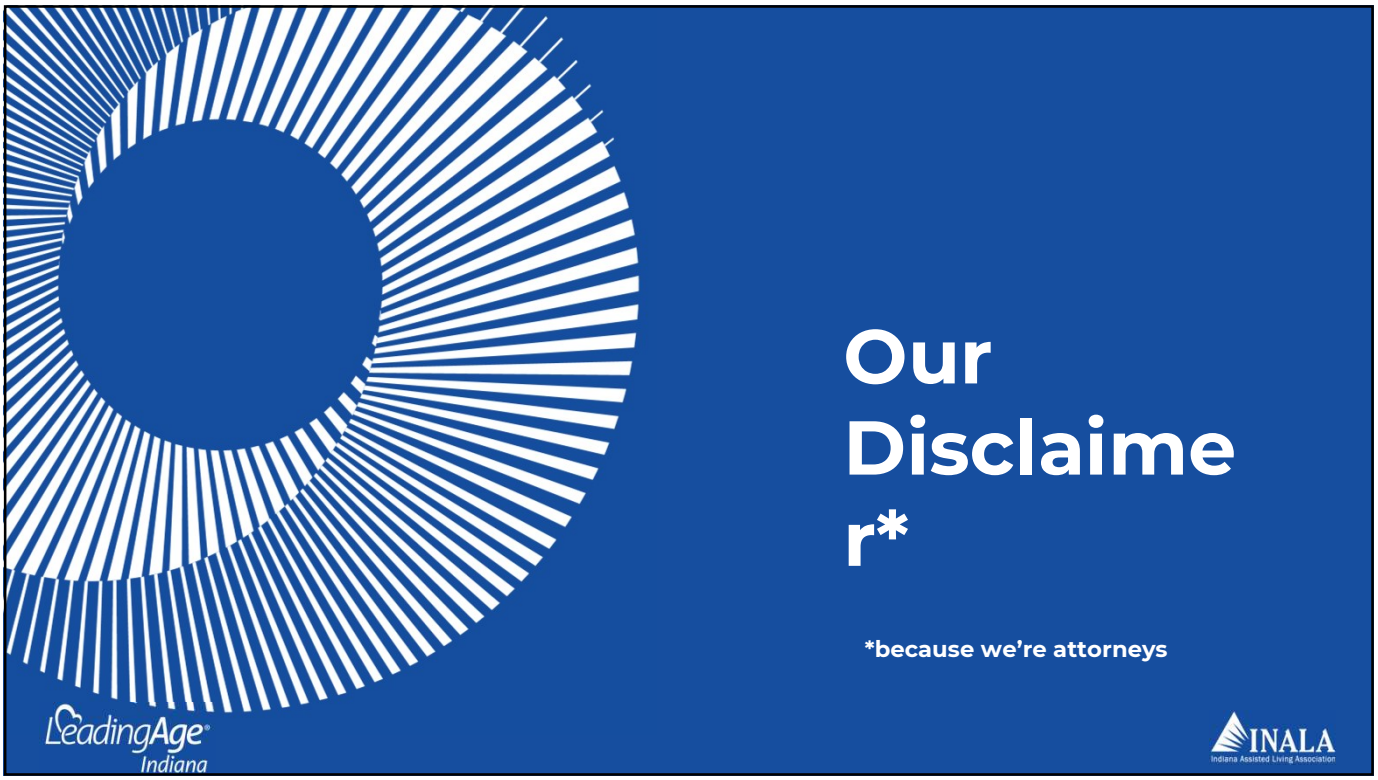

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WARNING!

- Many of our practical tips discussed today will be met by resistance from hospital administration and hospital discharge planners.
- Approach conversations delicately and always acknowledge the importance of patient care and patient choice.
- Always remember that discharge planners may be significantly pressured by the hospital (and even financially rewarded) to send patients to a particular provider.
- Be persistent.

