M E M O R AN D U M

TO: Richard D. McCord, Esquire

FROM: National Legal Research Group, Inc.
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RE: NJ/Business Planning/Antitrust/Health Care—Visiting Nurse

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STATEMENT OF FACTS

Viar Nurse Association of Southern Jersey, Inc. ("VNA"), provides a comprehensive range of in-home health-care services, including nursing; home health aide services; physical, speech, and occupational therapies; and medical social work. Specialized programs include home infusion therapy, hospice care, mental health services, nutrition services, cardiac care, diabetes care, and continence management.

For many years, VNA maintained a Home Care Intake Coordinator in the hospitals in the area served by VNA. The purpose of the Coordinator is to meet with patients who require nursing and other in-home health-care services after they leave the hospital. The Coordinator meets the patient, the patient's physician, and other hospital-based health-care professionals to determine the scope of in-home services that will be required by the patient. The availability of the Coordinator in the hospital naturally enhanced VNA's opportunity for postdischarge referrals.

During the last several years, Jersey First Medical Center, now a part of the Moravian Health System, has formed its own competing Viar nurse service. Until recently, Moravian has continued to permit the placement of a VNA Coordinator within Jersey First Medical Center. Moravian has now served notice that it intends to terminate its agreement with VNA, effective August 1, 1998. The effect of the termination will be to exclude VNA's Coordinator from the premises of the hospital and to reduce substantially the number of referrals VNA can expect from patients at Jersey First Medical Center.

Moravian's General Admission Consent/Outpatient and Emergency Room Consent form, which is required to be completed by patients being discharged, provides, in pertinent part, as follows:

> **HOME CARE DISCLOSURE**
>
> I give my consent to be evaluated while I am a patient in the Hospital for any home care services that may be needed from three certified licensed home care agencies: namely, Home Health Resources, Long View Public Health, and MROSS. Should I desire an agency other than Home Health Resources, I will write my selection below under "Other Instructions."
>
> I understand that Home Health Resources is a licensed and certified homecare Health agency that has been established jointly by Heath Innovations Unlimited (an affiliate of the Hospital) andCumberland Quality Health. Health Innovations Unlimited has a financial as well as a patient Health interest in Home Health Resources.
>
> I have read and understand the above and agree that if I have not otherwise indicated below in the space labelled "Other Instructions," Home Health Resources is my agency of choice to evaluate my need for home Health services.
>
> /s/_____

VNA is looking for some kind of legal recourse, if any, to obtain equal access to patients for purposes of postdischarge referrals. Two possibilities are explored. The first theory involves amendments to the Social Security Act adopted as part of the Balanced Budget Act of 1997, to be implemented by proposed regulations. The second theory examined involves legal recourse under the antitrust laws.

QUESTION PRESENTED

What theories of relief are presented by these facts?

CONCLUSION

The practices associated with postdischarge in-home health-care referrals are the subject of recently enacted statutory authority and proposed regulations. That authority will be addressed below. Similar practices have been challenged on antitrust theories, and the available authority in that context will also be addressed. It is unlikely that any of these sources of authority will be successful in providing theories for relief.

DISCUSSION OF AUTHORITY

A. Balanced Budget Act of 1997

The Balanced Budget Act of 1997 § 4321 amended the Social Security Act, which had provided, prior to amendment, in pertinent part as follows:

> **(ee) Discharge planning process**
>
> . . . .
>
> (2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative Care. The guidelines and standards shall include the following:
>
> . . . .
>
> (D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice services, and the availability of those services, including the availability of home care services through individuals and entities that participate in the program under this subchapter and that serve the area in which the patient resides and that request to be listed by the hospital as available.
>
> . . . .

(H) Consistent with section 1395a of this title, the discharge plan shall—

(i) not specify or otherwise limit the qualified provider which may provide post-hospital home care services, and

(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1395cc(a)(1)(S) of this title) or which has such an interest in the hospital.

