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Post-acute provider compliance risks: Patient charting and patient steering

by Beth Kastner and Shannon DeBra

When hospitalized patients no longer require ongoing diagnostic or therapeutic interventions or close monitoring for their acute health conditions, they are ready for discharge from the hospital setting. But not all hospitalized patients are ready to return home at discharge and require further care. The hospital's team must determine the most appropriate setting for the patient, so the patient can continue to recover and reduce the likelihood of re-injury or readmission to the hospital. This post-acute care (PAC) is often provided PAC providers, including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), hospices, and home health agencies (HHAs).

PAC providers and hospitals must, out of necessity, work together to coordinate care of hospital patients ready for discharge. Beyond these required day-to-day interactions for treatment and care coordination-type activities, hospitals and PAC providers may also explore other ways to work together to improve care coordination, achieve value-based payment metrics, or further other shared objectives. While collaborations between hospitals and PAC providers can positively impact the quality of care provided to their respective patients, such collaborations can also create an environment that increases certain compliance risks for the PAC providers and hospitals.

The purpose of this article is to highlight "patient steering" and "patient charting"—two practices that have been identified by the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), and Office of Inspector General (OIG) as compliance risk areas under one or more federal laws. This article does not intend to identify all practices or arrangements between hospitals and PAC providers that could implicate federal law. In addition, laws of the state where the PAC provider and hospital operate should also be considered, including any state fraud and abuse and patient privacy laws. This article also offers practical tips to help identify and mitigate the risks associated with these practices for hospitals and PAC providers.

Patient steering

Congress codified in Section 1802(a) of the Social Security Act the "basic freedom of choice" of Medicare beneficiaries to obtain health services "from any institution, agency, or person qualified to participate" in the Medicare program.[1] CMS emphasized the importance of freedom of choice for patients discharged from a hospital who need PAC by including in the hospital conditions of participation a specific condition pertaining to the hospital discharge planning process. Patient steering can inappropriately interfere with patient freedom of

choice and present a compliance risk for hospitals.

Before discussing the compliance considerations raised by patient steering, we will explain what activities or practices could constitute patient steering.

What is patient steering?

While no uniform or regulatory definition of "patient steering" exists, CMS has informally defined patient steering as "directing patients and/or their caregivers to PAC providers that do not align with the patient's goals of care and treatment preferences."[2] Patient steering can also be described as otherwise inappropriately influencing patients' and/or their caregivers' choice of provider. Inappropriate steering would include, among other things, a hospital referring a Medicare patient to a particular hospice or SNF based on financial motivations of the hospital, instead of making the referral based on what is in the patient's best medical interests.

What are the compliance risks associated with patient steering?

The OIG has identified patient steering and protecting patient freedom of choice as a risk area for hospitals, especially for hospital discharge planners who are in a position to refer patients to PAC providers such as HHAs and SNF and IRF providers.[3] Beyond possible compliance concerns specific to discharge planning and patient freedom of choice, patient steering in the hospital-PAC provider context can also raise concerns relative to possible violations of the federal Anti-Kickback Statute (AKS) to the extent that patients are steered to particular PAC providers in exchange for remuneration.

Patient steering may jeopardize a hospital's ability to comply with Medicare hospital discharge planning and patient freedom of choice requirements

CMS has developed Conditions of Participation (CoPs) that hospitals must meet to begin and continue participating in Medicare and Medicaid programs. If a hospital is out of compliance with CoPs, sanctions could include a mandated plan of correction or even possible termination from participation in the Medicare program.

Referring patients to PAC providers with whom hospitals have business relationships or collaborations might, at first blush, seem to make sense since hospitals may feel like they know more about the PAC providers they already work with, or they may even feel like it's the right thing to do to maintain good relations with the PAC provider. However, these types of referrals may impede a hospital's ability to comply with Medicare CoPs for hospitals—specifically the Medicare CoP for discharge planning. The discharge planning CoP requires hospitals to assist patients and their families in selecting a PAC provider by using and sharing certain data about available PAC providers; it also requires that hospitals give patients their choice of PAC provider and generally prohibits hospitals from "steering" patients to any particular PAC provider. Specifically, the discharge planning CoP requires hospitals—as a condition of participating in the Medicare program—to have an "effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care."[4]

The discharge planning CoP requires, among other things, that hospitals "inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient."[5] Additionally, the discharge planning CoP requires, for patients for whom the hospital has determined through the discharge planning evaluation that home health or post-hospital extended care services are indicated, that the hospital includes in the patient's

discharge plan a list of HHAs, SNFs, IRFs, or LTCHs (as applicable) that are available to the patient, that is participating in the Medicare program, and that serve the geographic area in which the patient resides (or, for SNFs, IRFs, or LTCHs, the geographic area requested by the patient).[6] CMS acknowledged the potential conflict of interest that hospitals may encounter in this area, noting that while hospitals may have "working relationships with some PAC providers," hospitals are still expected to present patients with the list of PAC providers consistent with the discharge planning CoP.[7]

At its core, the discharge planning CoP requires hospitals to provide accurate, unbiased information about available PAC providers that provide the post-acute services discharging patients need to assist patients in selecting a PAC provider that can meet the patient's needs without interfering with the patient's freedom to choose any Medicare-participating PAC provider. Hospitals that fail to comply with the discharge planning CoP by providing the required list of available PAC providers or by otherwise interfering with the patient's freedom to choose a PAC provider face possible CMS sanctions up to and including termination of the hospital's Medicare provider agreement.