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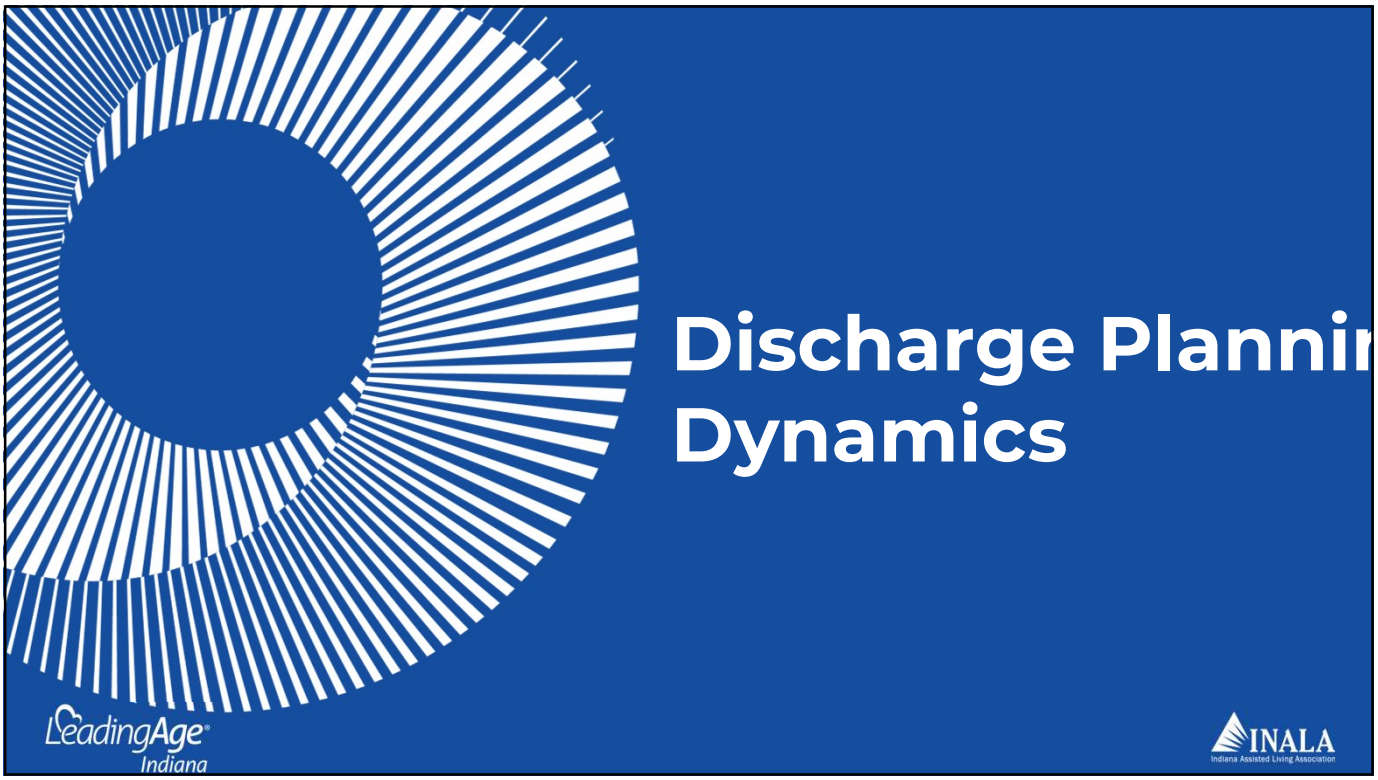

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The Dynamics of Discharge Planning

- **Patient Steering still occurs.**
  - Patient: "Who would you recommend?"
  - Discharge Planner: "If you enjoyed your experience at our hospital, we also have several affiliated post-acute care options…"
  - Hospitalist: "I serve as a medical director at _____ and round on patients there, so if you want to continue to see me, you may want to select that location."
  - Discharge Planner: "If you are having trouble making a decision, our default service provider is _____. They are a great provider."

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The Dynamics of Discharge Planning

- **Patient Steering still occurs.**
  - OIG conducted study of 1,000 discharge planners across the country
  - 62% of patients discharged from hospitals that owned a home health agency were referred to an agency owned by the hospital
  - 38% of beneficiaries who went to hospital-owned home health agencies reported that "the hospital just sent home care people" to them

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The Truth Behind Discharge Planning

DEPARTMENT: Legal	**POLICY DESCRIPTION:** Discharge Planning: Patient Choice for Post-Acute Providers/Services Upon Discharge
PAGE: 1 of 6	**REPLACES POLICY DATED:** 3/6/98, 11/12/98, 1/1/06; 11/15/06, 3/1/07, 5/15/10, 10/1/16, 2/1/17, 4/1/20, 1/1/21
EFFECTIVE DATE: July 1, 2021	**REFERENCE NUMBER:** LL.016 (formerly LL.HH.016)
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: This Policy applies to [redacted].

Other capitalized terms used in this Policy and not otherwise defined have the meaning given to them below in the Definitions section.

POLICY: A Hospital, as part of its effective Discharge Planning process, must focus on the patient's goals and treatment preferences and include the patient (and/or the patient's representative) and his or her caregivers/support persons as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from the Hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.

The Hospital must inform the patient (and/or the patient's representative) of their freedom of choice in selecting their Post-Acute Provider/Service and of any Disclosable Financial Interest the Hospital has in, or with respect to, such Post-Acute Provider/Service.

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The Truth Behind Discharge Planning

1. Discharge Planning services may only be performed by Hospital Case Management Personnel.

   Non-Hospital Personnel may **not** perform Discharge Planning services. Excluding Non-Hospital Personnel from those who may provide Discharge Planning services will avoid the opportunity for, and appearance of, their inappropriate influence over the patient's freedom of choice in selecting a Post-Acute Provider/Service.

   Please note this Policy is not intended to alter or otherwise limit employees of Hospital or any Affiliate of Hospital who access and utilize pertinent patient information to facilitate patient identification and screening activities that enhance the Discharge Planning process.

