Compliance and Ethics – The FINAL CHAPTER

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History

- OIG Guidance
- Affordable Care Act
- Final Rule – Phase III

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OIG Guidance

- 1998
  - Hospitals
  - Home Health Agencies
  - Clinical Laboratories
  - Third Party Medical Billing Companies
- 1999
  - DME
  - Hospices
  - Medcare+ (Advantage)
- 2000 – updated 2008
  - Nursing Facilities

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Affordable Care Act

- The ACA authorized the Secretary of HHS to mandate providers and suppliers establish compliance programs as a condition of participation – or in the case of SNFs Requirement of Participation.
  - No deadline for implementation
  - Guidance had already been issued by OIG (previous slide)

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Final Rule

- Definitions
  - Compliance and Ethics Program
    - A program that has been reasonably designed, implemented and enforced to be effective in preventing and detecting criminal, civil and administrative violations
  - High-level Personnel
  - Operating Organization

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Final Rule

- Required components - minimum

  1) Written compliance and ethics standards and procedures
    - Goal: Reduce the prospect of criminal, civil and administrative violations
  - Designation of an appropriate compliance and ethics contact person for reporting violations
  - Anonymous reporting
  - Disciplinary standards
  - Covers staff, contract employees and volunteers

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Final Rule

2) Assignment of an individual within high-level personnel responsible for oversight of program
- CEO
- Board of Directors or
- Directors of major divisions in the operating organization

3) Sufficient resources and authority to the designated individual to reasonably assure compliance

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Final Rule

4) Due care not to assign authority to “bad actor”

5) Communication of standards, policies and procedures
- Mandatory participation in training, or
- Orientation training; or
- Dissemination of information.

6) Reasonable steps to achieve compliance
- Monitoring and auditing
- Publicizing a reporting system to report violations
- Process for ensuring intergrity of reported data

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Final Rule

7) Consistent enforcement through disciplinary measures, including failure to report

8) After a violation is detected, reasonable steps to respond and prevent further violations

- Modifiying program to address weaknesses

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Final Rule

- Organizations with five or more facilities
  - Mandatory annual training on compliance and ethics program
  - A designated compliance officer
    - Reports directly to governing body and not subordinate to the general counsel, CFO or COO.
  - Designated compliance liaison at each facility

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Final Rule

- Annual review
  - All organizations must review their compliance and ethics program annually and as needed
    - Changes in applicable laws or regulations
    - Changes within organization

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Areas of concern

- To avoid criminal, civil and administrative violations
  - False Claims
  - Requirements of Participation
  - HIPAA and HITECH

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Final Thoughts:

"If you think compliance is expensive – try non-compliance."

Former U.S. Deputy Attorney General Paul McNulty

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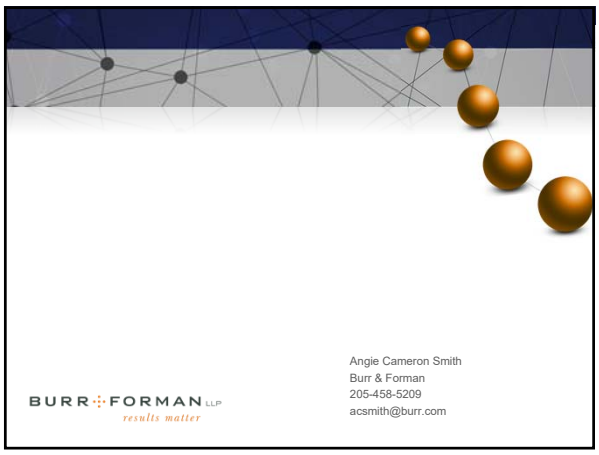

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Discharge Planning

- Final Rule issued in 2016
  - Resident Assessment 42 CFR 483.20 –
  - Comprehensive Care Planning 42 CFR 483.21
  - Admission, transfer and discharge rights 42 CFR 483.15 – F662
- F660 Discharge Planning, F661 Discharge Summary, F624 Orientation (when discharge planning not required)
- IMPACT Act in 2014

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Discharge Planning

- Effective discharge planning
  - Identification of discharge goals and plans
  - Development of discharge plan
  - Reevaluation of discharge plan
  - Update plan to reflect changes in treatment and goals of care
  - IDT involvement in discharge plan