42 U.S.C. § 1395x(ee)(2)(D), (H). The amendment adopted in 1997 as a result of the enactment of § 4321 provides as follows:

SEC. 4321. NONDISCRIMINATION IN POST-HOSPITAL REFERRAL TO HOME Care AGENCIES AND OTHER ENTITIES.

(A) NOTIFICATION OF AVAILABILITY OF HOME Care AGENCIES AND OTHER ENTITIES AS PART OF DISCHARGE PLANNING PROCESS.—Section 1861(ee)(2) (42 U.S.C. 1395x(ee)(2)) is amended—

(1) in subparagraph (D), by inserting before the period the following: ", including the availability of home care services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available"; and

(2) by adding at the end the following new subparagraph:

"(H) Consistent with section 1802, the discharge plan shall—

"(i) not specify or otherwise limit the qualified provider which may provide post-hospital home care services, and

"(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(S)) or which has such an interest in the hospital.".

(b) MAINTENANCE AND DISCLOSURE OF INFORMATION ON POST-HOSPITAL HOME Care AGENCIES AND OTHER ENTITIES.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking "and" at the end of subparagraph (Q),

(2) by striking the period at the end of subparagraph (R), and

(3) by adding at the end the following new subparagraph:

"(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1861(ee)(2)(H)(ii), or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

"(i) the nature of such financial interest,

"(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home care services, and

"(iii) the percentage of such individuals who received such services from such provider (or another such provider).".

(c) DISCLOSURE OF INFORMATION TO THE PUBLIC.—Title XI is amended by inserting after section 1145 the following new section:

"PUBLIC DISCLOSURE OF CERTAIN INFORMATION ON HOSPITAL FINANCIAL INTEREST AND REFERRAL PATTERNS

"SEC. 1146. The Secretary shall make available to the public, in a form and manner specified by the Secretary, information disclosed to the Secretary pursuant to section 1866(a)(1)(S).".

> (d) EFFECTIVE DATES.—
>
> (1) The amendments made by subsection (a) shall apply to discharges occurring on or after the date which is 90 days after the date of the enactment of this Act.
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> (2) The Secretary of Health and Human Services shall issue regulations by not later than the date which is 1 year after the date of the enactment of this Act to carry out the amendments made by subsections (b) and (c) and such amendments shall take effect as of such date (on or after the issuance of such regulations) as the Secretary specifies in such regulations.

P.L. No. 105-33, § 4321, 111 Stat. 394-95.

Consistent with the directive of Congress, the Department of Health and Human Services (HHS) and the Health Care Financing Administration (HCFA) have promulgated proposed rules, 62 Fed. Reg. 66,726 (Dec. 19, 1997), that would, if adopted, affect 42 C.F.R. Parts 416, 482, 485, and 489. HHS described the foregoing amendment to the statute as follows:

> Congress included in the Balanced Budget Act of 1997 (BBA '97), Public Law 105-33, enacted August 5, 1997, several amendments to section 1861(ee)(2) [42 U.S.C. § 1395x(ee)(2)] to address concerns about reports of some hospitals referring patients only to HHAs with which they have financial ties. Subsection 4321(a) of that legislation, effective November 3, 1997, amended the discharge planning evaluation requirements in section 1861(ee)(2)(D) and added a subparagraph (H) to section 1861(ee)(2). These changes are consistent with patient rights, the first core condition of patient-centered Care in this regulation. As a result of these changes a MediCare participating hospital now must: (1) Include in a patient's discharge planning evaluation the availability of home care services through MediCare participating HHAs which serve the patient's geographic area and which request the hospital to be listed; and (2) ensure that a patient's discharge plan does not specify or otherwise limit the qualified participating HHAs and identify any HHA with which the hospital has a "disclosable financial interest" if the patient is referred to such entities.

