Best Practices for Dealing with Difficult Discharges

Legal Framework for discharge planning

Every hospital at some time will face a situation in which a patient presents as a “difficult discharge.” This situation could result because the patient has limited social support, limited or no health plan coverage, complex and unique medical conditions, limited or no financial resources or just plainly refuses to leave. The hospital attorney whether in-house or outside counsel has a role to play in these difficult discharge cases.

Make sure your hospital client follows the state and federal legal and regulatory requirements along with health plan requirements. These requirements include:

- Medicare requirements for discharge planning, member rights and appeals.
- State licensing laws for hospitals related to discharge planning.
- Medicaid requirements for discharge planning, member rights and appeals.
- The Joint Commission requirements for discharge planning.
- Health plan provider contracts
  - NCQA requirement
- Health plan member contracts
  - NCQA requirements

Requirements Applicable to Discharge Planning

Medicare

Medicare has very specific requirements for discharge planning. 42 C.F.R. § 482.43.

Essentially these requirements are
that there is a discharge planning process for all patients

that a discharge planning evaluation occurs that addresses the likelihood of the patient needing post hospital services and the availability of those services

the evaluation and eventual discharge plan must be documented

the evaluation needs to be discussed with the patient and the family and the patient and family need to be counseled

If the patient needs to be discharged to a nursing home or home health agency the patient needs to be provided with a list to choose from and of their right to choose their provider

  o And the post discharge facility should be in the geographic area the patient has requested.

Patient preferences are to be respected whenever possible. Sometimes the patient’s preferences cannot be fulfilled and particularly with patients with complex conditions such as, ventilator patients, patients with Alzheimer’s or severe behavioral health issues, the patient’s choices will be limited.

Similarly if the patient is in a Medicare managed care plan the patient’s choices may be limited to providers within a specific network or there won’t be coverage or the patient will have to pay an increased cost sharing amount. Your discharge planners know that managed care plan requirements need to be taken into consideration when crafting a discharge strategy.

Medicare also sets requirements for patients to participate in their care planning, including discharge planning at 42 C.F.R. § 482.12. “The patient has the right to participate in the
development and implementation of his or her plan of care.” While the patient’s rights “include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate care.” 42 C.F.R. § 482.12 (2).

If the patient is a Medicare beneficiary, your hospital must follow Centers for Medicare and Medicaid Services (CMS) regulations prior to discharging a patient and must notify the patient of their hospital discharge appeal rights 42 C.F.R. § 405.1205 and their right for an expedited determination 42 C.F.R. § 405.1206.

If the patient is not willing to be discharged you must document that you have followed all of the legal/regulatory requirements, including health plan requirements. Follow your internal policies for notifying the patient of the discharge and of his/her right to appeal that decision.

Your hospital’s discharge planners and utilization review departments will already have a good understanding of those processes but you can familiarize yourself with information on Medicare Beneficiary Notices by going to the CMS website at www.cms.gov and entering “Beneficiary Notices Initiative” or “BIN” in the search engine or follow this link http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni

The Joint Commission

Related to Medicare requirements are the Joint Commission standards for accreditation. The Joint Commission has standards that address discharge planning. Among those requirements are:
• PC.04.01.03 The hospital discharges or transfers the patient based on his or her assessed needs and the organization’s ability to meet those needs.

• PC.04.01.05 Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment and services.

