“How to Honor Patients’ Right to Freedom of Choice”

WHAT CASE MANAGERS/DISCHARGE PLANNERS NEED TO KNOW ABOUT PATIENTS’ RIGHT TO FREEDOM OF CHOICE OF PROVIDERS

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Description

Case managers/discharge planners are required by law to honor patients’ right to freedom of choice of providers. Ethically, providers are also required to respect this important patients' right. Case managers regularly encounter a number of issues related to this legal and ethical right of patients. These dilemmas include: What should case managers do when patients cannot or do not wish to exercise this right? What about physicians who write orders for specific post-acute providers or who pressure patients to accept the provider of their choice? What does the Balanced Budget Act of 1997 require with regard to this right? What do Conditions of Participation (COP's) of the Medicare Program for hospitals have to say about this issue? What is the latest guidance from the Office of the Inspector General (OIG)? The purpose of this presentation is to address all of the issues described above as well as other dilemmas that case managers regularly confront in their efforts to comply with applicable legal and ethical requirements. The emphasis will be on recent developments and practical solutions to situations that providers regularly encounter.

Outline

I. Sources of patients' legal right to freedom of choice of providers.
   A. Court decisions.
   B. Federal statutes.

II. Recent developments.
   A. Hospital COP's.
   B. Enforcement by the Centers for Medicare and Medicaid Services (CMS).
   C. Court decisions.

III. Common dilemmas and practical solutions.
   A. When patients cannot or will not choose.
   B. Physicians who order services from specific providers.
   C. Physicians and office staff members who pressure patients to choose specific providers.
   D. Preferred provider relationships/Use of Preferred Provider Agreements.
   E. Applicable requirements in:
1. Skilled Nursing Facilities.
2. Assisted Living Facilities.

Objectives

1. List three (3) sources of patients' legal right to freedom of choice of providers.
2. Describe one (1) recent development with regard to patients' legal right to freedom of choice of providers.
3. Describe one (1) common dilemma case managers regularly confront and practical steps to take to resolve it.

Patients' Right to Freedom of Choice of Providers:
Complaint by Provider against Hospital Substantiated by State Surveyors

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Providers must have a steady stream of referrals in order to be viable. By the same token, all patients have the right to choose the providers who render care to them.

Several sources affirm the right of patients to choose their providers, including the following:

- Court decisions establish the right of patients to control the treatment they receive, including the right to determine who provides care. Thus, one source of patients' right to freedom of choice of providers is the so-called "common law." The right of freedom of choice of providers based upon the common law applies to all patients, regardless of treatment setting or payor source.

- Federal statutes of both the Medicare and Medicaid Programs guarantee patients whose care is paid for by these Programs the right to freedom of choice of providers, regardless of treatment setting.

- The Balanced Budget Act of 1997 and Conditions of Participation (COP’s) of the Medicare Program require hospitals only to develop a list of home health agencies that:
  - are Medicare certified
providing services in the geographic area in which patients' reside

- ask to be on the list

In addition, if hospitals have a financial interest in a home health agency that is included on the list, the hospital's financial interest must be disclosed on the list. This list must be presented to patients discharged from hospitals who receive home health services.

Providers that are not owned by or affiliated with hospitals have long complained that hospitals repeatedly violate patients' right to freedom of choice of providers. They have frequently asked what enforcement action may be taken in such instances.

Patients must be willing to pursue violations of the common law right to freedom of choice of providers and the federal Medicare and Medicaid statutes guaranteeing this right. Patients are often understandably unwilling to do so and responsible providers recognize that putting pressure on patients or putting them in the middle of conflict between agencies is simply unacceptable practice.

With regard to the provisions of the Balanced Budget Act, providers who alleged violations could certainly make reports to the regional and central offices of the Centers for Medicare and Medicaid Services (CMS). They could also make reports to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) when they suspected violations. On the whole, however, post-acute providers remain quite concerned about the lack of enforcement regarding this important right.