2. With respect to Non-Hospital Personnel (such as Post-Acute Provider/Service representatives) who are present in the Hospital, the following safeguards must be implemented to avoid actual or perceived inappropriate influence over patients' freedom of choice:

   - Non-Hospital Personnel shall not be in contact with any patient or patient family/representative regarding Post-Acute Providers/Services until the patient's choice of a Post-Acute Provider/Service has been obtained by Hospital Case Management Personnel (including, if applicable, via a signed Patient Choice Letter) to ensure the patient has exercised freedom of choice.

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The Truth Behind Discharge Planning

6. If the Hospital has established a post-acute provider network, Hospital Case Management Personnel may educate the patient on the potential benefit of receiving care from a Post-Acute Provider/Service participating in the Hospital's post-acute network. Hospital Case Management Personnel should document all these discussions with the patient in the patient's medical record.

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The Truth Behind Discharge Planning Policies

A Patient Choice Letter containing the patient's (or patient's representative's) signature indicating his/her choice of a Post-Acute Provider/Service must be retained in the patient's medical record. Attached is the required *Patient Choice Letter* for Hospital Case Management Personnel to use for the documentation of patient choice of a Post-Acute Provider/Service. This form should not be modified.

If the patient chooses specifically to make no choice of a Post-Acute Provider/Service, then the Hospital must notify the patient of the default Post-Acute Provider/Service.

If the patient comes to the Hospital from a Post-Acute Provider/Service and requests to return to that same Post-Acute Provider/Service upon discharge from the Hospital, the patient (or the patient's representative) is not required to provide written notice of this choice. Documentation that the patient (or the patient's representative) has requested to return to the Post-Acute Provider/Service of origin should be maintained in the patient's medical record.

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The Dynamics of Discharge Planning

- **Multiple Competing Goals**
  - Discharge Planners
  - Hospitals
  - Patients
  - Post-Acute Care Providers (Affiliated and Non-Affiliated)

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The Dynamics of Discharge Planning

- **Discharge Planner Goals**
  - Protect patient choice
  - Ensure proper transition and prompt quality care
  - Ensure prompt and efficient discharge process
  - Reduce readmissions
  - Discharge complicated/difficult patients quickly
  - Promote affiliated post-acute care options (to meet hospital demands) based on employment goals

*Discharge Planners often are nurses so ensuring patient receives quality care is critical.

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The Dynamics of Discharge Planning

- **Hospital Goals**
  - Promote in-network and affiliated post-acute providers
  - Prompt discharge of patients
  - Proper services and coordination of care
  - Improve value-based initiatives
    - Reduce avoidable readmissions
    - Control costs by initially placing patient in correct setting
    - Maximize value-based payments

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The Dynamics of Discharge Planning

- **Patient Goals**
  - Understand when, where, and how they will be discharged
  - Feel safe during discharge
  - Easy and pain-free discharge
  - Receive appropriate discharge instructions
  - Ensure all questions have been answered
  - Receive prompt quality post-acute care services
  - Convenient post acute care services (close to home)
  - Maintain relationship with Primary Care Physician

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The Dynamics of Discharge Planning

- **Post-Acute Care Provider Goals**
  - Obtain profitable patient volumes
  - Maintain positive relationships with Discharge Planners
  - Provide easy and efficient intake process
  - Provide quality medical services and coordination of care
  - Provide prompt medical services after discharge
  - Reduce readmissions to hospital

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In Light of these Conflicting Goals…

We hope to answer the following questions:

- What is legal and what is not during the discharge process?
- How can affiliated post-acute care providers showcase their services to improve patient referrals?
- How can non-affiliated post-acute care providers obtain more patients referrals if the deck is stacked against them?
- Which lines should not be crossed when trying to influence the discharge planning process?
- When does patient steering become illegal?

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Legal History and Evolution of Laws

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Legal Development

- **1997 HHS-OIG Report**
  - Findings on influence of hospital ownership in PAC providers.
    - Hospitals incentivized to maximize Medicare reimbursement by shifting patients from acute care (PPS) to post-acute care (cost basis).
    - Resulted in shorter hospital stays and longer stays in owned nursing homes.
    - Even stronger association with discharge to owned home health agencies (HHAs) and increased lengths of stay at owned HHAs.

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Legal Development

- **1997 HHS-OIG Report**
  - Identified regulatory areas for concern.
    - Federal Anti-kickback Statute (and state analogues)
    - Stark Law (and state analogues)
    - Home Health Conditions of Payment (SSA 1814(a))
    - Sherman Act (Anti-Trust)

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Legal Development

- **1997 Balanced Budget Act**
  - Addressed concern that hospitals were shifting costs from PPS to affiliates reimbursed under cost-based system.
  - Provided the basic framework upon which modern day discharge planning rules are based:
    - Disclosure of ownership;
    - Freedom of choice; and
    - Disclosure of information relating to PAC providers.

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Legal Development

- **IMPACT Act of 2014**
  - Required the standardization and reporting of PAC assessment data.
    - Patient assessment data;
    - Data on quality measures; and
    - Data on resource use and other measures.

