Experts estimate that, starting October 1, 2013, Medicare will levy $227 million in fines against 2,225 hospitals in 49 states under its Hospitals Readmissions Reduction Program. Dr. Eric Coleman, a director of the care transitions program at the University of Colorado who is credited with designing a method to reduce readmissions by coaching patients on what they need to do to stay healthy after leaving the hospital, told Kaiser Health News that: “[p]eople are starting to recognize that renaming discharge planning does not actually improve your readmission rate.” Dr. Coleman’s statement should please the Centers for Medicare and Medicaid Services (CMS), which administers the program. After all, when adopting its rules governing the program, CMS noted: “…readmission rates are important markers of quality of care, particularly of the care of a patient in transition from an acute care setting to a non-acute care setting, and improving readmissions can positively influence patient outcomes and cost of care.”

CMS has reason to take interest in the success of Medicare and Medicaid beneficiaries’ transition from acute care to post-acute care settings. “CMS research on Medicare-Medicaid enrollees in nursing facilities found that approximately 45% of hospital admissions among those receiving either Medicare skilled nursing facility services or Medicaid nursing facility services could have been avoided, accounting for 314,000 potentially avoidable hospitalizations and $2.6 billion in Medicare expenditures in 2005.”

CMS’ Efforts to Improve Coordination of Care Between Acute and Post-Acute Care Providers

By Mark D. Chouteau and Michael Crowe, Husch Blackwell LLP, Austin, TX
But transitioning a patient from an acute care setting requires coordination among physicians, hospitals, skilled nursing facilities, home health agencies, and other community care providers. This article will review some of the initiatives undertaken by CMS to promote coordination across the acute and post-care care spectrum as well as some of the challenges facing providers in these endeavors.

**CMS’ Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents**

Nursing facility and home health patients often experience avoidable hospitalizations, partly because they are particularly vulnerable to the risks that accompany hospital stays and the transition from hospitals to nursing facilities or home health agencies with such issues as medication errors, hospital-acquired infections, and pressure sores. CMS has found that approximately 45% of hospital admissions among those receiving either Medicare skilled nursing facility services or Medicaid nursing facility services could have been avoided. In 2012, CMS began its Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (Initiative) in an attempt to address the high percentage of hospitalizations that can be avoided.

In its solicitation for proposal, CMS cited past demonstrations and initiatives that showed the promise of care coordination and other evidence-based approaches for reducing hospital readmission rates from nursing facilities:

- **Beginning in 1994, the Health Care Financing Administration (now CMS) sponsored demonstrations with Evercare, a health plan that received capitated payments for the Medicare portion of costs for nursing facility residents.** The demonstrations utilized nurse practitioners who collaborated with primary care physicians to provide increased clinical care and intensive management of chronic conditions to prevent flare-ups and manage acute illnesses among nursing facility residents on site at nursing facilities. Evercare provided additional payment to the nursing facility for intensive service days to fund additional staffing resources for acutely ill patients who otherwise might be transferred to the hospital. Evaluations of this program indicate that Evercare reduced hospital admissions by 47% and emergency department use by 49%.

- **The Robert Wood Johnson Foundation supported a demonstration in New York in the mid-1990s where primary care was provided by nursing facility-employed staff providers, compared to provision of care through traditional fee-for-service providers.** Hospitalization rates, inpatient costs and emergency department visits were all reduced, and researchers estimated total Medicare Part A and B costs were 16.3% less than the control group.

- **Interventions to Reduce Acute Care Transfers (INTER-ACT) II, a quality improvement and information exchange intervention, was evaluated in 25 nursing facilities in three states.** The intervention included tools, on-site education, and biweekly teleconferences with a nurse practitioner focused on early identification, assessment, communication and documentation of changes in resident status. The evaluation found a 17% reduction in hospital admissions at an average cost of $7,700 per nursing facility with projected savings to Medicare of $125,000 per year per 100-bed nursing facility.

- **Transitions in settings of care between hospitals and nursing facilities for Medicare-Medicaid enrolled nursing facility residents are often negatively impacted by poor communication, inadequate coordination, and adverse drug events (ADEs).** Several evidence-based care transitions models (e.g., Care Transitions Intervention, Transitional Care Model) have been found to improve coordination, safety, and efficiency across care settings. These models have applicability to nursing facility residents, but they have rarely been explicitly tested among nursing facility residents.

- **Polypharmacy (i.e., the use of multiple medications by a patient) increases the likelihood of ADEs in nursing facilities.** Half of ADEs are preventable, and 80% of these preventable ADEs are due to failures in medication monitoring, rather than medication prescribing. ADEs can also lead to potentially avoidable hospitalizations. The Institute of Medicine recommends active medication monitoring systems to assess the safety of medication. Applying a consensus list of signals to detect potential ADEs in nursing facilities over a one-month period, researchers were able to identify 40% of nursing facility patients with a potential ADE.