Action taken by a post-acute provider in Indiana and other post-acute providers points to another possible enforcement route. Specifically, the provider documented instances of alleged violations and reported them to the state survey agency. Surveyors treated the reports like a complaint and conducted a complaint survey of the hospital's practices. Surveyors concluded that the hospital violated its own policies and procedures, the provisions of the Balanced Budget Act, and COP's in the process of making referrals for home health services. The hospital received a statement of deficiencies and was required to submit and follow a plan of correction (POC).

This action opens the door for clear enforcement action against hospitals that violate patients' right to freedom of choice. If violations are at the condition level of deficiencies, hospitals could lose their right to participate in the Medicare/Medicaid Programs.

Hospitals, hospital-based providers, and providers that are not affiliated/owned by hospitals must exercise caution as follows:

- Hospitals should carefully review their internal policies and procedures related to these issues. A careful reading of the Statement of Deficiencies issued to the hospital in the
case described above seems to indicate that the hospital's policies and procedures were unnecessarily restrictive with regard, for example, to whether coordinators/liaisons from home health agencies, HME companies, and other providers could participate in discharge planning meetings.

- Providers that are not owned or affiliated with hospitals must carefully document alleged violations of patients' right to freedom of choice of providers, preferably through signed statements from patients. They are likely to make little progress with regard to such violations if the word of staff members is pitted against the word of hospital staff.

The right of patients to choose providers has generated considerable conflict within the provider community. Knowledge and understanding of what is required of discharge planners/case managers and providers in this regard will go a long way to alleviating unnecessary contention.

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Patients' Right to Choose Providers

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The right of patients to choose providers who will render care to them is currently based upon three key sources:

Court decisions that establish the right of all patients, regardless of payor source and the setting in which services are rendered, to control treatment, including who provides it.

Federal statutes for both the Medicare and Medicaid Programs that establish the right of patients whose care is paid for by these programs to choose providers who render care in the absence of a waiver.
The Balanced Budget Act of 1997 (BBA), which currently requires hospitals only to provide a list of home health agencies to patients. According to the BBA, the list must meet the following criteria:

- Agencies that provide services in the geographic area in which patients reside, are Medicare-certified, and request to be included must appear on the list given to patients.

- If hospitals have a financial interest in any agency that appears on the list, this interest must be disclosed on the list.

Conditions of Participation (COP’s) of the Medicare Program that are the same as the provisions of the BBA described above.

Despite the existence of these requirements that are intended to protect the right of patients to choose providers, there is a lingering perception, however unfair it may be, that hospitals give “lip service” to patients’ right to freedom of choice, but still operate based upon a culture that emphasizes ownership of patients and the need, and perhaps even the right, to go to great lengths to keep patients “within the system.” Case managers/discharge planners are likely to see more enforcement actions by state survey agencies with regard to the rights of patients to choose their providers.

Action taken by a provider in Indiana is instructive. Specifically, the provider documented instances of alleged violations and reported them to the state survey agency. Surveyors treated the reports like a complaint and conducted a complaint survey of the hospital's practices. Surveyors concluded that the hospital violated its own policies and procedures and the provisions of the Balanced Budget Act in the process of making referrals for home health services. The hospital received a statement of deficiencies and was required to submit and follow a plan of correction (POC).

This action opens the door for clear enforcement action against hospitals and other providers who violate patients' right to freedom of choice. If violations are at the condition level of deficiencies, providers could, at least in theory, lose their right to participate in the Medicare/Medicaid Programs.

The right of patients to choose providers has generated considerable conflict within the provider community. This right is likely to be tested and reinforced. Case managers/discharge planners need a thorough understanding of the issues in order to stay out of the fray.

(To obtain more information about the fraud issues discussed above in a book entitled Medicare/Medicaid Fraud and Abuse: A Practical Guide for Providers, send a check to Elizabeth Hogue for $30.00 including shipping and handling to: Fulfillment, 107 Guilford, Summerville, SC
Many case managers refer patients on a regular basis to post-acute providers, such as home health agencies, private duty home care agencies, hospices, and home medical equipment (HME) companies. Relationships with post-acute providers assist case managers to control costs, an essential component of financial viability. Consequently, positive relationships with post-acute providers are essential to the success of discharge planners/case managers.