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Identification & Development

- Part of the care planning process
  - Begins on admission
- Must include the involvement of the IDT

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Reevaluation and Update

- Assessment on a “timely basis” and “regular reevaluation”
- Discharge plan must be updated, as needed, to reflect changes noted in the reevaluation.
- Update plan based on information received from referrals to AAA or other appropriate entities
  - Considering home health referral, but home health evaluates and indicates not appropriate

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What and When

- Documentation
  - Resident has been asked about interest in returning to the community
  - Referrals to any local contact agencies or other “appropriate entities”
  - If not feasible to return to community, who decided and rationale for why not feasible
  - “Document, complete on a timely basis based on the resident’s needs, and including in the clinical record, the evaluation of the resident’s discharge needs and goals.”

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IMPACT

- Reporting of standardized data
  - SNFs - MDS
  - LTCHs - LCDS
  - IRFs – IRF PAI
  - HHAs – OASIS
- Interoperable to allow for exchange of data among Post-Acute Care (PAC) Providers
- Use of this data to assist residents transferring to another provider to choose a PAC provider
- “Present the data to residents…in order to assist them in making an informed decision regarding selection”

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Office of Civil Rights

- Guidance and Resources for LTC facilities: Using the MDS to Facilitate Opportunities to Live in Most Integrated Setting
  - https://www.hhs.gov/sites/default/files/mds-guidance-2016.pdf
  - Guidance to assist facilities with “civil rights” obligations
  - Olmstead v. L.C. – unnecessary placement may consistute discrimination
  - Unjustified placement can include placement in inpatient facility when resident coujld live in more integrated setting.

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OCR Guidance

- MDS
  - Section Q
    - Gives resident a direct voice in expressing preference and gives facility means to assist residents in locating and transitioning
- Local Contact Agency – community based organization responsible for counseling nursing facility residents on community support options
  - Area Agency on Aging
  - Regular contact with agency
  - Seminars/presentations on a regular basis (every 6 months)

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OCR guidance

- Proper use of MDS Section Q
  - Is active discharge panning already occurring for the resident to return to the community?
    - Active discharge means a plan that is being currently implemented
      - Current goals to make specific arrangements for discharge
      - Active steps to accomplish discharge
      - Target date for discharge in the near future
    - If not, “Do you want to talk to someone about the possibility of” discharge?
  - Q400 – Is Active Discharge Planning occurring?
    - If not referral to Local Contact Agency, check “no”

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OCR guidance

- Q400, check yes if
  - Resident is currently being assessed for transition by the Local Contact Agency (AAA)
  - Resident has "Transition Plan" in place which has all of the required elements and has been incorporated into the resident's Discharge Plan; OR
  - Resident has an expected discharge date of 3 months or less, has a discharge plan in palce with all required elements and discharge plan could not be improved upon with referral to AAA.

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OCR Guidance

- If no to Q400, ask Q500
  - Do you want to talk to someone about possibility of leaving and returning to the community
    - Yes – must be referred to Local Contact Agency
  - The question is "intended to provide the opportunity for the resident to get information and explore the possibility of different settings for receiving ongoing care
    - "most residents do not know what alternatives exist…"

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OCR Guidance

- Q600 – Has a referral been made to the Local Contact Agency?
  - Answer yes to Q500 or expressing interest to staff should be referred to Local Contact Agency
  - Referral to be made within a "reasonable amount of time" – RAI recommends 10 business days
- Inappropriate reasons to not refer to Local Contact Agency
  - Facility overrides resident's expressed interest based on belief that resident's condition to severe to transition
  - A belief that discharge not possible due to no home or community support or previous transition unsuccessful
  - The family or caregiver does not want resident to move.

