The Maine joint committee of health and human services voted on 3/12/2013 to table LD-447 until April 2, 2013 and asked that stakeholders meet to discuss the bill's goals and language.

Stakeholder meeting is scheduled for March 25th, at 9am at the MHCA building in Augusta.

This synopsis is to recap the issues raised and review the documents presented thus far, ahead of the stakeholders meeting.

What is LD-447?

This bill expands and clarifies existing Maine law with regards to the obligation to provide healthcare choices and disclose conflict of interest to patients during transition of care.

LD-447 aims to improve patient choice in post acute care at the point of discharge, and calls for greater transparency and declaration of conflict of interest during the referral processes . The bill is not about changing individual discharge planners behavior, but rather, its about process improvement and system reform to meet practical needs of patients and providers competing with affiliated entities for patient referrals.

The improved patient choice and fair and transparent referral Practices in post acute healthcare would level the playing field for independent and small businesses in healthcare, while benefiting patients at the same time.

"Patient choice" in this bill remains subject to the existing limitations.

For instance, patients can not insist on a facility that can not meet their needs or has not agreed to accept them under current acceptable practices.

Anther example is that patients can not insist on a physician who is not on the medical staff of the receiving nursing home, even if it is their own primary care physician (this is consistent with current standards of practice; will be happy to provide more details on this issue at the meeting). Specific language can be included during DHS rule-making to reflect this, if deemed necessary by the work group.

The Bill can be explored in three sections:

Section A:

What does the bill add, and what is wrong with the current law regarding patient choice at point of discharge from the hospitals?

1. The first issue with existing law is that it is not enforceable. This bill's premise is that the lack of enforcement stems from the lack of clarity and standardization. It is not clear what exactly is expected of hospitals and post acute care facilities in terms of referrals and disclosure of conflict of interests. More is needed, not just to expand the scope of the law to include, physicians, hospices, and nursing homes, but also to provide guidance as to the practical applications.

For instance the law requires hospitals to offer patients choice of skilled facilities, but stipulates that the list should be made up of any facility that "asks to be included", regardless of service area.
Since there is no way to track which facilities called the hospitals to request such inclusion in facility list, there is no practical way for DHS to cite the hospitals for any omission, selective or otherwise.

2. The law does not mandate offering a choice of physicians when more than one option exist at the receiving SNF/nursing home facility. This is the case even when there is a clear conflict of interest in instances where the hospital referrals are exclusively given to physicians employed by the discharging hospital or the receiving facility.
This bill proposes that the nursing homes share with the hospitals their list of "staff physicians" and include this as part of their communication with the hospital during the process of accepting the patient.

Opponents of the bill testified that patients are already allowed a choice of physician and that keeping a list of physicians and sharing it would be considered an "administrative burden".

Those of us involved in SNF/nursing home care appreciate that the logistics of SNF admissions are as such that if patients don't have a physician chosen and declared before their discharge from the hospital then they are automatically assigned the "default" admitting physician, upon arrival to the nursing home without any opportunity for patients to be involved. This process renders the supposed patient choice of physician nonexistent due to logistics.

In a survey conducted by the Maine Medical Directors Association, over 92% of admission coordinators stated that they would not consider sharing the list of their medical staff with the hospital discharge planners a "burden". 100% knew which physicians were on staff at their nursing home.

It was also argued that sharing the "physician options" which patients on every discharge is "burdensome" unless there was a centralized database.

While at first glance a centralized database makes perfect sense, we should consider some implications of such proposal, aside from the time delay associated with establishing and paying for it.

Hospitals in Maine coordinate tens and hundreds of discharges to various nursing homes every day without utilizing a centralized data base for nursing homes. Adding the physician choices is no more burdensome than knowing which nursing home can provide IVs and which doesn't, or which nursing accepts which insurance, or if the nursing home is contracted to care for veteran patients, or any other component of the patient and facility information that is exchanged between the hospital and the nursing homes ahead of every discharge.

That aside, It stands to reason that even if a data base existed, there is nothing in the current law that requires the hospitals to offer patients a choice of physician upon discharge using available information given to them by the receiving facility or information that they collect through other means.

