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Discharge planning conditions of participation: Key to safe transitions and compliance risk

by Ronald Hirsch, MD, FACP, CHCQM, CHRI

To safeguard Medicare and Medicaid beneficiaries' health and safety, the Centers for Medicare & Medicaid Services (CMS) develops and publishes Conditions of Participation (CoPs) and employs designated organizations to assess compliance with CoPs. In addition, Appendix A of the State Operations Manual contains CMS survey interpretative guidelines..[1]

For case managers and case management leaders, the discharge planning CoPs at 42 C.F.R. § 482.43 help guide their daily work with patients, setting the minimum requirements for providing appropriate transitions of care. As hospital stays get shorter and the patient population gets older, the challenges of arranging a safe and effective discharge plan grow. And that challenge increased in 2019 when CMS updated the CoPs for discharge planning in September 2019.

Patient choice

Most of the discussion around that update centered on the issue of patient choice, with CMS adding the requirement that patients be offered a choice of not only home health agencies (HHAs) and skilled nursing facilities (SNFs) as required in the past but also inpatient rehabilitation facilities and long-term acute care hospitals. This addition, though, was also accompanied by a statement that "We expect discharge planning to facilitate patient choice in any post hospital extended care services, even though the statute does not require a specific list beyond HHAs, SNFs, IRFs [inpatient rehabilitation facilities], and LTCHs [long-term care hospitals]."[2] This would mean that choice should also be offered for hospice and durable medical equipment (DME) where applicable.

The issue of choice for SNFs has led to some ambiguity in interpretation. CMS states that patients must be presented with a list of SNFs available to the patient and in the geographic area requested by the patient. CMS expressly said that providers may not limit the list to those facilities that have agreed to accept the patient. That leads to the dilemma of the patient choosing a facility that can provide the post-acute care they need but does not have an open bed at the time. Must that patient choose another facility with an available bed, or can the patient insist on staying in the hospital without any financial liability until their preferred facility has an open bed? The answer is unknown, but it is hoped that CMS will address this in the interpretive guidelines once they are released.

On the other hand, in a June memo to survey organizations,[3] CMS was unambiguous in stating that they are concerned that hospitals are not complying with the CoPs for discharge planning in several areas. While

complying with every CoP is required, those specifically called out by CMS in such a memo should alert every provider to confirm that their processes meet both the letter and spirit of the regulation. CMS noted six areas that warranted extra scrutiny by the survey organizations, all related to providing information to post-acute care providers.

First mentioned is the omission of information related to patients with serious mental illness, substance use disorder, or complex behavioral needs. While details are not provided, their description suggested that hospitals did not relate to post-acute care providers the need for interventions to control behavior during the hospital stay that was discontinued prior to discharge. For example, a patient may have required a sitter at some point during their hospitalization. While the sitter was not required on transfer, CMS notes that such information would be crucial to convey so the post-acute care provider can be prepared if behavioral issues recur.