

Discharge Planning Issues in Hospitals: Steering to Preferred Certified Home Health Agencies and the Risks of Providing Free Discharge Planning Services to Hospitals

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Freestanding Certified Home Health Agencies (CHHA) often complain that hospitals are steering patients because the hospitals discharge most patients to the hospital's own home health agency. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has identified as a risk area tampering with patient's freedom of choice by hospital discharge planners steering patients to certain home health agencies, DME suppliers or long term care and rehabilitation providers. See *Compliance Program Guidance for Hospitals*, 63 Fed. Reg. 35, 8987, 8990 (2/23/98). In 1997, Congress addressed this issue by amending the statutory definition of a hospital, and amending its conditions of participation (COPs) to require that patients who need post-hospital services be given a list of providers located in the patient's geographic area to choose from. 42 U.S.C. § 1395a(a), Social Security Act (SSA) § 1802(a) entitled *Free Choice By Patient Guaranteed* is the basis for the Balanced Budget Act (BBA) '97 amendments. CMS has answered many questions involving these requirements in Frequently Asked Questions, most of which are summarized below. See also *CMS Program Memorandum Transmittal A-02-106* (10/25/02).

BBA'97 Amendments Impacting Discharge Planning

The definition of a hospital at 42 U.S.C. § 1395x(e),(ee), SSA § 1861(e),(ee), was amended to strengthen the discharge planning (D/C) process by requiring hospitals to follow standards detailed in its COPs at 42 C.F.R. § 482.43. Hospitals must identify patients who will need post hospital extended care, CHHA or hospice services, at an early stage in their hospital stay. This requirement applies to all patients in Medicare and Medicaid participating hospitals, regardless of whether the patient is covered by Medicare, Medicaid, managed care, private insurance or private pay. The hospital must evaluate patients that they have identified will need post hospital services, and also patients for whom an evaluation is requested by the patient, their representative or physician. The evaluation must be performed by a registered professional nurse, social worker, or other qualified personnel on an ongoing basis and in a timely manner to avoid delay in discharge, and ensure that post hospital care is in place. The D/C evaluation must be included in the patient's medical record, and its results discussed with the patient or their representative. The hospital must discharge the patient with necessary medical information to the appropriate provider chosen by the patient or his representative.

Patient Choice Requirements

The patient choice requirements are that the hospital must provide a list of CHHAs or post hospital extended care services to the patient or their representative. The list should only be provided to patients who need these services as indicated in the patient's discharge plan. This list should be given to the patient or their representative at least once prior to discharge. The hospital must list providers who request to be listed, if those providers are certified to participate in the Medicare program. Except for SNFs, the providers must make a request to the hospital to be listed, and they must be located in the geographic area where the patient resides.

Although the regulation, 42 C.F.R. § 482.43 discusses services provided by CHHAs and skilled nursing facilities (SNFs), the statute includes hospices. Therefore, a hospice which meets the requirements and requests to be listed on the post-hospital service list should be included. The discharge planner is expected to assist the patient with choices for other post-hospital services. Therefore, if a hospice or DME company or other post-hospital service, that is not a CHHA or a SNF, contacts the hospital to be included on the list, such a request made to the hospital may be honored. The list does not have to indicate the services provided by the provider. While the hospital should identify Medicare certified providers, there is no requirement that the hospital identify accreditations.

SNFs are not required to contact the hospital to be on the list. The Center for Medicare & Medicaid Services (CMS) recommends that SNFs can be identified from CMS's website at the Nursing Home Compare link, or by calling 1-800-MEDICARE (800-633-4227). The SNFs must be in the geographic area requested by the patient, which is not restricted to the geographic area where the patient lives. SNFs that are listed should be kept on the list regardless of whether they have available beds.