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OCR Guidance

- Update to policies and procedures
  - Discharge planning
  - MDS administration
  - Local Contact Agency referral process
- Training of staff
  - "All staff" – direct care staff, care teams, facility's senior management team members and workforce members in any other relevant position.
  - Using the State RAI Coordinator or someone recommended by RAI

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OCR guidance

- Training of staff (continued)
  - Topics
    - Section Q
    - Local Contact Agency which serves the facility
    - Services provided by Local Contact Agency
    - When and how to contact Local Contact Agency
    - How to work collaboratively with Local Contact Agency
    - Home and Community based services
- Other resources included in the memo

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Discharge Summary

- Recapitulation of stay – a concise summary of the resident's stay and course of treatment
  - Diagnoses
  - Course of illness/treatment or therapy
  - Pertinent lab, radiology and consultation results

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Discharge Summary

Final summary of resident's status

- Identification and demographic information
- Customary routine
- Cognitive patterns
- Communication
- Vision
- Mood and behavior
- Psychosocial
- Physicial functioning
- Continence
- Disease diagnoses
- Dental
- Skin
- Activity
- Medications
- Special treatments and procedures
- Discharge planning

Available for release to authorized persons or agencies, with the consent of the resident or resident's representative.

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Discharge Summary

- Reconciliation of pre-discharge medications with post-discharge medications (both prescribed and over-the-counter)
- Developed with the participation of the resident or with the resident's consent, the resident representative.
- Where the individual will reside
- Arrangements for follow-up care
- Post-discharge medical and non-medical services

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Transfer and Discharge Defined

- Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plan or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. (F-540)

42 CFR 483.5 Definitions

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Transfer and Discharge

- Transfer: the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility
- Discharge: movement of a resident from a bed in one certified facility to a bed in another certified facilty or another location in the community, when return to the original facility is not expected.
- Resident-initiated transfer or discharge – resident or RR has provided verbal or written notice of intent to leave the facility (does not include elopement)

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Transfer & Discharge

When can the facility transfer or discharge a resident?

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Transfer & Discharge

Six Reasons for a Facility Initiated Discharge

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IMPORTANT!

Documentation in the resident's clinical record must support the reason for the discharge.

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Reason #1: Resident's Welfare

- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.
  - What has changed from admission?
  - Documentation in record regarding attempts to address issues

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Reason #1: Resident's Welfare

- The facility must provide 30 days notice to the resident.
- The resident's physician must document the reason for the discharge in the resident's clinical record.
  - Specific resident needs that cannot be met
  - Facility attempts to meet resident needs
  - Services available at receiving facility to meet needs
- The resident's physician must document in the resident's record that the resident is appropriate for discharge and the level of care the resident requires.

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Reason #2: Improved Condition

- The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the facility's services.

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Reason #2: Improved Condition

- The resident's physician must provide supporting documentation in the resident's clinical record for the basis of discharge.
- A 30-day notice is required.
- The resident's physician must also document in the resident's clinical record that the resident is appropriate for discharge and the level of care required for the resident.

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Reason #3: Safety

- The safety of individuals in the facility is endangered due to clinical or behavioral status of the resident.

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Reason #3: Safety

- Although there is no federal requirement that the resident's physician document in the resident's medical record, the Alabama Medicaid Regulations require the resident's physician to document in the resident's record that the resident is appropriate for discharge and the level of care the resident needs.
- The facility can provide the discharge notice on an immediate basis.

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Reason #4: Health

- The health of individuals in the facility would otherwise be endangered.

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Reason #4: Health

- The documentation in the resident's clinical records may be made by any physician.
- The discharge may be made on an immediate basis (or as soon as practicable).
- The resident's physician must document in the resident's clinical record that the resident is appropriate for discharge and the level of care the resident requires.

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Reason #5: Non-payment

- The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility.

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Reason #5: Non-payment

- A resident cannot be transferred for non-payment if the resident has submitted to a third party payor all of the paperwork necessary for the bill to be paid.
- Non-payment occurs if a third party payor, including Medicare or Medicaid, denies the claim and the resident refuses to pay for the resident's stay.

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Reason #5: Non-payment

- If the resident is being discharged for non-payment, the resident's physician must document in the clinical record that the resident is appropriate for discharge and the level of care the resident requires.

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Reason #6

- The facility ceases to operate.

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Written Notice

- 1. Must be given to the resident; AND
- 2. Must be given to the legal representative or sponsor.
- Must copy the Office of the State Long-Term Care Ombudsman

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Documentation to Receiving Provider

- Contact information of practitioner responsible for the care of the resident
- Resident representative contact information
- Advance directive information
- All special instructions or precautions for ongoing care
- Comprehensive care plan goals
- Discharge summary and any other documentation to ensure safe and effective transition of care.