Maintaining a centralized data base would likely require a fiscal note and that system would be striving to accurately duplicate what every nursing home is already done, and that it is to know which physicians are on staff and open to new admissions.

A centralized data base would need data input by some entity which may not necessarily be as informed as the nursing homes themselves about the active medical staff in any given nursing home. Such centralized data base may in fact be more prone to errors than the simple list provided by nursing homes.

Considering all the obstacles, I would encourage the working group to consider the centralization of data as a potential option, but not as a pre-requisite for the hospitals to start including physician choice upon discharge.

The nursing homes can and are willing to submit their "physician list" to the hospitals now (per our survey data). They would likely be just as willing to submit that information to a centralized data base if and when it materializes. It is not a stretch to expect that most discharge planners would simply ask the nursing homes directly, in the process of each discharge, even if there is an eventual centralized data base. Medicare nursing home compare (link) is considered a centralized data of nursing homes with start rating, yet discharge planners rarely use that as a source of information when offering patients SNF choices. There is no reason to believe that discharge planners would use a centralized physician data base instead of simply asking their counterpart in the receiving nursing home to provide them with the physician choices.

3. The current law doesn't cover all aspects of post acute care.

The existing law doesn't cover physicians or hospice referrals. It also does not cover the nursing homes responsibilities when making referrals to home health and hospice, or to physicians when admitting long term care patients.

The bill proposes that the law cover nursing home/skilled facilities referrals to in house hospices or home health agencies post discharge from SNF. Nursing homes are currently free to deny contracts to hospice providers who wish to provide service in their

facilities. There are examples in Maine of healthcare facilities where major hospice competitors are excluded, in favor of a hospice provider with direct or indirect financial links to the nursing home, the hospital, or both.

In case of hospital and nursing home common ownership or affiliation with a home health/hospice, both the hospital and the nursing home are known to refer preferentially, or even exclusively, to the affiliated/owned home health and hospice provider.

In case of a nursing home chain ownership and affiliation with a hospice provider (common parent company), the nursing home is not mandated by the current law to ensure that major hospice competitors in the service area are offered in the list of choices.

Genesis healthcare recently acquired sunbridge healthcare. Sunbridge has its own hospice service, and in facilities outside maine, i.e homes in NH, their major competitors are excluded from the list of choices and the vast majority of patients are referred to their "hospice of choice". The Maine facilities owned by the same chain will soon follow that referral model just like their sister facilities in NH have. LD-447 would ensure that patients are offered a clear choice of hospice and that the conflict of interest is declared to all hospice patients.

During the HHS committee deliberations the role of physicians in hospice referrals came up and it appears that there maybe some confusion as to who actually makes the referral to hospices. While a physician or a midlevel provider can "order" hospice for terminal patients, the physician is not typically involved in the selection of the hospice service provider. Case managers and social workers are usually the point of contact and the persons assigning the patient to a particular hospice. If the facility or hospital has a "preferred hospice" then referrals can potentially be selective regardless of which physician ordered the hospice service. This bill simply ensures that choices exists and conflict of interest disclosure take place to limit the exclusion of competitors and allow patients and their families a broader choice of hospice providers.

5. The law requirement to declare direct and indirect financial interests does not cover "affiliations".

Back and forth referrals between affiliated entities does not constitute an indirect financial interest, yet the hospitals and affiliated facilities do gain from such preferential referrals. More transparency and clearer regulation would ensure that patients and their families are better informed when making a choice. The exact language of how affiliations and common ownerships are declared would be done in rule-making. The bill stipulates that designations such as "affiliated" or "owned by...." would be a simple and easy to understand way to declare conflict of interest.

6. The current law does not cover "swing beds" or "acute rehabilitation" facilities.

The bill doesn't directly address this, however the tabling of the bill provides an opportunity to insert specific language to ensure that the more expensive swing beds and acute rehab beds are not offered without also offering the cheaper alternative of SNF beds. This of course would still be subject to language changes under rule-making by DHS, taking into account input from stakeholders.

Section B.

Tackling the apparent pattern of referral abuse

The inadequate focus on patient choice and lack of adequate disclosures is resulting in a pattern, or at least the appearance, of referral abuse in the post acute care, which maybe contributing to the steady rise of post acute care expenditure by the state and federal government.