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Legal Development

- **IMPACT Act of 2014**
  - Intended to improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning.
  - Standardized quality measures were to be developed and implemented from quality measure domains and standardized patient assessment data elements for clinical categories.

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Legal Development

- **IMPACT Act of 2014**
  - **Quality Measure Domains**:
    - Skin integrity and changes in skin integrity;
    - Functional status, cognitive function, and changes in function and cognitive function;
    - Medication reconciliation;
    - Incidence of major falls; and
    - Transfer of health information and care preferences when an individual transitions.

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Legal Development

- **IMPACT Act of 2014**
  - **Resource Use and Other Measure Domains**:
    - Total estimated Medicare spending per beneficiary;
    - Discharge to community; and
    - All-condition risk-adjusted potentially preventable hospital readmissions rates.

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Legal Development

- **IMPACT Act of 2014**
  - **Assessment Categories**:
    - Functional status;
    - Cognitive function and mental status;
    - Special services, treatments, and interventions;
    - Medical conditions and co-morbidities;
    - Impairments; and
    - Other categories required by the Secretary.

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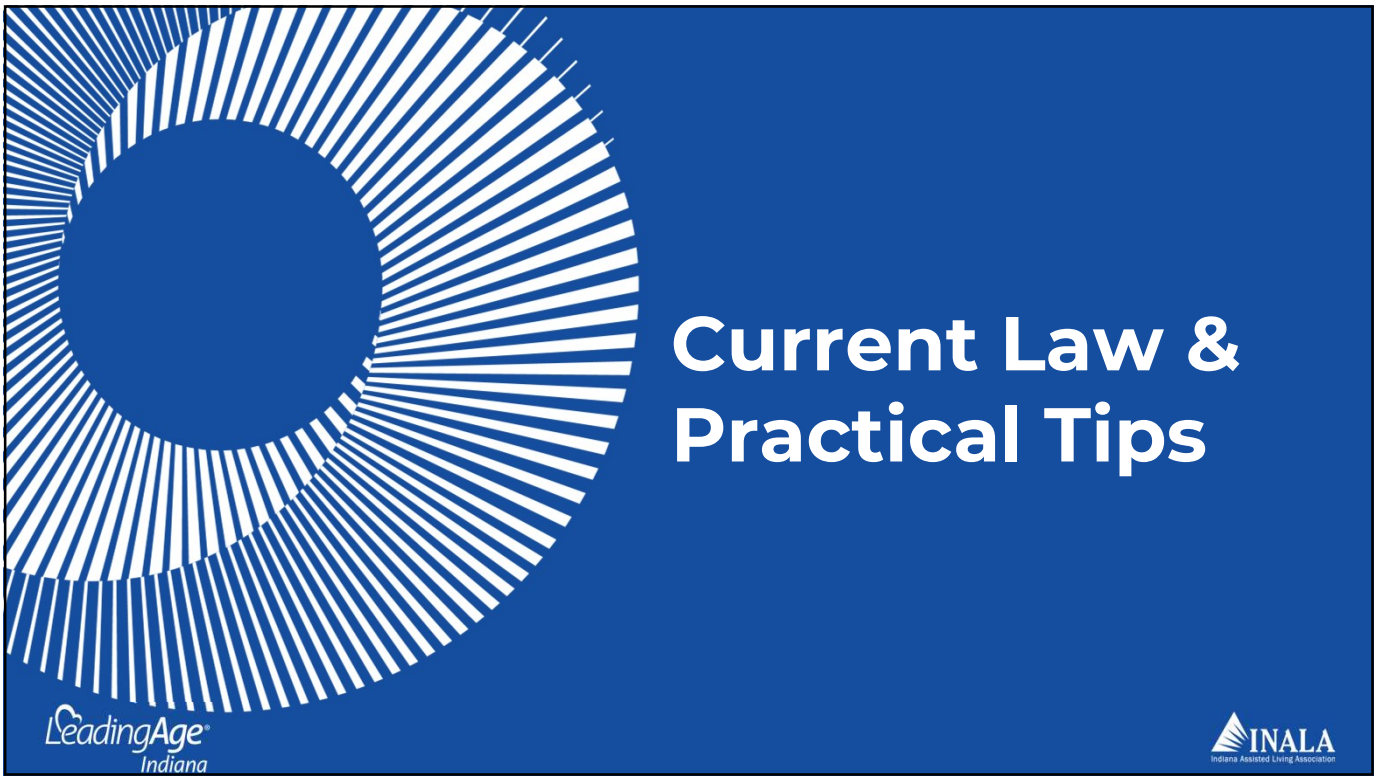

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Overview of 2019 Final Rule

- CMS finalized regulations implementing requirements enacted under the IMPACT Act of 2014 (the "Final Rule").
- The Final Rule adopted rules governing discharge planning from acute to PAC services.
- Hospitals must provide patients with information about PAC provider choices, such as **performance**, **quality**, and **resource-use measures**, as well as document in the medical record **patient goals** and **treatment preferences**.