Discharge planners/case managers may wish to use Preferred Provider Agreements in order to enhance their relationships with post-acute providers. That is, case managers may agree verbally or in writing to make referrals exclusively or on a preferential basis to specified post-acute providers in order to help ensure quality of care.

Reasons Why Case Managers May Support Preferred Provider Agreements

Case managers or their employers may be willing to sign Preferred Provider Agreements for a number of reasons.

Case managers may decide, for example, to limit the number of post-acute providers to which they are willing to refer on the basis that dealing with many post-acute providers may compromise their ability to implement appropriate plans of care effectively. Working with a number of post-acute providers may complicate communications which may have the potential to compromise implementation of appropriate plans.

Unless patients or physicians choose post-acute providers, it is permissible, however, for discharge planners/case managers to suggest that patients may choose post-acute providers with which discharge planners/case managers are familiar or are able to vouch for the quality of care. Discharge planners/case managers are not required to survey post-acute providers in
their geographic area to find every entity that provides care of a quality that is satisfactory to them.

**Key Provisions of Preferred Provider Agreements**

Preferred Provider Agreements may be verbal or written. They should obligate case managers to refer patients to specified post-acute providers. These Agreements should not, however, include a specific number of patients that case managers are expected or required to refer. In fact, they should explicitly indicate that case managers make no promises about the number or types of patients who will be referred.

**Patients’ Right to Freedom of Choice of Providers and Preferred Provider Agreements**

Both the Balanced Budget Act of 1997 and Conditions of Participation (COP’s) for hospitals guarantee patients the right to freedom of choice. Many patients, however, do not yet know enough about post-acute services and providers to be able to make choices. When attending physicians indicate that they prefer certain post-acute providers and patients do not choose other providers instead, physicians’ preferences/orders must be honored.

When patients cannot choose and their attending physicians have not indicated preferences for particular post-acute providers, discharge planners/case managers may wish to encourage patients to choose preferred providers.

Sound relationships with post-acute providers are crucial to the practice of case management. The use of Preferred Provider Agreements may foster such relationships.

(To obtain more information about fraud and abuse issues in a book entitled *Preventing Fraud and Abuse*, send a check for $30.00 made out to Elizabeth E. Hogue, Esq. to Fulfillment, 107 Guilford, Summerville, SC 29483)

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**Patients’ Right to Freedom of Choice of Hospices in Hospitals**

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All providers are required to abide by patients' right to freedom of choice. There are a number of sources of this right as follows:

1) All patients have a common law right, based upon court decisions, to control the care provided to them, including who renders it. Thus, when patients voluntarily express preferences for providers, their choices must be honored, regardless of payor source, level of care, or type of treatment.

2) Federal statutes of the Medicare and Medicaid Programs guarantee Medicare beneficiaries and Medicaid recipients the right to freedom of choice of providers. When Medicare and Medicaid patients voluntarily express preferences for post-acute providers of all types, these choices must be honored.

3) The Balanced Budget Act of 1997 (BBA) requires hospitals to develop a list of home health agencies and SNF's, not hospices. The list of home health providers must include agencies that:
   
a. Are Medicare certified;

   b. Provide services in the geographic areas where patients reside; and

   c. Ask to be on the list.

In addition, if hospitals place the names of agencies in which they have a discloseable financial interest on the list, the relationship between the hospital and the agency must be disclosed on the list.

This list must be presented to all patients who may benefit from home health services so that they can choose agencies they wish to provide services to them.

4) Hospital Conditions of Participation (COP's) include the basic requirements of the BBA described above.

Based upon the above, hospitals are required to honor patients' choices of hospices if they voluntarily express them. Hospitals are not required to offer patients choices of hospices, including lists of hospices. Some hospitals, however, voluntarily use lists of hospices even though they are not required to do so. If hospitals do so, hospices should make certain that their names appear on such lists.