The hospital must not specify or otherwise limit the providers who are listed. As part of the D/C planning process, the hospital must inform the patient or their representative or family *"of their freedom to choose among participating Medicare providers of post hospital care services and must, when possible, respect patient and family preferences when they are expressed."* See 42 C.F.R. § 482.43(c)(7). Although the hospital discharge planner is not required to document the attempts to implement patient choice by placing a patient in a CHHA or SNF requested by the patient, it is recommended that such documentation be kept in the patient record. Hospitals are required to document in the patient's medical record that a list of CHHAs or SNFs was presented to the patient or their representative. The hospital is not required to duplicate the list in the patient's medical record. The hospital has flexibility to determine how to document in the medical record that the list was presented.

The hospital must disclose a financial interest in any of the listed providers. A disclosable financial interest is the same definition that is used in the provider enrollment process at 42 C.F.R. § 420.201(3). Financial interests include a direct or indirect ownership of 5% or more, or an interest of 5% or more in any mortgage, deed of trust, note, or other obligation that equals 5% or more of the property or assets of the disclosing entity. The method of disclosure is up to the hospital since there are no specific requirements. The hospital could highlight or identify those entities by another method, or maintain a separate list.

Should the list be given to patients who are enrolled in Managed Care Organizations (MCO)? Most definitely, members of an MCO should receive a list which identifies available and accessible providers in their network, as well as other providers, because the patient has the right to choose a provider outside their network. However, it is recommended, but not required, that the list contain a statement to remind the member that there may be financial liability if services are obtained from a provider outside their network. The hospital should contact the MCOs that their patients use, and request a list of their in-network providers.

Hospitals can create the list of CHHAs and SNFs from the CMS website by including a list of CHHAs in the patient's geographic area where the patient resides taken from the Home Health Compare link. For post-hospital extended care services, a list of SNFs in the



geographic area requested by the patient can be printed from the Nursing Home Compare link. In the alternative, the hospital can choose to develop its own list.

If the hospital chooses to create its own list of CHHAs and SNFs, it must comply with the patient choice requirements discussed above. The hospital cannot recommend or endorse the quality of care of any CHHA or SNF. The list must be legible and current. It is recommended that the list be updated at least annually. CHHAs must request to be on the list, and must be geographically available. SNFs do not have to request to be on the list. SNFs that are in the geographic area requested by the patient should be included. This is not restricted to where the patient lives. If the hospital has a financial interest in a CHHA or SNF on the list, it must be disclosed on the list. A home health agency that is not certified to participate in Medicare may be placed on the list if it makes the request. Hospitals may have one list combining the different types of providers or separate lists. The list does not have to list the providers in alphabetical order. There is no requirement specifying how the hospital should update its list. The hospitals have flexibility to determine their own process. However, use of the CMS website is recommended. Hospitals are not required to have lists for different geographic areas, or for each patient. For example, a hospital could distribute a list of SNFs located in selected geographic areas, or the entire state. Patients cannot be directed to the CMS website in lieu of giving them a list.

Enforcement Against Steering

Complaints about not providing a list to a patient who requires post hospital services, or a hospital's steering to a specific CHHA or SNF, should be filed with the state survey agency, the New York State Department of Health (DOH). Theoretically, the DOH could determine that the hospital is not in compliance with the hospital conditions of participation. Sanctions could include a mandated Plan of Correction, or possible termination from participating in the Medicare program. However, before filing such a complaint, the hospital should be contacted by the complaining CHHA or SNF. This communication should occur at a President or CEO level, or health care counsel level. The purpose of the contact should be to explain the requirements concerning patient choice, the non-compliance, possible sanctions, and suggestions to remedy the situation before any government contacts are made. In addition to health care law violations, there may be anti-trust issues, as well as unfair competition by hospitals who engage in steering.

Kickback Risks Of Providing Free Discharge Planning Services

Another risk area identified in the *OIG Compliance Program Guidelines for Home Health Agencies* is incentives to actual or potential referral sources, such as hospitals, that may violate the anti kickback laws. See 63 Fed. Reg. 152, 42410, 42414 (8/7/98). Sometimes this occurs when a CHHA intake coordinator crosses the line and performs discharge planning services for the hospital. Examples include rounding with hospital staff or reviewing medical records for the purpose of identifying patients who need home health services before the patient has been referred to the CHHA. The hospital COPs require that the hospital provide D/C planning services, and the hospital is reimbursed for those services by Medicare and Medicaid. Therefore, if a CHHA provides the D/C planning services for free to the hospital, the free service is a kickback for the referral of the patient to the CHHA. The *OIG Special Fraud Alert on Home Health Fraud* issued in June 1995 discussed the paying or receiving of kickbacks in exchange for Medicare and Medicaid referrals to include "providing hospitals with discharge planners, home care coordinators, or home care liaisons in order to induce referrals."