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Overview of 2019 Final Rule

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Discharge Planning Process

- **Identify patients** at risk of adverse health consequences upon discharge.
- **Provide discharge planning evaluation** for all at-risk patients and any other patients upon the request of the patient, patient's representative, or patient's physician.
- **Ensure appropriate arrangements** for post-hospital care are made before discharge.
- **Evaluate need** for hospice, post-hospital extended care services, home health, and non-health care services and community-based care providers.

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Discharge Planning Process

- **Determine the availability** of appropriate services **and the patient's access** to those services.
- **Document** in the medical record the discharge planning evaluation.
- **Discuss** with the patient (or representative) the results of the evaluation.
- Upon the request of a patient's physician, arrange for the development and **initial implementation of a discharge plan** for the patient.

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Discharge Planning Process

- **Inform patient of right to choose** among participating Medicare providers and suppliers.
- When possible, **respect the patient's goals of care and treatment preferences**, as well as other preferences they express.
- **Not specify or otherwise limit** the qualified providers or suppliers that are available to the patient.
- **Reevaluate the patient's condition regularly** to identify changes that require modification of the discharge plan.
- **Update the discharge plan**, as needed, to reflect these

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Discharge Planning Process

- Assist patients in selecting a PAC provider by **using and sharing data** on quality measures and data on resource-use measures.
- Ensure that the PAC **data is relevant and applicable** to the patient's goals of care and treatment preferences.
- **Assess their discharge planning process** on a regular basis, which includes ongoing, periodic review of a representative sample of discharge plans.

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Transfer of Information

- The Final Rule implemented standards designed to facilitate efficient transfer of information from the hospital to PAC providers and suppliers.
- Upon discharge, the hospital must transfer all necessary medical information pertaining to:
  - Current course of illness and treatment.
  - Post-discharge goals of care.
  - Treatment preferences.
- Information is shared with PAC providers, suppliers, facilities, agencies and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.

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Disclosure Rules

- **List of Available PAC Providers**
  - A hospital must include in the discharge plan **a list** of all
    - Home Health Agencies (HHAs),
    - Skilled Nursing Facilities (SNFs),
    - Inpatient Rehab Facilities (IRFs), and
    - Long-Term Care Hospitals (LTCHs)

  that are available to the patient and participate in Medicare in the relevant geographic area.

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Disclosure Rules

- **Disclosure of Financial Interests**
  - The discharge plan **must identify** any HHA or SNF to which the patient is referred in which the hospital has a **disclosable financial interest**.
  - A disclosable financial interest is an ownership or control interest in any entity totaling 5 percent or more.
  - If a joint venture, a disclosable financial interest is an ownership of 5 percent or more of any company participating in the joint venture.

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Disclosure Rules

- **Disclosure Rules only apply when:**
  - A patient is discharged to home and referred to a HHA, or
  - A patient is transferred to a SNF, IRF, or LTCH.

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Disclosure Rules

- **Circumstances when Disclosure Rules do not apply:**
  - A patient is discharged to home without being referred to an HHA, or
  - A patient is referred only for:
    - Durable medical equipment;
    - Infusion services (unless provided by HHA);
    - Outpatient rehab;
    - Hospice; or
    - Other outpatient services.

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Enforcement

- Discharge planning rules are conditions of participation and surveyed accordingly.
- See Appendix A, CMS State Operations Manual.
  - Some guidance is still pending.
  - Heavy emphasis on communicating freedom of choice.

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_a_hospitals.pdf

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FAQ: List of Available Providers

Question:

Must the list of available providers be ranked alphabetically, according to quality measures, or other specific criteria?

Answer:

No. The Disclosure Rules do not dictate the order of the list of available post-acute care providers.

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FAQ: List of Available Providers

Practical Tip #1 (Hospitals and Affiliated Providers):
Hospitals should place their affiliates at the top of the list. This allows a patient to identify, and for the hospital to quickly highlight, which services are available within the health system. Those entities in which a financial interest exists must be identified, which may be done merely by using an asterisk or other identifying mark. Nothing more.

Practical Tip #2 (Non-Affiliated Providers):
Building relationships with discharge planners is key. Reach out to your local discharge planners, attend hospital meetings when possible, try to understand hospital discharge initiatives and goals, and attempt to create joint quality initiatives. Offer something that the affiliated providers don't (ability to accept difficult discharge patients, provision of specialized services, willingness to accept all insurances, fast admission decisions, warm handoff process between hospital and post-acute care services, internal training to prevent unnecessary readmissions). Provide a unique service that makes discharge planning easier, so that discharge planners want to showcase your services high on the list.

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FAQ: Quality and Resource Measures

Question:
May a hospital or post-acute care provider showcase specific quality and resource measures in which it excels?

Answer:
Yes. The discharge planning rules only require that post-acute care data on quality measures and data on resource use measures be relevant and applicable to the patient's goals of care and treatment preferences.

