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Strategies for Handling the Difficult to Discharge Patient

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Roadmap

1. **Setting the Stage**
2. Fraud and Abuse Landscape
3. Model Strategies
4. Case Studies
5. Q & A

Appropriate Discharge

> "The hospital must discharge the patient . . . to the appropriate post-acute care service providers and suppliers . . . responsible for the patient's follow-up or ancillary care."

42 C.F.R. § 482.43(b)

Code of Medical Ethics

"Physicians' primary ethical obligation to promote the well-being of individual patients encompasses an obligation to collaborate in a discharge plan that is safe for the patient."

AMA Code of Medical Ethics Opinion 1.1.8

Barriers to Discharge

- Behavioral Challenges
  - Aggression, Violence, Justice-Involved
- Resistant Family Members
- Expensive Medications
- Specialized Needs
  - Substance Use Disorder
  - Mental Health
  - Significant Obesity

Anti-Discrimination Risks

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Thursday, September 8, 2022

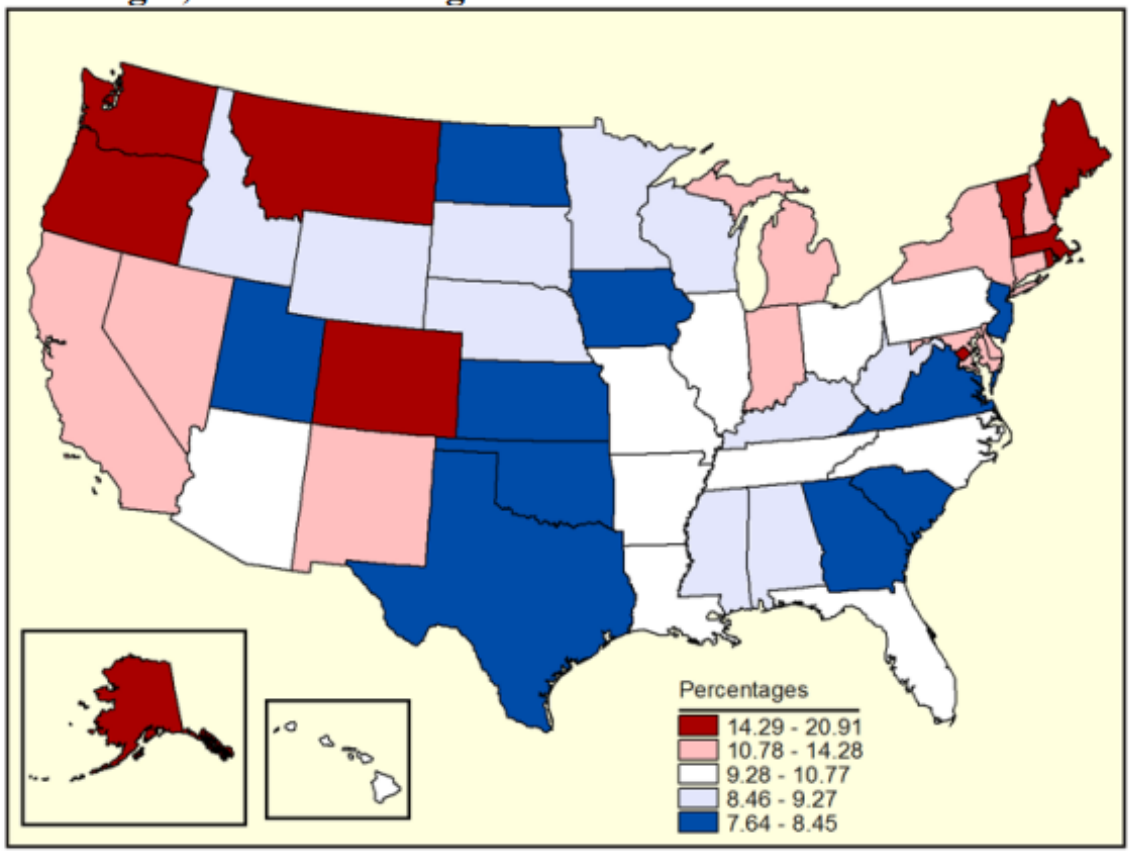
Operator of 21 Massachusetts Skilled Nursing Facilities Agrees to Resolve Allegations of Disability Discrimination

Operator allegedly denied admission to 548 patients who were prescribed medications for Opioid Use Disorder

BOSTON – The U.S. Attorney's Office reached an agreement with Next Step Healthcare, LLC (Next Step), the operator of 21 skilled nursing facilities in Massachusetts, to resolve allegations that Next Step violated the Americans with Disabilities Act (ADA) by turning away patients who indicated they were prescribed medications for Opioid Use Disorder (MOUD).