- **CMS is operating a Nursing Home Value-based Purchasing Demonstration in Arizona, New York, and Wisconsin to improve the quality of care of nursing facility residents and achieve Medicare savings by reducing hospitaliza-
The participating nursing facilities receive annual payment awards based on attained performance level or improvements across four sets of performance measures; potentially avoidable hospitalizations are one measure of nursing facility performance that makes up 30% of an overall quality score. The financial awards are funded by the savings from reduced hospitalizations and subsequent skilled nursing facility stays.

The U.S. Department of Health and Human Services’ Office of the National Coordinator for Health Information Technology (ONC) has partnered with Colorado, Maryland, Massachusetts, and Oklahoma to make rapid progress in improving secure health information exchange (HIE) between acute and long-term and post-acute care settings. The states are targeting the technology, care delivery, and policy interventions needed to achieve timely electronic exchange of clinical summaries, medication lists, advance directives, and functional status content.

Under the 2012 Initiative, CMS has partnered with seven non-nursing facility organizations in as many states to study evidence-based interventions that show promise of improving care and lowering costs. The Initiative, which will conclude in 2016, involves approximately 107 nursing homes. Several of these studies involve care coordination:

HealthInsight of Nevada will implement an intervention in 25 nursing facilities in Nevada. The intervention, named the “Nevada Admissions and Transitions Optimization Program” or “ATOP,” includes the creation of pods that consist of a physician extender (nurse practitioner or physician assistant) and two registered nurses (RNs) who will be physically on-site at nursing facilities. Each one of the five pods will provide enhanced care and coordination to residents in five facilities.

Indiana University will implement an intervention in 20 nursing facilities in the Indianapolis region of Indiana. This organization has created a program called “OPTIMISTIC” (“Optimizing Patient Transfers, Impacting Medical quality, and Improving Symptoms: Transforming Institutional Care”), which includes the deployment of RNs and advanced practice nurses (APNs) to be on-site at the nursing facilities, allowing for enhanced recognition and management of acute change in medical conditions. RNs and APNs will coordinate with nursing facility staff and residents’ primary care providers.

The Curators of the University of Missouri will implement an intervention in 16 nursing facilities in Missouri. In this intervention, advanced practice RNs (APRNs) will be assigned to facilities to provide direct services to residents while mentoring, role-modeling, and educating the nursing staff about early symptom/illness recognition, assessment, and management of health conditions commonly affecting nursing home residents. Additionally, the intervention includes the use of social workers who will work closely with each facility’s social worker, the residents’ primary care providers, nursing facility staff, and APRNs, to assure consistent communication about residents’ needs and preferences.

Transitional Care Management Codes

Physicians have long complained that traditional Medicare fee-for-service (FFS) does not pay them to help patients transition from acute to post-acute settings. In 2012, CMS initiated a proposed rulemaking seeking input on how to improve care management for a Medicare beneficiary’s transition from hospitals to community settings within the existing statutory structure for physician payment and quality reporting.

With the help of public comment, and particularly input from workgroups established by the American Medical Association and the American Academy of Family Physicians, CMS adopted, effective January 1, 2013, two new CPT codes, 99495 and 99496. These codes are used to report Transitional Care Management (TCM) services for those Medicare beneficiaries whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient’s community setting (home, domiciliary, rest home, or assisted living).

The TCM Codes cover a 30-day service period that begins on the day of discharge. Only one individual may report TCM services once per patient within 30 days of discharge. Billing for the codes requires the following elements:

- Communication (direct contact, telephone, or electronic) with the patient and/or caregiver within two business days of discharge;
A face-to-face visit with the beneficiary within seven calendar days (for CPT 99496) or 14 calendar days (for CPT 99495) of discharge; and,
Medical decision making of at least moderate complexity (for CPT 99495) or high complexity (for CPT 99496) during the service period. CMS has valued Code 99495 at approximately $163 and Code 99496 at approximately $230.

Accountable Care Organizations
One of the most discussed care coordination initiatives is the Medicare Shared Savings Program (SSP) and the development of Accountable Care Organizations (ACOs). CMS’ stated intent in developing the program is to promote accountability for a population of Medicare beneficiaries, improve the coordination of FFS items and services, encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery, and incent higher value care. ACOs are formed by one or more ACO “Participants,” which can include any Medicare enrolled entities. So, while the Affordable Care Act, which authorized the development of the SSP and ACOs, did not specifically identify skilled nursing facilities, home health agencies, hospice agencies, or long term care hospitals as Participants, it is clear that CMS does not want to exclude them from becoming ACO Participants.