62 Fed. Reg. at 66,742.

HHS proposed to implement the foregoing statutory amendment by adopting new regulations, having the following effect:

> To implement section 4321(a) of the BBA '97 *we would specify under proposed 482.55(b)(7) that the discharge planning evaluation must include a list of home care agencies that participate in the MediCare program and whose services are available to the patient, serve the area in which the patient resides, and request to be listed*. Since, section 4321(a) requires listing the availability of individuals and entities, we have been questioned as to who those individuals and entities are. We have determined that since section 1861(m) of the Act identifies home care services as items or services furnished by a home care agency, or by others under arrangement with the agency, section 4321(a) is referring to MediCare participating home care agencies. Also in § 482.55(b)(7), we have proposed that the HHA should determine the geographic area in which the patient resides. We believe the HHA should determine the geographic area because the HHA is in the best position to know its service area and presumably, would not misrepresent its services by requesting to be listed for an area it does not serve. Discharge planning is effective if there are resources available to the patients at discharge. A hospital's ability to provide patients with outside resources for posthospital Care are essential to allow many patients to stay at home which is a much less expensive alternative than institutionalization.

Id. (emphasis added).

Neither HCFA nor HHS has promulgated final regulations, even though the comment period was to have expired at the close of business on February 17, 1998.[1] HCFA did offer the following observations regarding comments that it had received:

> HCFA has received a number of questions concerning section 4321(a).
>
> These questions include: How does the hospital compile the list of agencies? What is the hospital's responsibility and liability for providing a list? Is there a form for home care agencies to complete to request placement on a hospital's

[1]HCFA has informally advised that the final regulations, substantially in the form of the proposed regulations, will probably become final by the end of July 1998.

> list? We welcome public comments on these questions and we will take these comments into consideration when developing the final rule.
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> The process of making a choice includes being provided options to make an informed and confident decision. [The] Hospital providing a list of available MediCare-certified home care agencies will assist patients in making such decisions. *Although a hospital is free to design the list's format, the list is neither a recommendation nor endorsement by the hospital of any particular home care agency's quality of Care*. If HHAs do not meet all criteria, the hospitals are under no obligation to place that HHA on the list. *The list should be legible and should not be used to specify or limit the choice of a HHA*.
>
> Under proposed § 482.55(c)(7), we would state that the discharge plan must identify those entities to whom the patient is referred in which the hospital has a disclosable financial interest or those entities which have a financial interest in the hospital. "Disclosable financial interest" will be defined in the rule-making process which implements section 1866(a)(1)(S) of the Act. In the interim, we suggest that hospitals reference the Disclosure of Ownership and Control provisions of 42 CFR 420 subpart C, which sets forth requirements for providers to disclose ownership and control information and identities of managing employees. *If a hospital refers patients about to be discharged and in need of services, only to entities it owns or controls, then the hospital is infringing on the rights of the patient to choose the facility they would like to go to for services*. The proposed disclosable financial interest requirement is an effort to increase the beneficiary's awareness of the actual or potential financial incentive a hospital may receive as a result of the referral. This regulation supports and extends our focus on patient-centered outcomes of Care. We invite comments on this proposed requirement and other concerns hospitals may have regarding their ability both operationally and financially to undertake this approach.

Id. at 66,743 (emphasis added).

The regulation to which the comment refers, 42 C.F.R. pt. 420 subpt. C, discusses *what* must be disclosed, but it does not address *how* that disclosure must be presented. It does not, therefore, directly address the issue presented here. The Appendix to this Memorandum embodies the text of proposed 42 C.F.R. § 482.55, 62 Fed. Reg. at 66,758-759, which may or may not be adopted in this form or at all. (Typically, HCFA is very slow

to adopt final regulations.) In the absence of final regulations, a definitive conclusion cannot be reached regarding whether Moravian is in compliance with the requirements imposed by the amended statute. It appears, however, that no particular form of disclosure of competing providers is contemplated by the statute or its proposed implementing regulations. It certainly cannot be said conclusively, however, that Moravian is in violation of the statute.