Practitioners who have reviewed survey guidelines published by the Centers for Medicare and Medicaid Services (CMS) may note the following language:
...we expect hospitals to provide a list of Hospice [emphasis added], HHA’s or SNF’s that are available to patients, that participate in the Medicare program, and that serve the geographic area that the patient requests.

Survey guidelines, however, cannot be enforced by CMS like the statutes and regulations describe above. Hospitals are not legally required, therefore, to present lists of hospices to patients as they are required to do for both home health agencies and SNF’s. But hospitals may be wise to do so in order to avoid Statements of Deficiency if they are surveyed by state survey agencies.

The hospice industry has changed dramatically. The competition for patients is fierce. Hospices should use all of the tools available to them in order to compete. Hospital discharge planners/case managers have an obligation to protect patients’ rights regardless of legal requirements.

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Private Duty Home Care Services and Patients’ Right to Freedom of Choice of Providers

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In order to be appropriate for home health or hospice services paid for by any payor, including the Medicare Program, patients must either be able to care for themselves or they must have a primary caregiver. Patients’ family members or others may be willing to fulfill this role on a voluntary basis. If not, discharge planners/case managers should offer patients and/or their family members the option to pay privately for a primary caregiver who can meet patients’ needs between visits from professional staff from home health agencies and hospices. Patients and their families may also wish to pay for skilled care themselves, such as nursing or therapy services. These types of services are often referred to as “private duty home care services.”

The option to pay for private duty home care services should be offered to all patients who cannot care for themselves and who have no voluntary primary caregivers. Patients who can care for themselves or have voluntary primary caregivers may also wish to contract for additional assistance, including skilled care. Discharge planners/case managers should,
therefore, offer this option to all patients who may benefit from these services.

Discharge planners/case managers may be reluctant to offer these services to patients and their families because of the cost of such services. They may erroneously conclude that patients and their families cannot afford them. Discharge planners/case managers should not make assumptions about who can afford these services. Instead, private duty home care services should be offered to every patient and family who may benefit from them. This conclusion is consistent with legal and ethical requirements that govern the practice of case management.

From a legal point of view, discharge planners/case managers must comply with Conditions of Participation (COP’s) that govern hospitals. Specifically, discharge planners/case managers are required to develop appropriate discharge plans, if necessary, for all patients. Development of appropriate discharge plans undoubtedly includes private duty home care services for patients who may benefit from them.

In addition, the Case Management Society of America (CMSA) has published national standards of care for case managers. They are likely to apply to all discharge planners, regardless of whether they are certified as case managers, because they are practicing as case managers. These standards make it clear that case managers have a duty to advocate on behalf of patients. As advocates for patients, discharge planners/case managers have an obligation to make sure that patients understand all of the options available to them, including the option to pay privately for home care services.

Case managers/discharge planners also have an ethical obligation to inform patients about the availability of private duty services. Autonomy is an important ethical principle applicable to the practice of case management/discharge planning. This ethical principle generally requires case managers to provide information to patients so that they can make informed choices.

Patients cannot make choices about the care they wish to receive unless they have information about all services available, including private duty services. Discharge planners/case managers, therefore, have a clear ethical obligation to provide information about private duty home care services to all patients who may benefit from them.

Discharge planners in hospitals are required to present a list of Medicare-certified home health agencies to patients who meet the requirements of COP’s of the Medicare Program. The requirement to present a list does not apply to private duty home care services. Unless patients/family members voluntarily express a preference for a particular agency, discharge planners/case managers may suggest that patients choose private duty agencies that discharge planners/case managers believe can meet patients’ needs consistent with the above requirements.

Discharge planners/case managers must make specific recommendations of private duty agencies in order to fulfill their responsibilities, under applicable national standards of care.
described above. It is unacceptable for discharge planners/case managers to hand patients and families the yellow pages and tell them that they must pick an agency themselves. Discharge planners must include specific arrangements for care, including private duty care, if needed, in the discharge plans they develop and implement.

Most discharge planners/case managers are licensed as either nurses or social workers. When they fail to fulfill the obligations described above with regard to private duty care, they may risk discipline by state licensure boards.