• RI.01.01.01 The hospital respects the patient’s right to participate in decisions about his or her care, treatment and services. That right however is not to be interpreted as a right to demand medically unnecessary or inappropriate care. While patients have the right to refuse care or choose a particular course of care that doesn’t mean hospitals have to provide what the hospital providers believe to be inappropriate. [Excerpted from The Joint Commission 2011 Hospital Accreditation Standards, PC-Provision of Care, Treatment and Services and RI Rights and Responsibilities of the Individual]

State Medicaid program requirements

Your state’s Medicaid program will have discharge planning requirements for the hospital. As an example I have included an excerpt from the Michigan Medicaid Provider Manual that addresses discharge planning:

“As part of utilization review, the hospital should consider various alternatives for care of the beneficiary through discharge planning. The medical and social services personnel of the hospital should assist in this effort. If so requested by the hospital, the local DHS [Department of Human Services] county office assists in relocating the beneficiary.” Michigan Medicaid Provider Manual, Chapter-Hospital, Section 5 – Discharge Planning (Version Date January 1, 2013)

The Manual then goes on to describe certain alternatives for care covered under the program, i.e. care in the home and ventilator care, and the financial penalties a beneficiary may face if they decline placement.

The Manual also sets out patient rights and the financial liability for Medicaid patients who refuse to be discharged from the hospital. Your own state’s Medicaid program should have specific requirements for these situations. Check your state Medicaid program requirements.

**State Licensing Laws for Hospitals**

Check your state’s hospital discharge planning requirements by looking at your state’s licensing statutes, guidance documents, surveyor tools and administrative rules or regulations. As an example – Michigan has licensing statutes that address patient rights that speak to discharge planning.

The state of Michigan has licensing statutes that address hospital patient rights and administrative rules for hospital licensure (that reference Medicare and Joint Commission requirements)

In Michigan a patient has a right to adequate and appropriate care and is entitled to receive information concerning his or her continuing health needs and alternatives for meeting those needs MCLS § 333.20201 (e), and to be involved in his or her discharge planning, if appropriate. MCLS § 333.20201 (j). Note the use of the terms “adequate” and “appropriate” which is not the same as the “best” care or the care that is demanded by the patient. No patient
wants to hear that she has a right to adequate care. People want the right to the “best” care which isn’t always possible and which often leads to the discharge disputes.  

**Commercial Health Plans**

Private payers will generally establish their own discharge planning criteria in the provider contract and related provider manuals and often those requirements are based upon accreditation standards such as NCQA (National Committee for Quality Assurance).

Remember that the goal of the health plan is to coordinate care and provide coverage for medically necessary care at the right time in the most appropriate and often the most cost effective setting.

Most commercial health plans have the follow elements:

- Member rights and responsibilities described in the health plan coverage documents, governed by state and federal laws, give members substantial rights to appeal denied claims. As a side note, these rights have been in existence for many years but the Affordable Care Act has really strengthened member appeals rights

http://cciio.cms.gov/programs/consumer/appeals/index.html. Just as with Medicare and Medicaid appeals to QIO’s, your patients with commercial plan coverage can appeals denials while in your hospital. Be prepared for the patient to remain in your hospital until the patient’s appeal rights have been exhausted.

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1 I call this the “Curse of the Medicare Five-Star Quality Ratings.” Often the patient does not want to go to the first available nursing home if it is less than five stars. CMS should be applauded for making nursing home survey information and rankings available, however, the transparency of the Five-Star reports produces expectations by patients and family that they can stay in the hospital until their preferred Five-Star nursing home is available. It comes as a shock to the patient and family that their commercial health plan, Medicare and Medicaid will not permit them to stay in the hospital until a “preferred” nursing home bed becomes available.
• Case management departments of the health plan that can assist with identifying facility/services available after discharge

• Utilization review (UR) departments of the health plan that can work with your hospital UR department to identify potential difficult discharges early on in the admission. The UR personnel of both the health plans and hospitals exchange information on the patient’s condition and if the health plan knows early on that the discharge may be difficult, they can bring in case managers to assist with complex discharges.

• Written denials of care that are very specific and explain to health plan members that the members will have to pay out of pocket for denied care. Often the health plan denial of care with its description of the financial liability is the impetus a patient needs to decide to cooperate with a discharge plan.