B. Antitrust Law

The fact that the agency which has immediate access to patients being discharged, Home Care Resources, is an affiliate of Moravian has antitrust significance. Home Care Resources obviously is exploiting its affiliation with Moravian to secure access to referrals that would not be present if VNA's in-house counseling privileges had not been terminated. The mere substitution of one competitor with another is of no competitive significance, at least for purposes of the Sherman Antitrust Act, 15 U.S.C. §§ 1 et seq., unless the favored entity is controlled by a parent which is exploiting its market power to secure an advantage in a related market.

Section 1 of the Sherman Act, 15 U.S.C. § 1, proscribes "contracts, combinations, and conspiracies in restraint of trade." Accordingly, it cannot usually be violated in the absence of concerted conduct by nonaffiliated entities. Section 2 of the statute, 15 U.S.C. § 2, proscribes monopolies, conspiracies, and attempts to monopolize. It can be violated by unilateral conduct or by simply unlawfully occupying the status of being a monopoly. There is no concerted conduct evident here, so liability, if it is to be premised on an antitrust theory, probably must rely on § 2. The Supreme Court has made it clear that making out a claim for liability under § 2 of the Sherman Act is a long haul indeed:

> [T]he plaintiff charging attempted monopolization must prove a dangerous probability of actual monopolization, which has generally required a definition of the relevant market and examination of market power. . . . [T]o establish monopolization or attempt to monopolize under § 2 of the Sherman Act, it would be necessary to appraise the exclusionary power of [the defendant's actions] in terms of the relevant market for the product involved. . . . The reason was that "[w]ithout a definition of that market there is no way to measure [the defendant's] ability to lessen or destroy competition." . . .
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> Similarly, this Court reaffirmed in Copperweld . . . that "Congress authorized Sherman Act scrutiny of single firms only when they pose a danger of monopolization. Judging unilateral conduct in this manner reduces the risk that the antitrust laws will dampen the competitive zeal of a single aggressive entrepreneur." [Citation omitted.] Thus, the conduct of a single firm, governed by § 2, "is unlawful only when it threatens actual monopolization." . . .
>
> . . . Consistent with our cases, it is generally required that to demonstrate attempted monopolization a plaintiff must prove (1) that the defendant has engaged in predatory or anticompetitive conduct with (2) a specific intent to monopolize and (3) a dangerous probability of achieving monopoly power.

Spectrum Sports, Inc. v. McQuillan, 506 U.S. 1041, 1045 (1993).

The fact that a single firm has a dominant market position is not, standing alone, sufficient to establish the existence of monopoly power, although a large market share is compelling evidence of market power, defined as the ability to exclude competition in the relevant market either by restricting entry of new competitors or by driving existing competitors out of the market.[2] *U.S. Anchor Manufacturing, Inc. v. Rule Industries, Inc.*, 7 F.3d 986, 994 (11th Cir. 1993). Although there is no universally accepted standard for

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The term "market power" also is sometimes used. The two terms are functionally interchangeable. *U.S. Anchor Manufacturing, Inc. v. Rule Industries, Inc.*, 7 F.3d 986, 994 n.12 (11th Cir. 1993).

precisely what numerical market share creates a presumption of monopoly power,[3] the principal measure of monopoly power is market share. *Id.* at 993-94, 999. Generally, as market share approaches 67%, the presumption of monopoly power becomes more compelling. *See United States v. Aluminum Co. of America*, 148 F.2d 416, 424 (2d Cir. 1945) (L. Hand, J.). Proof which would tend to rebut the presumption of monopoly power arising as a result of market share in excess of 67% would be evidence that the market exhibits competitive behavior despite the level of concentration.[4]

Even if it can be established that a firm, in fact, possesses monopoly power, there must be some showing that the monopoly power was achieved by unlawful means, as opposed to normal accretion through innovation or collapse of its rivals. In other words, it must be shown that the actor, to have achieved monopoly power, has engaged in "conduct without legitimate business purpose that makes sense only because it eliminates competition." *Morgan v. Ponder*, 892 F.2d 1355, 1358 (8th Cir. 1989). As a practical matter, it is very difficult for a private plaintiff to prevail on a § 2 claim because the requisite standard of proof is so high.