Patients are in the driver’s seat when it comes to decisions about their care, but they cannot make appropriate choices unless they have information about all of the types of available care. Consequently, discharge planners/case managers have legal and ethical obligations to make sure that patients have information about specific private duty home care providers.

(To obtain more information about the obligations of discharge planners/case managers in a book entitled Case Management: Legal Issues, send a check for $30.00 made out to Elizabeth E. Hogue, Esq. that includes shipping and handling to: Order Fulfillment, 107 Guilford, Summerville, SC 29483.)

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Discharge Planners/Case Managers Must Make Neutral Presentations of Patients’ Right to Freedom of Choice of Providers

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All patients have the right to freedom of choice of providers. Discharge planners/case managers have legal and ethical obligations to honor this right.

There are a number of sources of this right as follows:

5) All patients have a common law right, based upon court decisions, to control the care provided to them, including who renders it. Thus, when patients, regardless of payor
source or type of care, voluntarily express preferences for providers, their choices must be honored.

6) Federal statutes of the Medicare and Medicaid Programs guarantee Medicare beneficiaries and Medicaid recipients the right to freedom of choice of providers. When Medicare and Medicaid patients voluntarily express a preference for a home health agency, these choices must be honored.

7) The Balanced Budget Act of 1997 (BBA) requires hospitals to develop a list of home health agencies that meet the following criteria:

   a. Are Medicare-certified;
   
   b. Provide services in geographic areas where patients reside; and
   
   c. Ask to be on the list.

In addition, if hospitals place the names of agencies in which they have a discloseable financial interest on the list, the relationship between the hospitals and the agencies must be disclosed on the list.

This list must be presented to all patients who may benefit from home health services so they can choose the home health agency that they wish to provide services to them.

8) Hospital Conditions of Participation (COP's) of the Medicare Program for discharge planning include the basic requirements of the BBA described above. Based upon an interpretive guideline published by the Centers for Medicare and Medicaid Services (CMS), hospitals may also be required to present lists of hospices to patients.

Hospitals are subject to possible loss of reimbursement from the Medicare and Medicaid Programs if they do not meet the COP's.

Although hospitals are not required to present lists of all types of post-acute providers to patients, some hospitals voluntarily decide to do so.

Discharge planners/case managers are required to present lists to patients without “prejudicing the case.” Anecdotally, it appears that discharge planners/case managers may sometimes say things to patients that they should not when they present lists of providers to them such as:

   - “Choose the hospital’s provider so that we can get orders faster and you can go home sooner.”
   
   - “The Hospital’s provider can offer continuity of care, which other providers can’t.”
Or even worse, it appears that discharge planners/case managers may attempt to convince patients to change clearly stated choices by saying things like:

- “Why do you want to choose that hospice? They are no good.”
- “They’re terrible! Just go with our provider.”

A “neutral presentation” of the list means that discharge planners/case managers take the list described above to patients’ rooms and say something like the following (and nothing else that may persuade patients to choose particular agencies):

“You have the right to choose the provider that you would like to provide services to you. Here is a list of providers that render services in the area in which you reside.”

If, in response, patients choose providers, then case managers/discharge planners may not try to dissuade them or make negative comments about their choices. The only response to patients who make choices from case managers/discharge planners must be either “Yes, Ma’am” or Yes, Sir.”

If patients say they cannot choose, case managers/discharge planners must assist them to do so. Case managers/discharge planners, however, do not ever make choices for patients. Instead, case managers/discharge planners may help patients to choose by saying something like the following:

- “As you can see from the list, our hospital owns this hospice. Perhaps you would like to choose this one.”
- “Our hospital has a preferred provider relationship with this provider. Perhaps you would like to choose this one.”
- “This provider has a specialty program in orthopedics, which will be the focus of the services you need, so perhaps you would like to choose it.”