Referral pseudo-monopolies benefit the few while hurting many, including the patients we serve.

More than 70% of nursing homes responding to our survey believe that their skilled referrals would likely increase if hospitals provided patients with choice.

The existing Referral abuse in post acute care:

1. Most SNF/nursing home facilities acknowledge, despite claims to the contrary, that the current law has not stopped hospitals from selectively or preferentially referring to their affiliated facilities and providers. In practice, hospitals are known to fill their swing beds and acute rehab beds first then refer patients to affiliate SNF, before they discharging any patients to unaffiliated facilities.

2. The list of facilities provided to patients at time of discharge are not standardized, i.e alphabetical or inclusive of all facilities in a certain service area or near patient's home.

The hospitals are also not declaring their conflict of interest consistently and clearly. During testimony we heard that lists used don't use language such as "affiliated" or any other easily understood terms. The parent company or the name of the healthcare system is used as declaration of conflict of interest, without providing any context.

3. When hospitals own their home health and hospice, the majority of patients are referred to the in house home health agency with very little declaration of conflict of interest.

4. Physician referral issues.

Using the Portland service area as an example, there are clear instances where selective referrals are resulting in limited choice of physicians in the Portland area nursing homes.

1. Hospital owned nursing home practice has driven other practices out of affiliated nursing homes at a time of national and state shortage of geriatric providers:

Local Example 1. (Based on publicly available information)

MMC recently affiliated with the local facilities of a for profit nursing home chain (first Atlantic) in Portland. Based on this affiliation, MMC placed hospital employed physicians in these facilities and all unassigned new admissions were then referred by the facility and the hospital to the hospital employed physicians at the exclusion of other existing geriatric providers. Within a few months these facilities went from having three choices of geriatric providers (mature care, Maine geriatrics, MMC physicians) to one choice only, "MMC employed provider". The facilities went as far as calling patients families and switching service from existing physicians to the new preferred MMC physician in order to rapidly grow the new "affiliated practice".

Local Example 2.

When a standalone not for profit Portland facility, The Cedars nursing home, became affiliated (with no direct or indirect financial links) with MMC, the only available option for physicians became "hospital employed providers", at the exclusion of at least two other practices that existed as options in prior months and years.

2. Nursing home chains ownership of physician practices and elimination of other provider choices:

An example of that in the Portland area can be seen with a for profit national nursing homes chain, Genesis Healthcare.

A few years ago Genesis facilities in Portland were assigned physicians employed by "Genesis Physician Services". The Genesis facilities with assigned GPS physicians began referring "all" new SNF and NF admissions to the employed physicians. Again provider choices went from a few to just one.

Current law does not require the nursing home facilities to offer a choice of physicians or declare their conflict of interest when referrals are made to practices owned or affiliated with their parent company. In this case Genesis healthcare owned both the nursing home and the physician practice (through a separate LLC) yet DHS surveyor have to law or regulation that would help them enforce patient choice or transparency.

Section C.

Medical Director provision in LD-447

This provision calls for explicit language in the Maine regulations that would emphasize that there can be no delegation of medical director responsibilities to committees and corporate officers.

The current federal and state guidelines have no such language even though large corporate nursing homes do sometimes use their local medical directors as rubber stamps for decisions made outside the facilities, and often outside the state.
This common practice ranges from not permitting medical directors to alter standing orders to more complex issues.

This provision does not change the original duties and responsibilities outlined in state and federal regulation in any way. It simply provides a safeguard against centralized decision making, and allow our local medical directors to fulfill their mandated role in providing the local facilities with unbiased input regardless of their employment status.

Thank you and will look forward to a lively discussion around these complex yet important issues in post acute care.

Other documents included in this email:

1. The plain language version of the LD-447 (details can be refined under rule-making.

2. The official (amended) LD-447 as presented on 3/12/2013. Please keep in mind that there was an additional amendment that calls on DHS to involve stakeholders during the rule-making process.

3. MMDA survey of nursing home admission coordinators:
Please note that 0% of responders thought the hospitals "always" offer choice", and only 1/3 thought that choice is offered most of the time.
100% of responders said they already have a list of their medical staff and 92% were willing to share it with the hospitals during the process of admission.