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FAQ: Quality and Resource Measures

Practical Tip #3 (Hospitals and Affiliated Providers):

Lead with your best quality stats that are meaningful to patients. Hospitals should highlight those quality measures in which it performs best if such quality measures and other data are relevant and applicable to the patient's goals of care and treatment preferences. Intersperse non-quality data that the patient values (number of food options, percent of individuals receiving pool therapy, most desired amenities). It is strongly advised that patients (or representatives) be referred to the appropriate online resources for all other up-to-date quality and resource use measures to assist the patient with making an informed decision.

Practical Tip #4 (Non-Affiliated Providers):

Present and showcase your best quality stats that appeal to the discharge planner's nursing experience. For example, Five-Star quality ratings on CMS Nursing Home Compare website may not align with hospital priorities. A top score on the CMS scale does not necessarily correlate with a low readmission rate. Low readmission rates, speed/timing of post-acute care services, infection rates, medication error rates, etc. may all assist in getting a discharge planner to favorably recommend your services if a patient asks for assistance in selecting a provider.

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FAQ: Marketing Materials

Question:

May a hospital include marketing materials within its discharge planning packets?

Answer:

Yes. There is no rule prohibiting a hospital from providing physical marketing materials (e.g., color brochures) in connection with the discharge planning process that educate the patient on the benefits of remaining within the system.

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FAQ: Marketing Materials

Practical Tip #5 (Hospitals and Affiliated Providers):

The hospital might emphasize the benefits of selecting an affiliated service provider by showcasing its integrated medical records systems, the ability to quickly transfer information, joint quality initiatives, ease of booking appointments, ease of verifying insurance information, etc. Color brochures may also showcase amenities available at a particular facility. This information will assist the patient in making an informed decision.

Practical Tip #6 (Non-Affiliated Providers):

Ensure discharge planners have your marketing materials to provide to patients. Provide marketing materials that appeal to both the discharge planner and the patient.

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FAQ: Post-Acute Care Partners

Question:

May a hospital refer to post-acute care providers in which the hospital has a disclosable financial interest as “Partners” of the hospital?

Answer:

Yes. There is no rule prohibiting a hospital from designating entities in which it has a disclosable financial interest as “Partners” of the hospital.

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FAQ: Post-Acute Care Partners

Practical Tip #7 (Hospitals and Affiliated Providers):

Hospitals may refer to those facilities with which it has a financial interest as "Partners," but must not otherwise limit the qualified providers or suppliers that are available to the patient. In preamble to the Final Rule, CMS stated that "***hospitals must not develop preferred lists of providers.***" In this case, the term "partners" is used to identify a fact (a disclosable financial interest and greater care coordination) and not to limit the list of PAC providers available to the patient.

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FAQ: Next Available Appointment

Question:

When documenting patient choice, if the hospital includes an option to place the patient at the next available provider/agency, can the hospital first determine availability at its affiliated Partners prior to determining availability at other unaffiliated providers/agencies?

Answer:

Yes. The discharge planning rules do not prohibit a hospital from first determining availability within its affiliated Partners so long as the process for determining the next available provider is disclosed to the patient and the patient is still permitted to select other alternatives (i.e., the patient may specify an unaffiliated provider).

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FAQ: Next Available Appointment

Practical Tips #8 (Hospitals and Affiliated Providers):

Hospitals should prioritize convenience with direct access to quickly check available appointments at affiliated PAC providers. Patients selecting the "Next Available Appointment" option are then notified that the hospital will first determine availability at its affiliated PAC providers, and if there is no availability within a short defined timeframe, the discharge planner will then reach out to unaffiliated providers/agencies for further options.

Practical Tips #9 (Non-Affiliated Providers):

Non-affiliated providers should work hard to become discharge planners preferred provider. Ease of admission/booking appointments, ease of verifying insurance, and the ability to quickly transfer information (including integrated medical record systems) may persuade a discharge planner to give your facility priority if the patient checks "Next Available Appointment" option.

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FAQ: Other Services

Question:

Is the hospital required to provide a list of available providers of services that fall outside of the Disclosure Rules?

Answer:

No. The Disclosure Rules and list requirements only apply when a patient is being discharged to home and referred to a HHA, or transferred to a SNF, IRF, or LTCH. Accordingly, the hospital is not obligated to provide a list of other available service providers for patients discharged to home (without referral to an HHA), or for patients requiring DME, infusion services (if provided by the hospital and not a home health agency), outpatient rehab, or hospice.

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FAQ: Other Services

Practical Tip #10 (Hospitals and Affiliated Providers):

While not always the case, hospital leadership, in consultation with medical staff, patient advocates, and other relevant stakeholders, should decide whether the hospital will provide a list of available service providers that fall outside of the Disclosure Rules and whether that list will be limited to the hospital's affiliated providers. The hospital may also choose to disclose its financial interest in these providers, but is under no regulatory obligation to do so under the Disclosure Rules.