Patients are likely to adopt the suggestions of case managers/discharge planners under the circumstances. There is a clear difference, however, between choosing for patients, which case managers/discharge planners cannot do, and assisting patients with making informed choices. Discharge planners/case managers must never lose sight of the fact that patients are in the drivers’ seats. Patients’ choices “trump!”

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Standards governing the practice of case management were first published in 1995 by the Case Management Society of America (CMSA). The standards were revised for the first time in 2002 and again in 2010. This is the second in a series of articles about the legal and ethical implications of the standards revised this year.

Standards by CMSA clearly require case managers to behave and practice ethically. Specifically, according to CMSA’s standards, case managers must comply with this Standard by demonstrating:

“Awareness of the five basic ethical principles and how they are applied: beneficence (to do good), nonmalfeasance (to do no harm), autonomy (to respect individuals’ rights to make their own decisions), justice (to treat others fairly) and fidelity (to follow-through and to keep promises).

Recognition that a case manager’s primary obligation is to his/her clients.

Maintenance of respectful relationships with coworkers, employers and other professionals.

Recognition that laws, rules, policies, insurance benefits, and regulations are sometimes in conflict with ethical principles. In such situations, case managers are bound to address such conflicts to the best of their abilities and/or seek appropriate consultation.”

These requirements, especially adherence to the principle of autonomy, must govern the practice of case managers/discharge planners in hospitals, who are required to honor patients’ right to freedom of choice of providers.

The Balanced Budget Act of 1997 (BBA) and Conditions of Participation (CoP’s) of the Medicare Program require hospitals to provide lists of home health agencies that meet applicable criteria. Prior to discharge, this list must be presented to all patients who may benefit from home health.
services, so that patients may choose the agency from which they wish to receive services. Based on Interpretive Guidelines published by the Centers for Medicare and Medicaid Services (CMS), there is a sound basis for concluding that hospitals must also present lists of hospices from which patients may choose.

The problem remains, however, that may patients and their families do not know enough about home health and hospice services to make a choice. Anecdotally, it appears that case managers may then decide to choose post-acute providers for patients and their families. This practice is clearly contrary to the Standard of practice for case managers described above. Case managers/discharge planners must demonstrate respect for individuals’ right to make their own decisions. Deciding for patients is inconsistent with this standard.

Instead, case managers/discharge planners must help patients to make their own decisions. They may, for example, point out that an agency has a specialty program in the area of patients’ greatest need, such as orthopedics. In short, case managers/discharge planners never choose for patients; they carry out the wishes of patients and their families. This conclusion is reinforced by language in the Standard that makes it quite clear that case managers’ primary obligations are to clients or patients.

Patients and their families are becoming more knowledgeable about post-acute services and are better equipped to make choices. They may, however, still require assistance from case managers/discharge planners. Remember that the patient remains solidly in the “driver’s seat” at all times!

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Honoring Patients’ Right to Freedom of Choice of Providers

Anecdotally, hospitals are not honoring patients’ right to freedom of choice of post-acute providers as they are required to do by federal law, especially according to agencies that are not owned by or affiliated with hospitals. Hospital-based agencies often tell a completely different story. Some of them are certain that they are not getting their fair share of referrals
of discharged patients.

The “horror stories” are legion! We all certainly recognize that the “stories” must be carefully investigated in order to determine what actually happened. A review may indicate that the facts are not quite as they seemed initially, for better or for worse. I have had only two family members who were entitled to freedom of choice of home health agencies. Here are their stories:

The first family member was a Medicare patient who was hospitalized with a broken shoulder. The discharge planner/case manager came into her room while I was on the telephone with her. The patient explained to the discharge planner/case manager that she was going to do whatever I recommended. The patient suggested that I talk directly to the discharge planner/case manager who then came on the telephone line. Her first words to me were: “I assume you want the Hospital’s agency.” I responded by saying that we did not and that I had already arranged for services from one of our clients. No choice was ever given to the patient or to me, including the presentation of a list of home health agencies, which is contrary to applicable statutory and regulatory requirements.