Care coordination among all Participants and providers is a key element of ACOs. CMS’ SSP regulations require that ACOs must:
- define their care coordination processes across and among primary care physicians, specialists, and acute and post-acute providers . . .
- define its methods to manage care throughout an episode of care and during its transitions . . .
- submit a description of its individualized care program as part of its application [to CMS] along with a sample care plan and explain how [its] program is used to promote improved outcomes for, at a minimum, their high-risk and multiple chronic condition patients . . . [and]
- describe additional target populations that would benefit from individualized care plans.

Identifying Challenges: The National Transitions of Care Coalition
The National Transitions of Care Coalition (NTOCC) is an organization established in 2006 composed of organizations and individuals specifically interested in addressing the problems associated with transitions of care. Challenges presented to collaboration in the transition of care from the acute care setting to a post-acute setting was the focus of the NTOCC Midwest Region Summit held in Cleveland in October 2012. The NTOCC Midwest Region includes leading hospital and health systems, some of whom have already formed contract-based and partnership-based relationships with long term care facilities in their area. Participating hospitals noted that the acute care environment is ahead of long term care providers in the area of care transition since most hospitals have had some sort of electronic medical record (EMR) system in place for years and because acute care is currently the central focus of CMS’ initiative to reduce re-hospitalizations. Caregivers recognize that solving the problem of hospital readmissions requires more than just better documentation and accountability. It requires better communication between acute care and long term care providers at every level.

Acute care facilities have problems keeping track of their patients after discharge, which can result in misinterpreted post-discharge care plans, poor medication compliance, and problems getting patients to complete follow-up lab tests. This is the backdrop upon which these hospitals face penalties for readmissions. At the same time, long term care providers in many instances do not have the ability to capture and exchange care data electronically with other care partners or even within their own organizations. At the time of the NTOCC Conference in October 2012, Hospice of the Western...
Reserve in Cleveland was six months into a new “medical and social” program called “Western Reserve Navigator” that uses around-the-clock advanced practice nurses, palliative medicine staff, and social workers to coordinate discharges from local nursing homes to the hospice setting. Joan Hansen, a director at Hospice of Western Reserve, was quoted as saying: “hospice is a six-month Medicare benefit, but we found that many hospice patients are only there for about eight days. Better transitions of care can allow hospices to have early intervention and prevent costly readmissions.” These types of transitions to hospice should be considered more frequently in discharge planning at the hospital, which could be coordinated with a contract-partner hospice as well. But, the changing landscape of care transitions goes beyond the discharge summaries and should be a part of medical and nursing education as a whole. From primary care to emergency departments, long term care providers and rehabilitation facilities, physicians and nurses should be trained to deliver care in the new service models. A collaborative approach to health care is emerging as the key to reduce re-hospitalizations.

Key Legal Issues
There are numerous legal obstacles that must be overcome when providers choose to collaborate; indeed, too many to discuss in this article. The following are offered as a few of the key legal issues to consider:

Care coordination relies heavily on health information technology and other communications between and among health care providers, implicating the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and state laws protecting access to protected health information. Sharing information for the purposes of care coordination is a permitted activity under HIPAA, not requiring formal consents. States, however, may have more restrictive privacy laws than HIPAA that should be assessed at the outset.

The federal Anti-Kickback Statute, the Stark law, and comparable state statutes are also a concern. For example, many of the models promoted by CMS’ Initiative concerning hospital readmission of nursing facility patients involve reliance on hospital-supplied nurses. This implicates the federal Anti-Kickback Statute (and in some cases, the Stark law) if the hospital is a referral source of the nursing facility. In the case of ACOs participating in the SSP, CMS and the Department of Health and Human Services Office of Inspector General have identified five specific waivers to the Anti-Kickback Statute, Stark, and the Civil Monetary Penalties law.

State and federal antitrust laws could be implicated should competitors be involved in negotiating reimbursement, together with the collaborative model that ultimately is utilized. The Department of Justice and the Federal Trade Commission have offered some relief from federal antitrust laws with respect to ACOs that participate in the SSP, allowing collaboration (up to a point) between otherwise independent providers.

Finally, state statutes and regulations regarding standards of practice, scope of practice, corporate practice, and insurance (in cases involving risk sharing) should also be reviewed for each particular arrangement.

Conclusion
Providers are moving rapidly in the direction of integrating and practicing collaborative care. Various legal impediments should be removed in order to pave the way. Ultimately, however, if hospitals are going to reduce readmissions significantly, they need to invest in the added staff necessary to provide smooth transitional care, and they need to partner with post-acute providers in order to facilitate whatever model of integration or collaboration they choose.
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Endnotes

2 Id.
5 Id.
7 See Initiative to Reduce Avoidable Hospitalizations, supra note 4.
9 Id.
12 Id.
22 Id.
23 Id.
24 Id.
25 Id.
26 Id.
27 Id.
28 Id.
29 Id.
30 Id.
31 Id.
33 See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 181. See also TEX. BUS. & COM. CODE ANN. § 521.

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