Practical Tip #11 (Non-Affiliated Providers):

If you are a DME, outpatient rehab, or hospice provider, educate the discharge planners on your services, appeal to their desire to protect patient choice, and attempt to get discharge planners to include you on a list during discharge planning (even though there is no legal requirement).

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Getting a Fair Shake

- **How can a non-affiliated provider get a fair shake?**
  - –Communication is key.
  - –Most discharge planners are open to calm discussions regarding concerns of patient steering. Hospital administrators may need to be involved.
  - –Hospital compliance officers and anonymous compliance hotlines are possible options if no improvements are made.
  - –Build partnerships with hospital.
    - •Accountable Care Organizations
    - •Integrated medical record systems

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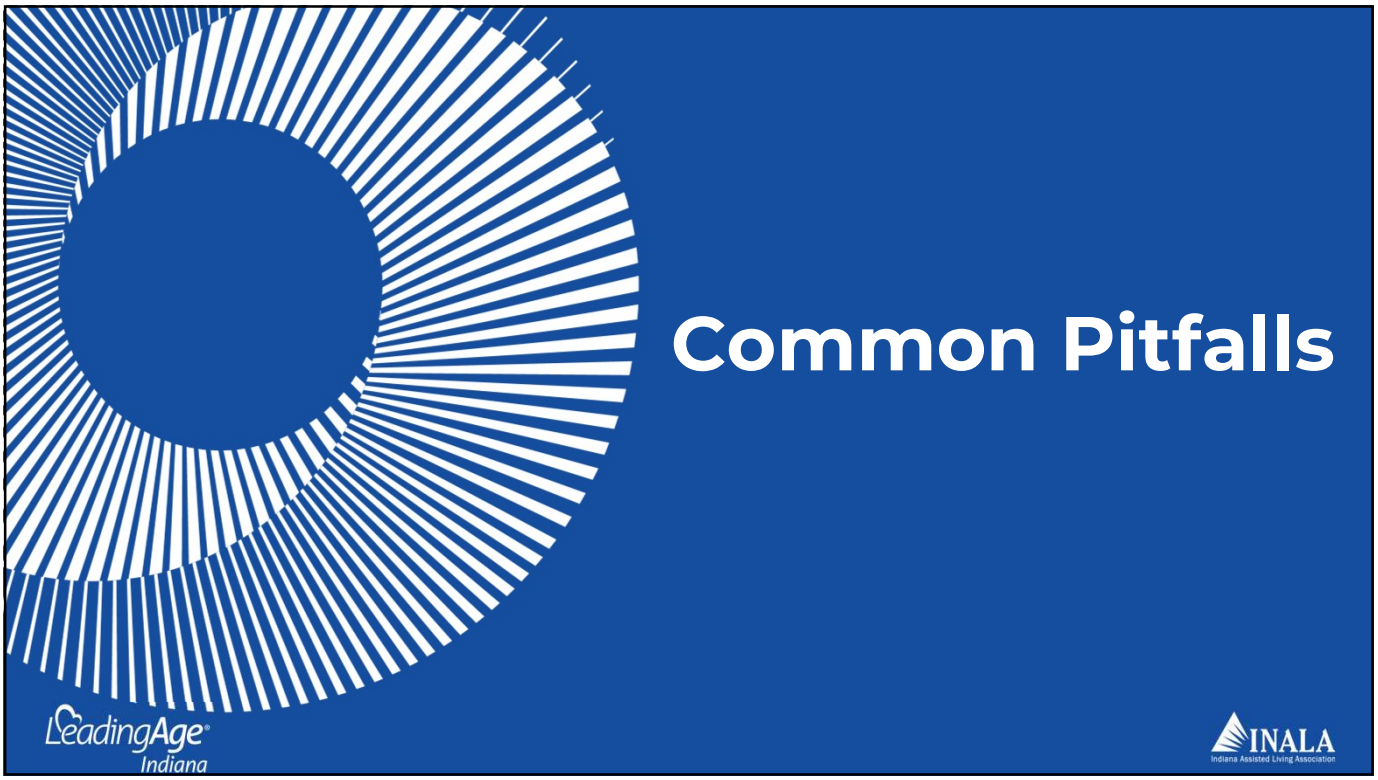

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Common Pitfalls

- **Kickbacks**
  - –Cash, Gift Cards, Gifts, Trips to discharge planners (Amity Home Health Care)
  - –Free discharge planning services to hospital (Lahey Health System)
    - Hospital liaisons, discharge coordinators, etc.
  - –Accepting charity care patients in exchange for future business
- **Failing to Provide or Document Patient Choice**
  - –Ensure clear policies regarding patient choice
  - –Do not restrict list of available providers
- **Joint Ventures**
  - –Post-acute care providers entering JV with hospital as a