How Health Plans Can Help Facilitate Difficult Discharges

If your patient’s health plan is lacking in some coverage necessary for the patient’s discharge such as private duty nursing, the health plan may be willing to cover these “uncovered services” by substituting a covered benefit. You can negotiate with payers for creative solutions for covering care necessary to discharge a complex patient from your hospital. Health plans have an interest in moving patients out of expensive acute care into less intensive and less cost effective settings. Most health plans are willing to partner with hospital and other providers to find creative solutions for patients that will help keep the patient out of the hospital. Health plans will consider out of network services or customized care but may achieve that customized care by converting certain benefits into other benefits. So as an example, SNF benefits may be converted to home care days or home care days converted to private duty nursing hours.
The attorney can assist the discharge planner and care team to obtain a modified benefit for the patient that may help facilitate the discharge to a less acute setting.

A commercial plan, however, still can’t act as a surrogate decision maker and “force” a patient to consent to a transfer or to a discharge plan.² The commercial health plan only makes a decision regarding payment for care.

**Patient Rights and Responsibilities**

Patients have responsibilities as well. The NCQA establishes health plan member rights in addition to those created by state and federal law. Among these rights are:

- A right to a candid discussion of appropriate or medically necessary treatment option for their conditions, regardless of cost or benefit coverage.
- A right to participate with practitioners in making decisions about their health care.

In addition the NCQA establishes certain responsibilities for health plan members:

- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

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² Health plans and healthcare providers may want to consider putting language in their plan documents and consent to care documents, respectively, in which the member/patient agrees to a transfer to a less acute setting, subject to an appeal process. I have never seen such language enforced by a court or used to transfer a patient to another setting against the patient’s express wishes but arguably this is something that could work, particularly in an accountable care organization where the subacute providers are all part of one ACO.
These patient responsibilities are important because in any legal proceeding a failure of the patient to fulfill these responsibilities should be pointed out to the court. If a patient has failed to supply information or to cooperate in care planning, you’ll need to bring this to the attention of a court in any successful proceeding.

Legal Proceedings: The Last Resort

It has been my experience that a legal proceeding should be initiated as a last resort. The only exception would be a situation where a patient is not able to participate in decisions regarding his/her care. If the patient is not able to participate due to cognitive issues or due to some other disability, the hospital attorney can pursue a guardianship and should pursue that process quickly.

Guardianships and Surrogates

You will have to check your state probate court requirements but generally if a patient is not able to participate in the decision making process and any surrogate decision makers available by operation of your state’s laws are not cooperating with discharge planning, you can pursue the appointment of a guardian.

Be careful though, because oftentimes it’s the family member or surrogate who is the impediment to discharge planning. Courts have an obligation, generally, to appoint a family member as the guardian or to consider the wishes of the alleged incapacitated person when appointing a guardian. You may end up with a legally appointed guardian who continues to
frustrate plans for discharge. And once that guardian is appointed it is hard to remove that person absent some proof that the guardian is not acting in the best interests of the patient.

Some strategies you could employ are to ask the court for a limited guardianship that would limit the guardian’s authority to placement in an appropriate facility. If you can prove to the probate court that a family member or surrogate responsible for medical decision making is not acting in the best interests of the patient “for purposes of discharge planning and care planning” you are likely to be more successful due to the limited nature of your perceived attempts to usurp a family member or surrogate preferred by the patient. Similarly you can request a temporary and limited guardianship, thus assuring the family/surrogate and the probate court that the hospital’s interest is limited to facilitating an appropriate discharge.

Michigan has a probate proceeding the permits a court to issue a “protective order” when a person is unable to managed property and business affairs effectively for reasons that include “confinement” and “physical illness or disability”. MCLS § 700.5401. Confinement is not defined but arguably would extend to a confinement in an inpatient setting. You could seek a protective order for a one time transaction to enter into a contract for services at a nursing home or with a home care provider. MCLS § 700.5408 Protective arrangements include but are not limited to “contracts for life care”. Check your state law for similar proceedings.

And if you are in a probate process seeking a guardian appointment you may also consider asking for a financial conservator to be appointed if the patient has assets that will need to be used to pay for care after discharge.