Barriers to Discharge

Figure 1a ***Illicit Drug Use in the Past Month among Individuals Aged 12 or Older,*** **by State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.

Impact on Health Care System

- 2013 Kaiser Health News study found that 1% of patients account for 21% of U.S. health spending

> "A 58-year-old Maryland woman breaks her ankle, develops a blood clot and, unable to find a doctor to monitor her blood-thinning drug, winds up in an emergency room 30 times in six months."
>
> "A 42-year-old morbidly obese woman with severe cardiovascular problems and bipolar disorder spends more than 300 days in a Michigan hospital and nursing home because she can't afford a special bed or arrange services that would enable her to live at home."

Impact on Hospitals

- Hospitals have patients taking a bed for months or years when they could be discharged if a safe placement were identified
  - Cost of caring for the patient can be extremely high
  - Contributes to lack of beds for other patients who need care
  - Not the best environment for the patient to recover
- Patients who don't receive the care they need on discharge far more likely to be readmitted

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Health Care Fraud and Abuse Laws

- **Federal**
  - Anti-Kickback Statute
  - Civil Money Penalties Law, including prohibition on Beneficiary Inducement
  - Anti-Supplementation Rules
  - "Stark" Physician Self-Referral Law
- **State**
  - All-payer Anti-Kickback Statutes
  - Fee Splitting prohibitions
  - Mini "Stark" laws
  - State Medicaid Fraud Laws

Federal Anti-Kickback Statute

Whoever knowingly and willfully offers, pays, solicits, or receives any remuneration directly or indirectly, in cash or in kind, in connection with:

(A) referring an individual for the furnishing of any item or service for which payment may be made under a Federal health care program, or

(B) purchasing, leasing, ordering, or arranging for any good, facility, service, or item for which payment may be made under a Federal health care program

shall be guilty of a felony and fined not more than $100,000 or imprisoned for not more than 10 years, or both

42 U.S.C. § 1320a-7b(b)

Beneficiary Inducement Prohibition

Any person that

> "offers . . . remuneration to any [Medicare or Medicaid beneficiary] that such person knows or should know is likely to influence [the beneficiary to order] from a particular provider, practitioner, or supplier any item or service for which payment may be made . . . under [Medicare or Medicaid]"

shall be subject to civil money penalties of up to $20,000 per item and triple damages

42 U.S.C. § 1320a-7a(a)(5)

Anti-Supplementation Rules

- As a condition of its Medicare provider agreement and under applicable Medicaid regulations and a criminal provision precluding supplementation of Medicaid payment rates, a nursing facility must accept the applicable Medicare or Medicaid payment (including any beneficiary coinsurance or copayments authorized under those programs), respectively, for covered items and services as the complete payment.

Anti-Supplementation Rules (cont.)

- Criminal penalties for Medicaid providers who charge patients rates in excess of those set by the State for covered services
- In most circumstances, Medicare providers may not charge beneficiaries or other individuals for items or services covered under Medicare
- Nursing facilities may not accept any "gift, money, donation, or other consideration" for the admission or continued stay of a Medicaid beneficiary

See 42 U.S.C. §§ 1320a-7b(d)(1), 1395cc(a)(1)(A); 42 C.F.R. §§ 447.15, 483.15(a)(4), 489.20(a).

Anti-Supplementation Rules (cont.)

"For example, an SNF may not condition acceptance of a beneficiary from a hospital upon receiving payment from the hospital or the beneficiary's family in an amount greater than the SNF would receive under the PPS." *OIG Supplemental Compliance Program Guidance for Nursing Facilities*, 73 Fed. Reg. 56832, 56846 (Sept. 30, 2008).

- Anti-supplementation does not apply to patients not covered by Medicare or Medicaid.
- Makes planning for uninsured, homeless, etc. easier.

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Historical Solutions

- Bed Reserve Agreements
- Personal Services and Management Contracts Safe Harbor
- Provide and Bill Practitioner Services

See 56 Fed. Reg. 35952 (July 29, 1991); 73 Fed. Reg. 56832 (Sep. 30, 2008)

New AKS Safe Harbors

- Care Coordination Arrangements
- Outcomes-Based Payments
- Patient Engagement Tools and Supports
- Risk Contracting for Value-Based Arrangements
  - Full Financial Risk
  - Substantial Downside Financial Risk

See 85 Fed. Reg. 77684 (Dec. 2, 2020); 42 C.F.R. § 1001.952

Other Strategies

- Local Transportation Safe Harbor
- Accountable Care Organization (ACO) Waivers

Digging in on Bed Reserves

- CMS recognizes that a "hospital may pay a skilled nursing facility (SNF) to set aside a certain number of beds for the hospital's discharged patients."
- Contemplates either cash payments or "free or discounted services" as compensation for bed reserve
- Cautions providers to avoid triggering anti-supplementation rules

See CMS Pub. No. 15-1 (Provider Reimbursement Manual) § 2105.3

Digging in on Bed Reserves (cont.)