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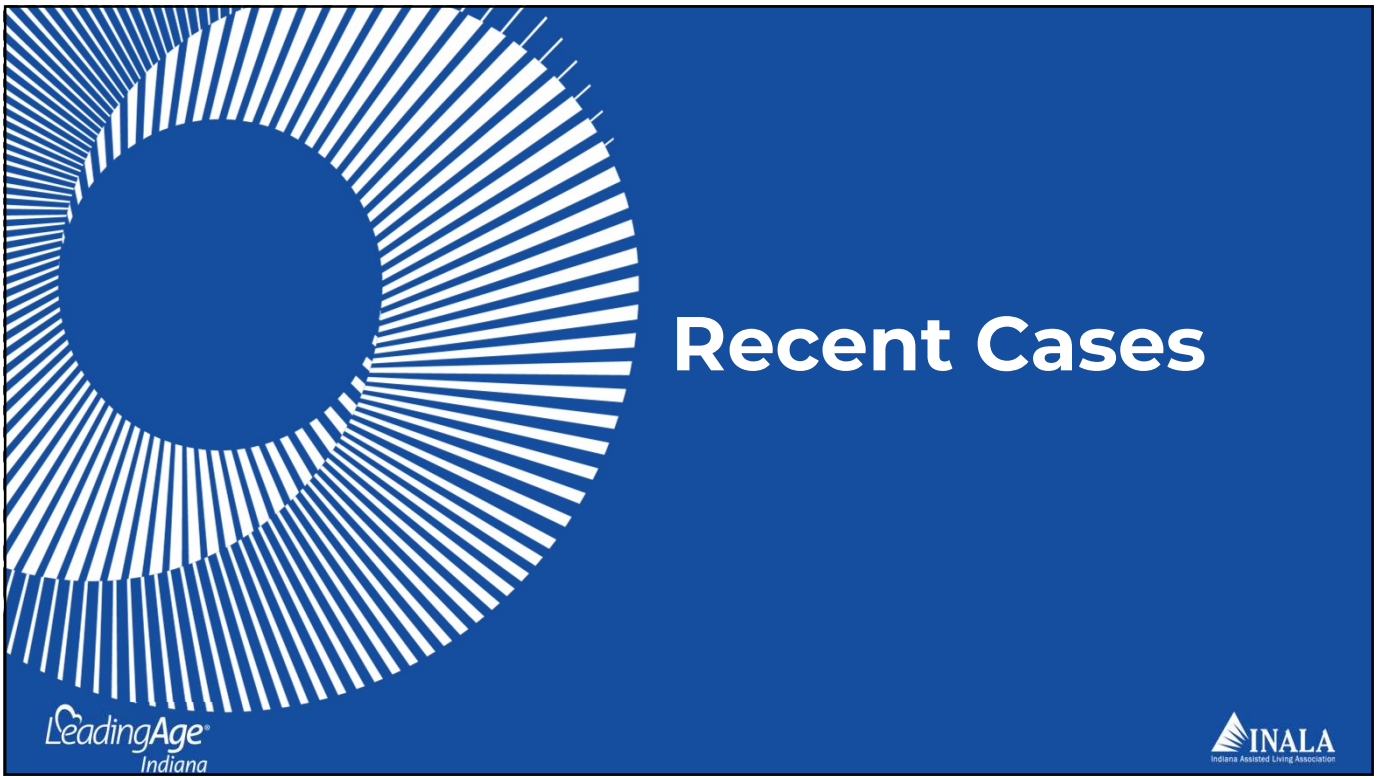

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Recent Cases Involving Discharge

- **Jeay Medical Services, LLC v. Centers for Medicare & Medicaid Services (Sept. 24, 2019).**
  - Administrative appeal of CMS's termination of an Oklahoma hospital's Medicare provider agreement for failure to adopt and implement discharge planning policies.
  - Termination upheld on appeal.
    - P&Ps did not address transfers and referrals.
    - P&Ps did not require ongoing reassessment.
    - P&Ps "substantially limited capacity to furnish adequate care and adversely affected the health and safety of

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Recent Cases Involving Discharge

- **U.S. ex rel. Hanlon v. Columbine Mgmt. Servs. (D. Colo. Feb. 23, 2016).**
  - –Whistleblower alleged defendant hospital violated the AKS and FCA because hospital engaged in patient steering and failed to disclose to patients its disclosable financial interest.
  - –"Based on careful review of the regulation, it contains no language which prohibits steering patients towards certain nursing home facilities, so long as the patients are informed of the nursing home options in their geographic region."

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Recent Cases Involving Discharge

- **Am. Home Healthcare Servs. v. Floyd Mem'l Hosp. & Health Servs (S.D. Ind. June 26, 2020).**
  - –HHA alleged defendant hospital violated the Sherman Act (antitrust) by attempting to "monopolize home healthcare referral of patients discharged from its hospital."
  - –HHA was included on the discharge list along with 20 others. The list included Floyd Home Care at the top and included information on each HHA and directed patients to Medicare website for more information. Hospital affiliated HHAs captured ~63.5% of referrals.
  - –Dismissed on summary judgment.
  - –HHA failed to establish a relevant market, that the hospital exercised market power, or that the hospital engaged in

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Questions and Answers

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