Establish a relationship with the local probate court. Invite the probate administrator or staff to meet informally with the hospital legal department or hold in-services for the social work and discharge planning staff. You’ll have a better sense for how the court views patients
refusing to leave a hospital. For example, the local probate court I was most familiar with in Michigan doesn’t consider a patient staying over in the hospital an emergency situation requiring an emergency appointment of a guardian. From the court’s perspective, the patient is in a safe environment in the hospital and the emergency just doesn’t exist. That same court, however, was willing to entertain the “protective order” action, which was unique, when a patient who no longer needed inpatient care was refusing to leave the hospital. The good relationship the legal office of the hospital developed with the local probate court administration, along with a reputation for not wasting the court’s time with frivolous actions, and a genuine concern for patients, likely helped persuade the court to entertain a rather unique action.

Your discharge planning staff should be able to identify early on in the admission if a guardian will be needed and the hospital attorney can help develop a process to expedite the filing of any guardianship petitions.

**Evictions/Actions for Trespass/Injunctions**

The most onerous of the legal processes and the one most likely to generate public relations concerns is an action for eviction/trespass or an injunction to remove a patient.

The attorney first must make sure that all appropriate notices have been provided to the patient and caregivers. These notices include the notice that inpatient services are no longer needed, denials by the relevant health plans, all notices of appeal rights and presenting the patient/family members with a claim/invoice for services and an estimate the daily cost of additional care. I can’t emphasize this enough the need to generate an invoice for services.
If the patient has any financial assets the patient needs to be shown the potential liability that he or she will have by staying on in the hospital. The court also needs to understand the potential loss of assets [when the patient has financial assets] and the cost to the hospital for a holdover patient. So give the patient an invoice for payment received to-date and tell them what the estimated costs will be for each day going forward. Then present the patient with an updated invoice on a weekly basis. It sounds harsh but sometimes the reality of the financial costs of staying on can motivate a patient to decide it’s time to engage in the discharge planning process.

The legal process you select will depend on your state laws. Generally you will be filing an action to recover possession of real property along with an eviction. You will see in the analysis of case law in a later section that some states have an injunction process that can also be used.

For example, Michigan it is a misdemeanor to “remain without lawful authority on the land or premises of another after being notified to depart by the owner or occupant or the agent of the owner or occupant.” MCLS § 750.552 (b). Anyone violating that statute may be imprisoned in the county jail for no more than 30 days or fined no more than $250 or both. But your goal is not to put the patient in prison or have a fine assessed. You want the patient to leave the hospital.

Michigan also has a cause of action to recover possession of real property to evict a tenant, a trespasser or someone who entered the premises legally but is now refusing to leave. 

http://courts.mi.gov/Administration/SCAO/Forms/courtforms/landlord-tenantlandcontract/dc102c.pdf
If the court enters a judgment in favor of the hospital and the defendant refuses to leave the hospital as described in the judgment, the hospital can file an application with the court to have the patient evicted by specific categories of peace officers.

North Carolina has a specific statute that makes remaining at the hospital after an appropriate discharge a criminal offense. N.C. Gen. Stat. § 131E-90. The authority is given to the hospital administrator:

*The case of a patient who refuses or fails to leave the hospital upon discharge by the attending physician shall be reviewed by two physicians licensed to practice medicine in this State, one of whom may be the attending physician. If in the opinion of the physicians, the patient should be discharged as cured or as no longer needing treatment or for the reason that treatment cannot benefit the patient's case or for other good and sufficient reasons, the patient's refusal to leave shall constitute a trespass. The patient shall be guilty of a Class 3 misdemeanor. (1965, c. 258; 1983, c. 775, s. 1; 1993, c. 539, s. 959; 1994, Ex. Sess., c. 24, s. 14(c).)*