- OIG cautions against "reserved bed payments that may give rise to an inference that the arrangement is connected to referrals."
  - Double-dipping (payments for occupied beds)
  - Payments for more beds than the hospital legitimately needs
  - Payments that exceed the nursing facility's costs or the actual revenues it reasonably expects to forfeit by holding a bed

See 73 Fed. Reg. 56832, 56845 (Sep. 30, 2008).

Are Bed Reserves Worth It?

Issue	Analysis
AKS Liability	 Low risk if payment less than SNF costs or expected revenues
Beneficiary Inducement	 No meaningful impact on bene
Anti-Supplementation	 Low risk if pay for unused days only
Practical Burden	 Cost of payment or in-kind service

Digging In On Care Coordination

- Allows participant in a Value Based Enterprise (VBE) to offer substantially discounted *in-kind* supports
- Could protect provision of medication, equipment, and health professional services
- 13 regulatory elements must be met, including establishing a VBE, recording the arrangement in writing, and monitoring legitimate outcome measures
- Some perceived to be high-risk entities may not participate (e.g., labs, pharma, most DME)

Care Coordination Elements (42 C.F.R. § 1001.952(ee)

- Exchange between VBE participants
- In-kind remuneration used for value-based activities
- Remuneration not used for billing, financial management, marketing, patient recruitment, or other unlawful purposes
- Commercially reasonable and does not take into account V or V of non-target referrals
- Terms set in advance in writing and signed by participants
- Parties establish legitimate outcome or process measures
- Recipients pay at least 15% of the offeror's cost
- Arrangement does not undermine patient-focused decision-making or impose inappropriate referral requirements
- No ineligible participants (e.g., pharmacy manufacturer, DMEPOS, laboratory)
- Special rules for limited technology participants
- Monitoring and reporting to VBE accountable body at least annually
- Corrective action or termination if arrangement compromises quality of care
- Six-year record keeping requirement

Is Care Coordination Worth It?

Issue	Analysis
AKS Liability	 Safe harbor eliminates risk
Beneficiary Inducement	 No impact on bene
Anti-Supplementation	 May somewhat mitigate risk
Practical Burden	 Added admin. costs
Improved Patient Outcomes	 VBE may drive improvements

Digging in on Outcomes Based Payments

- Achievement of one or more legitimate outcome measures used to quantify:
  - Improvements, or the maintenance of improvements, in quality of care; or
  - Material reduction in costs to or growth in expenditures of payors while maintaining or improving quality of care
- Methodology for aggregate comp. must be set in advance, commercially reasonable, FMV, and designed not to take into account the V. or V. of referrals / other business payable by a FHCP

See 42 C.F.R. § 1001.952(d)(2)

Additional Elements (42 C.F.R. § 1001.952(d)(2)

- Agreement between parties set out in writing and signed in advance
- Agreement does not limit any party's ability to make decisions in their patient's best interest nor induce any party to limit medically necessary items or services
- Term of at least one year
- Services do not involve the counseling or promotion of an activity that violates any State or Federal law
- Regular monitoring and assessment of agent's performance, including the impact of the arrangement on quality of care
- Periodic revision, as necessary, of benchmarks and remuneration
- Policies and procedures to promptly address and correct identified material performance failures or material deficiencies in quality of care resulting from the arrangement

Are Outcomes-Based Payments Worth It?

Issue	Analysis
AKS Liability	 Safe harbor eliminates risk; aggregate comp. must comply
Beneficiary Inducement	 No impact on bene
Anti-Supplementation	 May somewhat mitigate risk
Practical Burden	 Added costs
Improved Patient Outcomes	 Incentive may drive improvements in quality

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Scenario 1: High Cost Patient

- Hospital X has a patient who needs hospital care, but requires skilled nursing services
- The patient takes a medication that costs more per day than the SNF PPS rate
- Hospital X would like to discharge the patient to SNF Y, but SNF Y cannot afford to pay for the patient's medication
- SNF Y occasionally refers patients to Hospital X

Scenario 2: Unhoused SUD Patient

- Hospital X cares for substance-use disorder (SUD) patients who do not have access to shelter
- The patients do not need hospital care, but it would be dangerous to discharge them to the street
- Recuperative Care Program Y, which operates beds for unhoused individuals, partners with Home Care Z so that residents are visited by nurses
- Hospital X has been experiencing frequent readmissions of its unhoused SUD patients

- Discussion Topic:
  - What models are you seeing?

Questions and Discussion

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