In *Key Enterprises of Delaware, Inc. v. Venice Hospital*, 919 F.2d 1550 (11th Cir. 1990), *vacated and reh'g en banc granted*, 979 F.2d 806 (11th Cir. 1992), *vacated on ground of mootness*, 9 F.3d 893 (11th Cir.), *cert. denied sub nom. Sammett Corp. v. Key Enterprises*

"The relative effect of percentage command of a market varies with the setting in which that factor is placed." *United States v. Columbia Steel Co.*, 334 U.S. 495, 528 (1948).

In the case of claims of attempts to monopolize, market shares of 30% to 50% normally are rejected as evidence of market power, in the absence of a showing of "invidious conduct." *Rebel Oil Co. v. Atlantic Richfield Co.*, 51 F.3d 1421, 1438 n.10 (9th Cir.), *cert. denied*, 116 S. Ct. 515 (1995).

of Delaware, Inc., 511 U.S. 1126 (1993), the plaintiff durable medical equipment (DME) supplier sued a large Venice, Florida, hospital (and others) on various antitrust theories. Venice Hospital formed a joint venture with a competing DME supplier, and, thereafter, the hospital encouraged nurses and others to steer discharged patients to obtain DME from the hospital's own affiliated DME supplier. There is little price competition in the DME business, since virtually all DME is paid for or reimbursed by third-party payers, so in a very short time the hospital's affiliate obtained a commanding position in the referrals of business by the hospital's discharged patients.

The court's opinion is detailed but confusing. It sustained the plaintiff's theory of recovery on several grounds.[5] First, it accepted that the hospital, its joint venture partner, and the joint venture itself were engaged in a "reciprocal dealing conspiracy," whereby the parties agreed to refer business only to each other.[6] Second, it found that there could have been proven a case of "monopoly leveraging," whereby a monopolist uses its power in one market to coerce buyers of its product to purchase from it in another wholly distinct market. All of the theories presupposed the existence of market power on the part of Venice Hospital, but there was no finding specifically to that effect. The court noted that there were only two hospitals "in the Venice area," 919 F.2d at 1533 (without defining that area), of which Venice Hospital was by far the largest.

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[5]The plaintiff had obtained a substantial jury verdict, which was set aside by the district court on the defendants' motion for judgment n.o.v.

[6]Clearly the hospital referred business to the affiliated DME supplier. It is not known how the supplier could have referred or did refer business to the hospital.

The court placed great emphasis on the fact that the plaintiff's referral business went from 73% of the market—i.e., the market comprised of Venice Hospital referrals—before the formation of the joint venture to about 30% of the market after its formation, all in a space of about two years. In other words, the market became even less concentrated than it had been previously by virtue of the formation and operation of the joint venture, yet the court affirmed the jury's imposition of liability even though, in effect, the business had only been transferred from one entity to another. Moreover, the court focused on the market for sales of DME by Venice Hospital alone, rather than any effects on the sales of DME suppliers overall or in some broader market.

Under similar facts, the court in *Advanced Care-Care Services, Inc. v. Giles Memorial Hospital*, 846 F. Supp. 488 (W.D. Va. 1994), came to the opposite conclusion. A hospital and a DME supplier entered into a joint venture agreement. Essentially, the hospital provided office space, and the DME supplier provided in-hospital personnel and DME. They shared revenues on all referrals to the joint venture. The competitor alleged that the hospital used its monopoly power to "steer" patients to the joint venture. The court awarded summary judgment to the defendants on two grounds. First, the court held that the relevant market was not the single hospital defendant, but instead was comprised of all hospitals within the county that competed for patients with each other. Enlarging the market obviously diluted the defendant hospital's market share below the level where it could be said that it possessed market power. Second, the hospital provided a form to patients that (1) advised

patients of all DME suppliers in the community, (2) refrained from recommending any particular supplier, and (3) required the patient to select a supplier.[7]