While an eviction may work with an ambulatory and competent patient, I don’t believe that it is an appropriate resolution for patients who are non-ambulatory and not competent...unless your hospital want to be featured on CBS 60 Minutes

http://www.cbsnews.com/2100-18560_162-2823079.html or become a headline story.³

Any action for eviction for a non-ambulatory patient would still require a discharge plan in place that assures that the patient will be in a relatively safe environment otherwise the

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³ The CBS 60 Minutes episode focusing on patient dumping and related media coverage ultimately led to a Los Angeles city ordinance prohibiting hospitals from discharging patients to homeless shelters without first determining that the shelter would accept the patient. http://www.californiahealthline.org/features/2010/moving-homeless-patient-discharge-from-the-streets.aspx

The COP requirements include:

4.6 Did the evaluation include an assessment of the patient’s post-discharge care needs being met in the environment from which he/she entered the hospital?

4.10 If the patient or family/support person is unable to meet care needs or there are additional care needs above their capabilities, did the evaluation include an assessment of available community-based services to meet post-hospital needs?

There are other COP’s related to referrals for appropriate post-discharge services that would arguably be violated if a non-ambulatory patient in need of continuing care is evicted and “dumped” or sent to a homeless shelter with no arrangements for continuing care. So while an available legal process may permit you to evict non-ambulatory patients or patients with ongoing health care needs there are risks associated with those processes such as regulatory non-compliance and the attending negative media coverage.

Even if the eviction process is successful and the hospital wants to do the right thing and find an appropriate placement, there are many barriers to success:

- Finding a nursing home that will accept a competent patient who will not consent to transfer although if the patient came from a nursing home that
home should accept the patient back under applicable bed hold policies. 42 C.F.R.§ 483.12 (b)

- Finding a nursing home that will accept a patient if no one with “legal access to a resident’s income or resources” will sign a contract to provide payment from those sources…. or maybe there aren’t any sources of income. Nursing homes shouldn’t require a third party guarantor 42 C.F.R. § 483.12(d)(2) and many may be willing to become a representative payee for Social Security or veteran’s benefits but if the patient has no source of income or assets and is not eligible for Medicaid the nursing home may want a payment source. That could be a church organization or some other non-profit agency. You need to get creative and your hospital needs to have good strong relationships with public and private social services providers in the community.

- Finding a home care provider that can accommodate complex cases with often unpleasant and combative patients. How much abuse does home care staff have to tolerate before they can refuse to accept a patient?

- Modifications may be needed to the home for a safe discharge. Who will pay for that modification? The hospital? A community or church group?

The following cases illustrate attempts by hospital providers to remove patients based on varying legal theories and statutes:


NY has an injunction statute within its Public Health Code, NY CLS Pub Health § 2801-c that the hospital sought to enforce requiring the patient to leave the hospital on the basis that he no longer required acute hospital care and unreasonably refused to cooperate with his discharge plan. The court said that review of the relevant guidelines in NY revealed that they were
meticulously followed. The Medicare regulations regarding notification of discharge along with appeal rights were also followed and the relevant QIO decision was part of the application for the judgment. The patient’s failure to consider any other alternatives (to discharge) deprived the public and other needy patient of a bed at the hospital to meet their acute medical needs. A judgment was granted requiring the patient to discharge himself forthwith” from the hospital and to “accept placement in any appropriate skilled nursing facility that offers a bed for admission”


The court in Matter of New York Methodist cited Wyckoff. In Wyckoff the respondents included not only the patient but a visiting nurses association which argued that the hospital had no standing to maintain an action for a mandatory injunction ordering the patient to leave the hospital. The patient opposed the discharge on the grounds that he was unhappy with the health care facility that agreed to accept him.

The visiting nurses association refused to provide the patient with any home health care because the patient had been violent, abusive, threatening and harassing to all the home health attendants in the past.