The second family member was a private insurance patient who was hospitalized for knee replacement surgery. Discharge planners/case managers must comply with applicable Conditions of Participation (CoP’s) for hospitals for all patients who may benefit from home health services, including presentation of a list of agencies. No list of agencies was provided to her, but she was asked if she wished to choose a home health agency. She replied that she wanted an agency that is a client of ours, which we agreed she would choose in advance of her surgery.

After expressing her choice to the discharge planner/case manager, the patient received a call from the Hospital’s home health agency asking if she would like to receive services from them despite the choice she had already made. The patient replied that she still wanted services from the agency she chose earlier.

The patient was discharged and went home. She waited a day or so and had not received any communication from the home health agency she chose. She then called the agency and was told that they never received a referral for her. They quickly obtained the information they needed and initiated services.

These instances certainly fall short of compliance with applicable requirements. Apart from compliance issues, why does it matter?

It matters because the right to control one’s body, including who provides healthcare, is a fundamental right. In fact, it undergirds our society and culture. Imagine what it would be like if we did not have this right and had to receive healthcare services from providers who we did not select, regardless of the quality of care rendered.
Case managers/discharge planners are key to the protection of this legal and ethical imperative. As we emphasized in previous articles, they are required to make a neutral presentation of post-acute providers without “stacking the deck.” They are also required to honor patients’ choices without efforts to persuade them to change their choices. When patients cannot choose, discharge planners/case managers must assist them to do so, as opposed to selecting for them. Assistance may include recommendations from discharge planners/case managers about which agencies may be helpful to patients, including their own hospitals’ agencies.

It’s time to get it right!

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Part 6 – Accountable Care Organizations (ACOs): Patients’ Right to Freedom of Choice of Providers

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Patients who are assigned or “aligned” with physicians who participate in ACOs are not required to receive services from such physicians or from any other participants in ACOs. Patients who are aligned with physicians in ACOs still have the right to freedom of choice of all types of providers. The Centers for Medicare and Medicaid Services (CMS) emphasizes this fact in commentary to the final regulations governing ACO’s as follows:

“We have also been vigilant in protecting the rights and benefits of FFS beneficiaries under traditional Medicare to maintain the same access to care and freedom of choice...”

“An ACO will not receive an assignment of those beneficiaries that choose not to receive care from ACO providers.”
“We also noted that the strategies employed by an ACO to optimize care coordination should not impede the ability of a beneficiary to seek care from providers that are not participating in the ACO, or place any restrictions that are not legally required on the exchange of medical records with providers who are not part of the ACO. We proposed to prohibit the ACO from developing any policies that would restrict a beneficiary’s freedom to seek care from providers and suppliers outside of the ACO.”

“It is important to note that the term ‘assignment’ for purposes of this provision in no way implies any limits, restrictions, or diminishment of the rights of Medicare FFS beneficiaries to exercise complete freedom of choice in the physicians and other health care practitioners and suppliers from whom they receive their services. Thus, while the statute refers to the assignment of beneficiaries to an ACO, we would characterize the process more as an ‘alignment’ of beneficiaries with an ACO, that is, the exercise of free choice by beneficiaries in the physicians and other health care providers and suppliers from whom they receive their services is a presupposition of the Shared Saving Program.”

“...the Shared Savings program is certainly not intended to be a managed care program in a new guise. One important distinction between an ACO and many MA organizations is that beneficiaries are not locked into receiving services from the ACO to which they are assigned, and may continue to seek care from any provider they choose.”

“Beneficiaries who are assigned to ACOs under the Shared Savings Program remain Medicare fee-for-service beneficiaries, retaining their full freedom of choice regarding where to receive services. We therefore take this opportunity, as requested by a number of commenters, to confirm and emphasize that basic beneficiary rights are maintained under the Shared Savings Program, most especially (but not exclusively) the right to receive care from physicians and other medical practitioners of their choice outside the ACO at no penalty to the patient.”

“The ACO model does not include the use of networks or any restrictions on where beneficiaries can receive care.”

It remains to be seen how ACOs will work in practice, but the final regulations are quite clear that patients in ACOs retain their right to freedom of choice of providers.