The Provider Reimbursement Manual (PRM) §§ 2113 – 2113.5 defines in detail the difference between home health intake coordination activities and discharge planning type activities. A CHHA can claim home health intake coordination activities on their Medicare cost report. After a patient's physician determines that home health services are medically necessary as documented in the patient's medical record and there is a referral to a CHHA chosen by the patient or his representative, the CHHA's nurse or social worker commences intake coordination activities. Intake activities include explaining CHHA's policies to the patient and family; developing the home health plan of care prior to D/C; assessing the patient for home health services such as nursing, therapies, home health aide services, medical supplies, DME and medications; and making the appropriate arrangements to ease the patient's transition from the hospital to the patient's home. These intake activities take place while the patient is still in the hospital, but only after the patient has been referred to the CHHA. Intake activities must be medically necessary, and not duplicative of services already performed by the hospital and for which the hospital is reimbursed, such as D/C planning activities. Intake coordinators are prohibited from reviewing medical records, visiting the patient and family, or participating in hospital rounds to determine the level of care needed by the patient once the patient is discharged. If the decision to refer the patient for post hospital care has not been made, and the patient has not been referred to a CHHA, SNF or hospice, the activities needed to reach that decision are included as part of the hospital D/C planning activities.

Solutions Found In Safe Harbor

The anti-kickback law is a broad prohibition precluding an offer, solicitation, payment or receipt of anything of value, direct or indirect, overt or covert, in cash or in kind, that is intended to induce referral of patients for items or services reimbursed by all federal programs, including Medicare, Medicaid, and programs covering veterans' benefits. Remuneration is anything of value including money, rebates and free services. Both the offeror and recipient of a kickback violate the law. A kickback can exist if one purpose of the payment is to induce referrals, regardless of the legitimate reason for the payment. Offering or receiving a kickback is a felony punishable by imprisonment, fine, automatic exclusion, and civil money penalties. See 42 U.S.C. § 1320a-7b(b)(2), SSA § 1128(b)(2).

However, there are "safe harbors" that describe different types of business relationships. If you follow the requirements of the safe harbor, there is no criminal or civil sanction. Failure to meet the requirements of a safe harbor is not automatically a kickback arrangement. The facts of the business relationship must be evaluated to determine intent. There are twenty-six business relationships for which there are safe harbors, including contracting for personal services. If state law permits, a hospital could contract with a CHHA to purchase discharge planning services. The contract and its implementation must comply with the safe harbor for contracting for personal services.

Those safe harbor requirements are: the contract must be in writing, signed by both parties, for a period of a year or more, and describe the discharge planning services to be provided. If the services are not provided on a full time basis, the contract must describe the schedule or interval when the contracted services will be provided. Payment must be set in advance, be fair market value (FMV), and have no link to the volume of referrals from the hospital. The contract must not promote a violation of federal law, and it must have a reasonable business purpose. See 42 C.F.R. § 1001.952(d). FMV generally means the price paid in an arm's length transaction, and does not take into account the volume or value of any referrals or business paid by Medicare, Medicaid or other government funded programs.



In addition to the potential kickback issue, the CHHA would have to obtain prior approval from its Medicare contractor, formerly called a fiscal intermediary, for a method to allocate the salary and fringe benefits of its nurses or social workers who will be performing the D/C planning services for the hospital, as well as providing services for the CHHA.

Conclusion

Both the steering and the kickback issue invite government scrutiny and sanctions. Relationships between hospitals and CHHAs, SNFs and hospices should be periodically examined by the provider's compliance officer with health care counsel to ensure that what is occurring in real life is consistent with the many requirements.