The Wyckoff court granted the injunction and noted that the applicable procedures were followed meticulously. The patient was notified of his right to appeal the discharge which he did. His Medicaid appeal rights were followed and the peer review organization upheld the determination of the hospital that the patient was ready to be discharged. The fact that the patient wasn’t satisfied with the adult home that had agreed to accept him was not “material” in the view of the court. The court concluded that because of the patients history of violence he
forfeited any claim to demand an adult home of his choice. The patient couldn’t return home with home care because the visiting nurse agency refused to treat him.

The court noted that there were no cases squarely on point but referenced a recognized injunctive right to eject a hospital patient who refuses to leave in New Jersey, citing Jersey City Med. Ctr. v Halstead, 169 NJ Super 22, 404 A2d 44 [1979]; a federal court case Lucy Webb Hayes Nat’l Training School v. Geoghegan, 281 F. Supp. 116 (D.D.C. 1967) and the North Carolina statute N.C. Gen. Stat. § 131E-90 that make patients liable for criminal trespass for refusing to leave a hospital.

The Wykoff court held that the “hospital may utilize appropriate means to effectuate the injunction including the request for a warrant of eviction should the patient refuse to comply with the injunction.” The hospital then had to take a second step, which was the warrant of eviction.

Lucy Webb Hayes Natl. Training School for Deaconesses & Missionaries v. Goeghegan, 281 F. Supp. 116 [D DC 1967] Injunction requiring removal for trespass. This case is interesting because the husband of the patient was willing and able to pay “whatever the hospital would charge” but the court did not consider that to be relevant. The court focused on the waste of scarce hospital resources intended for people who needed inpatient care.


If you only have time to read one case read this one. The court does a very nice job laying out thirteen very specific findings of fact. In addition to providing a court with documentation that you have complied with all state and federal requirements related to
discharge planning, notification and appeal rights, consider providing the kind of information that the hospital gave to the court in Midstate. The hospital was able to establish convincingly that this patient was stable for transfer to a subacute facility or home with homecare services but had refused to cooperate to the point that she had rescinded all of her authorizations necessary for transfer. The court didn’t find authority directly on point but considered that courts in Connecticut routinely issue injunctions against continuing acts of trespass.

Interestingly the court ordered this patient to “desist and refrain from refusing to cooperate and refusing to be discharged to a subacute facility with an available bed” and she was ordered to sign all necessary papers to affect a transfer and to accept a discharge to the next available facility.

In the alternative, the court said, the defendant “shall be discharged to her last known residence or another address in the state of Connecticut that she provider prior to the execution of discharge buy the hospital. “ The judge went on to say “thereafter if the patient presented at the hospital “she shall not do so unless she is in need of acute medical care.” “If and when such event occurs, it is ordered that when it is determined that the patient is medically stable and an appropriate candidate for transfer to a subacute facility or to her home after this or any future hospitalization, that she be restrained from failing to cooperate with that transfer.”

I think it’s fair to say that the judge was as frustrated with this patient as the hospital. This judge not only granted the injunction, he ordered the patient to cooperate and ordered her to agree to be discharged. This judge anticipated future encounters between the patient and the hospital and crafted his order in anticipation of on-going concerns.

4 Testimony in this case cited in the court’s opinion said that hospital security found the patient wandering into the hospital walk-in cooler and eating the food.
If you decide to move forward with a legal process be sure to:

• Explain all of the processes that your hospital followed to comply with legal, regulatory and accreditation requirements.
  
  o We involved the patient in the plan of care and discharge plan.
  o Followed Medicare, Medicaid and health plan appeal processes (if any).
  o Provided copies of notices of non-coverage to patient.

• Explain member rights and responsibilities and explain what the patient failed to do.
  
  o Would not participate in planning for care or post-discharge services.
  o Rejected X number of nursing home placement, home care providers, etc.
  o Failed to follow care plan.

• Most importantly establish that it is no longer medically necessary for the patient to remain in an in-patient hospital setting.

• If you are at capacity introduce data that your facility is turning patients away. See Midstate case.

• If the patient has been abusive or disruptive introduce that information. See Wyckoff.