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Written Notice

- Timing of the Notice: 30 days unless exception applies

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Exceptions to 30 day Notice Requirement:

- Endangerment to the health or safety of others.
- Resident's health has improved to allow a more immediate discharge.
- The resident has urgent medical needs.
- The resident has not resided in the facility for 30 days.
- Resident initiated transfer or discharge.

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Exceptions to 30 day Notice Requirement

- If an exception applies, the notice must be given as soon as practicable.

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Contents of the Notice

- Reason for Discharge;
- Effective Date of Discharge;
- The location to which the resident is being transferred or discharged;
- A statement that the resident has the right to appeal the transfer or discharge by filing a written request with Medicaid within 30 days;

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Contents of the Notice

- The name, address, and telephone number of the state long term care ombudsman;
- For residents with developmental disabilities or mental illness, the mailing address and telephone number of the Alabama Disabilities Advocacy Program (“ADAP”).
- If information in the notice changes prior to effective date of transfer or discharge, facility may update notice as soon as practicable.

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Discharge following rehab

- SOM states:
- *Discharges following completion of skilled rehabilitation may not always be a resident-initiated discharge. In cases where the resident may not object to the discharge, or has not appealed it, the discharge could still be involuntary and must meet all requirements of this regulation.*

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Declining treatment as basis for discharge

- Not generally a ground to discharge
- Unable to meet resident's needs or protect the health and safety of others
- Document communication re: risks of refusing treatment and assessments for alternate treatment

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Emergent transfers

- Residents sent to the ER are considered facility-initiated transfers
- Must be permitted to return to the facility unless the resident meets one of the criteria for discharge
- Notice to ombudsman can occur on a monthly basis (all other transfer/discharges must be sent at the same time notice provided to resident/resident representative)

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Appeal Rights

- Residents can appeal a transfer or discharge by filing a written request within 30 days of the discharge notice.

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When can I discharge the resident?

- The facility cannot discharge the resident until all administrative appeals have been exhausted, UNLESS…

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When can I discharge the resident?

- A facility may discharge a resident pending the outcome of the appeal ONLY if there is documented verifiable evidence in the resident's medical record indicating that the facility can no longer meet the resident's needs or he is a danger to the health and safety of other resident's in the facility AND an appropriate placement has been located.

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When can I discharge the resident?

- BE careful if trying to discharge the resident pending the appeal. It could subject the facility to enforcement action by ADPH.

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When can I discharge the resident?

- Filing a notice of appeal does not stay the enforcement of the agency's decision.
- The resident must seek a stay from the agency or reviewing court.
- If resident appeals while in the hospital, facility must allow resident to return, unless there is evidence facility is unable to meet needs or the health and safety of individuals is at risk.

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When can I discharge the resident?

- When transferring a resident, don't forget F-624, which requires the facility to provide sufficient orientation and preparation.

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Orientation

- Nursing homes must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.
- "Sufficient preparation" means the facility must inform the resident where he or she is going and take steps under its control to minimize anxiety.
- The facility should actively involve, to the extent possible, the resident and the resident's family.

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Examples of Orientation

- Trial visits by the resident to the new location.
- Working with family to ask their assistance in assuring that the resident valued possessions are not left behind or lost.
- Orienting staff in the receiving facility to the resident's daily patterns.
- Reviewing with staff routines for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression and recognizes characteristic resident reactions identified by the resident assessment and care plan.

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Discharge Plan of Care

- A discharge plan of care must be provided to the resident.
- It must include a plan of care to meet the needs of the patient and assist in the patient's adjustment.
- Medicaid interprets this to include a place of discharge to meet the patient's needs or plans by which his needs will be met at some location other than another facility.

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Discharge Plan of Care

- Simply listing the sponsor or family's address as the place of discharge is not sufficient.
- Documentation should be sent which ensures that the patient's needs can be met.
- A copy of the post discharge plan of care as well as documented efforts of the facility with finding other placement should be provided both in the notice and for the review.

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QUESTIONS?

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