Advanced Care-Care is the more persuasive authority.[8] Similar facts were presented in *Delaware Care Care, Inc. v. MCD Holding Co.*, 957 F. Supp. 535 (D. Del. 1997). The owner and operator of a large hospital in New Castle County (Wilmington), Delaware, was affiliated with an entity that provided home care-Care services in competition with those offered by the plaintiff. It was alleged that the hospital's "discharge planner" previously had recommended one of several such service providers on an informal rotating basis. Later, the hospital was directed to recommend to patients only the services offered by the hospital operator's affiliate. The affiliate had other advantages, such as the opportunity for direct contact with patients prior to their discharge. The court granted the defendants' motion for summary judgment, rejecting the plaintiff's theory of monopoly leveraging. The court held that the plaintiff had failed to sustain its burden of proving the relevant market, without which no determination of market power could be made. It accepted evidence that other service providers were prepared and willing to come into New Castle County from elsewhere in Delaware, Maryland, New Jersey, and Pennsylvania. In so finding, the court found as

[7]The "discharge planner" with whom the patients interacted was employed by the hospital, not by the joint venture or by the DME supplier.

[8]The continuing vitality of *Venice Hospital* has been questioned by the court in *Continental Orthopedic Appliances, Inc. v. Care Insurance Plan of Greater New York, Inc.*, 994 F. Supp. 133, 141 (E.D.N.Y. 1998).

particularly persuasive the opinion of the court in *Advanced Care-Care*. *Delaware Care Care, Inc.*, 957 F. Supp. at 545.[9]

Accordingly, it is unlikely that the practice at issue could be challenged successfully on antitrust grounds.

[9]Other theories were advanced by the plaintiff, but those theories were so weak that they do not merit discussion. Viar Nurse Association of Delaware was a defendant in that action.

APPENDIX

§ 482.55 Condition of participation: Discharge planning.

The hospital must have in effect a discharge planning process that applies to all patients. This process assures that appropriate posthospital services are obtained for each patient, as necessary.

(a) Standard: Identification of patients in need of discharge planning. The hospital must identify, at an early stage of hospitalization, all patients who are likely to suffer adverse care consequences upon discharge if there is no adequate discharge planning.

(b) Standard: Discharge planning evaluation.

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

(2) A registered nurse, social worker, or other appropriately qualified personnel must develop or supervise the development of the evaluation.

(3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing posthospital services, including hospice services, and of the availability of those services.

(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-Care or of the possibility of the patient being Cared for in the environment from which he or she entered the hospital.

(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for posthospital Care are made before discharge, and to avoid unnecessary delays in discharge.

(6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

(7) The evaluation must include a list of HHAs that are available to the patient, that participate in the MediCare program, the geographic area (as defined by the HHA) in which the patient resides, and that request to be listed by the hospital as available to provide home care services to patients the hospital discharges.

(c) Standard: Discharge plan. (1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

(2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

(3) The hospital must arrange for the initial implementation of the patient's discharge plan.

(4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing Care needs or the appropriateness of the discharge plan.

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for posthospital Care.

(6) The discharge plan must inform the patient or patient's family as to their freedom to choose among participating MediCare providers of Care when a variety of willing providers is available and must, when possible, respect patient and family preferences when they are expressed. However, the discharge plan must not specify or otherwise limit qualified providers that are available to the patient.

(7) The discharge plan must identify, in a form and manner specified by the Secretary, any home care agency to whom the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary consistent with section 1866(a)(1)(S) of the Act, or those entities that have a financial interest in the hospital.

(d) Standard: Transfer or referral. The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary Care.

(e) Standard: Reassessment.

(1) The hospital must reassess its discharge planning process on an ongoing basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

(2) The hospital's discharge planning process must be an integral part of the hospital's quality assessment and performance improvement program.