Why Legal Processes Can’t Solve the Problem of Difficult Discharges

If certain legal processes are available and can be successful then why does the problem still exist?
What we don’t know from the legal cases discussed above is what ultimately happened?

In the Midstate case did Jane Doe agree to be discharged or did the hospital have to seek a warrant to evict? Did the hospital find out that no nursing home would accept the patient? We just don’t know. This author’s attempts to discuss the Midstate case with the hospital was unsuccessful when the hospital declined citing privacy laws and declining even to discuss the public court filings.

A recent case in Florida illustrates the fact that an eviction process is really just the beginning of a process for seeking an amicable resolution for all parties. Adam Martin was served with a complaint by Sarasota Memorial Hospital for recovery of possession of real property, specifically, Martin’s room in the hospital. See the complaint at the Herald Tribune website, April 30, 2012 at http://www.heraldtribune.com/assets/pdf/SH25012510.PDF .


An article in the New York Times discusses the continuing problems in that city with patients staying on in hospitals.

“Patients fit to be discharged from hospitals but having no place to go typically remain more than five years, Ms. Brown said. She estimated that there were about 300 patients in such a predicament throughout the city, most in public hospitals or higher-priced skilled public nursing homes, though a smattering were in private hospitals.” NY Times quoting LaRay Brown, senior vice-president for the city’s Health and Hospitals Corporation.

Hospitals and their attorneys need to look to legislative changes and creative solutions to help resolve the difficult discharge dilemma.

**The Impact of the Affordable Care Act on Difficult Discharges**

Certain Affordable Care Act provisions may help or hinder hospital efforts regarding difficult discharge cases:

These provisions may help:

State Health insurance exchanges in 2014 are supposed to make purchasing coverage more consumer-friendly and more affordable. Tax credit assistance will be available for individuals who meet certain income eligibility requirements. More patients enrolled in health plans may make it easier for hospitals to facilitate complex discharges because patients will have health plan coverage (or be eligible for that coverage. Healthcare. Gov at [http://www.healthcare.gov/law/features/choices/exchanges/index.html](http://www.healthcare.gov/law/features/choices/exchanges/index.html) and see the IRS website at [http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions](http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions), the section on the Health Insurance Premium Tax Credit.

Under ACA and as refined by the Supreme Court decision in *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (U.S. 2012) states have the option to expand coverage of the Medicaid program to include persons with incomes less than 138% of federal poverty levels. Persons with
incomes up to as high as 400% of the poverty level would be eligible for tax credits that could be applied to premiums and those with incomes up to 250% would also be eligible for cost sharing subsidies.

For health plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.

These provisions may hinder:

If the hold over patient is enrolled in a health care plan that patient will have more robust appeal rights which may delay discharge from the hospital.

Persons who are not “lawfully present in the United States” are ineligible to purchase health plan coverage on the health insurance exchanges, ineligible for tax credits and cost sharing subsidies. See the March 22, 2011 Congressional Research Service, CRS Report 41714, *Treatment of Noncitizens Under the Patient Protection and Affordable Care Act*, by Alison Siskin.5

Hospital attorneys and their clients could advocate for their states to elect to expand Medicaid coverage to reduce the number of uninsured. However, as part of that advocacy hospitals should consider changes to legislation that would permit a hospital provider to transfer a patient and a nursing home facility to accept such a transferred patient once the patient no longer requires hospital care.

Similarly, considering advocating for provisions in health plans sold on health insurance exchanges to permit hospitals to transfer plan members to other providers for continuing care

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once the need for inpatient hospital care has been established. The health plan members should be able to appeal any decision but once a final decision has been made the hospital (and the health plan) should be able to transfer the patient to another facility.

**Final Recommendations to Facilitate a Complex Discharge:**

- Comply with all health plan requirements, Medicare, Medicaid and any commercial plan requirements.
- Comply with any specific state requirements for hospital discharge planning (licensing requirement) or any local requirements.
- Establish good relationships with downstream providers (nursing homes, home health agencies), social services agencies and your locate probate court.
- Define and hardwire a formal escalation communication process for potential and actual high risk discharges that includes an attorney.
- Attorneys can assist the team as advisers but with the attorney as the lead you have created an instant adversarial relationship with the patient and the patient’s family. The legal process should be the last step after all other attempts have been exhausted.

**Practice Tips**

PRACTICE TIP: Identify an interdisciplinary team that includes leadership from the following departments: Case Management/Social Work; Medical Staff/Physician Advisor; Finance; Public Relations/Government Affairs; and Legal Affairs. This team would be the initial responders to concerns from front line staff and physicians. The role of the attorney would be as a resource only as needed and allows the attorney to be aware of issues before legal action is
requested or warranted. Define a second level interdisciplinary leadership team to review issues and actions for cases needing legal interventions that may also produce media interest. This team should include the Chief Legal Officer; Chief Financial Officer; Chief Nursing Officer; Chief Operating Officer; and Public Relations/Government Affairs. This team should be advised and have input before outside action is taken. Someone from this second level group should be accountable to keep the Chief Executive Officer apprised of planned legal actions.

PRACTICE TIP: If you must resort to a legal process be sure that you have buy-in from your administration (as above) in addition to the patient care team. It is not uncommon for care team members to assume the organization is acting in a harmful manner towards the patient so it is critical they be informed of both the legal action and the reasons behind the legal action. If you’re doing the right thing you shouldn’t fear publicity or dissention but you will need to communicate the hospitals concerns effectively and without violating HIPAA. Look at the guidance document on Difficult Discharge Scenarios attached to this paper to help you work through the issues of your current situation.

PRACTICE TIP: If the barrier to discharge is patient/caregiver concerns about nursing homes it helps if your hospital client can explain to patients and their caregivers that while the only available bed may be at a three star facility, the facility is still licensed by the state and approved by Medicare to be a Medicare provider. No nursing home is perfect and a patient can go to one facility that is not the number one choice and get on a waiting list for another nursing home that the patient prefers. These concepts are difficult for patients and their families especially if this is their first experience with being transferred to a nursing home. I am an advocate for making the Medicare Five Star rating information available to patients and families proactively and then walking them through what the ratings mean and explaining that less than
Five Stars doesn’t mean a nursing home is substandard. The hospital should have a robust program in place to educate patients and their caregivers about the nursing home experience and how to maximize their satisfaction with nursing home stays.

PRACTICE TIP: Your hospital ethics committee can be a very good resource in these difficult discharge situations. Ethics committees generally seek input from the patient and family in addition to the care team. And the opinions of ethics committees are shared with patients and families. A well thought out ethics opinion can help educate patients and families and can also be useful in any legal proceedings. Judges pay attention to ethics committee opinions that are easy to understand and that reflect consideration of the patient and caregivers yet explain why the in-patient setting is inappropriate. Get to know your ethics committee members and committee processes.

PRACTICE TIP: Get creative. Engage local human and social services agencies whose mission is to assist people who are homeless, undocumented or who have behavioral health issues all of whom are in groups that are often complex discharge cases. As you develop accountable care organizations be sure to include these types of agencies in your ACO. They have the mission and the skill set to get the severely disadvantaged persons the services they really need, shelter, food, transportation and access to medical services. These agencies are also typically skilled in identifying available government programs and health plan coverage for disadvantage persons and it has been my experience that they are monitoring the expansion of Medicaid and the development of health care exchanges to determine how those programs can assist the population they serve.

Encourage your hospital to either help fund or help create a medical respite program for these difficult to place patients. See some of the successful medical respite program stories at
http://www.nhchc.org/resources/clinical/medical-respite/ and consider creating a medical respite program with other hospitals in your area.

BEST PRACTICE: Establish an internal team of patient care staff that can triage and expedite difficult discharges. Participants need excellent communication and mediation skills and “thick skins”.