

## BREATHING LIFE INTO DISCHARGE PLANNING

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*The planning involved in moving a patient from one care setting to another under Medicare and related statutory schemes is an important issue facing elderly patients. Alfred J. Chiplin, Jr. addresses the concerns involved in the planning of a discharge from a care facility and the transitional care that follows to ensure that patients not only have a smooth transition from one care facility to another, but also that patients will continue to get the care they need. Mr. Chiplin begins by extensively outlining the relevant statutory provisions and the precise practices and procedures under the*

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*current discharge-planning framework. He then discusses various statutory recommendations that he and his colleagues have devised to provide for the development of coordinated care services. Next, Mr. Chiplin describes the suggestions certain advocacy groups have made for improvements to the law of discharge planning. The article concludes with a call for better-defined standards for health care professionals so that they may provide smooth transition care and discharge planning for elderly patients.*

## I. Introduction

Discharge planning includes a variety of activities in preparation for leaving a hospital, a skilled nursing facility, a rehabilitation center or hospital, or for terminating services of a home health agency. It is part of the larger enterprise of “transitions,” moving from one care setting to another, including returning to one’s home after an acute illness or a period of rehabilitation or convalescence. It often involves helping patients and their families understand likely care needs as they move from one care setting to another, including arranging for services and support.

This article focuses on discharge planning across several care settings, each with its own legal framework. It gives particular attention to the acute care hospital setting, noting the importance of the acute care hospital as a setting from which discharge planning and transitions from one care setting to another most often spring.

In addition, the article examines the discharge-planning requirements of the Medicare statute in some detail. It identifies two principle Medicare-related shortcomings: (1) the failure of the Medicare statute and its regulations to give specific guidance about the responsibilities and duties for discharge plan implementation as patients move from care setting to care setting and (2) the lack of vigorous oversight and monitoring of discharge planning as a condition of participation in the Medicare program.

The article also offers strategies for improvement, embracing a variety of approaches. These approaches include strengthening the Medicare statutory framework so that it is more specific about care transitions and responsibilities, such as payment; working with the Medicare agency in expanding program oversight and guidance; looking to state laws as a basis for expanding beneficiary rights to discharge planning and transitions services; and building upon the dynamic research regarding the importance of care transitions, both as to

clinical standards and better patient outcomes, and expanding patient and family education opportunities.

## II. Background

Medicare beneficiaries are left on their own to sort out and apply the bits and pieces of Medicare law, regulation, and policy relevant to discharge planning and transitions. In many instances, the need to assert these rights arises when Medicare beneficiaries and their advocates are confronted with a discharge or reduction in services in hospital, skilled nursing, and home health care settings, or when services called for in a discharge plan are not in fact instituted. As a consequence, the beneficiary must be on notice to: (1) carefully read all documents that purport to explain Medicare rights or to have family members, friends, or other representatives read such documents if the beneficiary is unable to do so; (2) question treating physicians, nurses, social workers, home health care providers, and other care providers about necessary services as the beneficiary's condition improves, remains the same, or requires more services, and to voice opinions and concerns about his or her care, and participate fully in all care decisions; (3) become familiar with Medicare guidelines about eligibility for hospital-, home-, and community-based care available under both state and federal schemes; and (4) identify and become familiar with the health care services that are available, such as visiting nursing services, home health agencies, nursing homes, respite care, friendly visiting services, and religious and civic groups that provide services.

Discharge planning provides important opportunities for advocates to assist patients in arranging post-hospital services through developing both administrative and court initiatives to assure the Centers for Medicare & Medicaid Services (CMS) appropriately implements federal discharge-planning requirements and policies through its interpretive and enforcement mechanisms.<sup>1</sup> The work of advocates also involves collaboration with ombudsmen, other community advocates, discharge-planning staff of Medicare-participating hospitals, and researchers in transitions. These persons are generally knowledgeable about community-based resources and can help in the

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1. Nondiscrimination in Post Hospital Referral to Home Health Agencies and Other Entities, 67 Fed. Reg. 70,373 (Nov. 22, 2002). The federal statutory scheme, 42 U.S.C. § 1395x(ee) (2004), and its implementing regulations, 42 C.F.R. § 482.43 (2004), provide a useful frame work for this advocacy.

discharge-planning process through identifying community resources and in assisting patients and families in utilizing identified resources.

While acknowledging that the process of discharge planning, including the patient evaluation and the development of the plan, should be continuous, advocates have suggested that the Secretary of Health and Human Services must be more specific about when the discharge-planning process should begin.<sup>2</sup> Absent specific timeliness requirements, discharge planning is often a “last-minute” exercise and options for post-hospital care are not fully explored. The Secretary has acknowledged that sufficient opportunity for the involvement of family and friends in the consideration of post-hospital needs and options is important. Discharge planning is particularly important to the acute care hospital setting, the nursing facility setting, and the home health care setting.

#### A. The Acute Care Hospital Setting

##### 1. NOTICE OF NON-COVERAGE AND IMPORTANT TIME FRAMES

For persons in a hospital that is part of a managed care plan, also known as a Medicare+Choice Organization (MCO), or “Medicare Advantage” Organizations (as redesignated in the Medicare Modernization Act 2003),<sup>3</sup> the MCO, or the hospital that has been delegated the authority to make the discharge decision, must provide the beneficiary with written notice of non-coverage when the beneficiary disagrees with the discharge decision or the MCO is not discharging the individual but no longer intends to continue coverage of the inpatient stay.<sup>4</sup>

CMS takes the position that the “Important Message from Medicare,” is the only written notice that an inpatient will receive about his or her rights, unless, upon being told that he or she is about to be discharged, the inpatient disagrees with discharge. If the patient disagrees, he or she will be given a notice of non-coverage with specific information about the basis of the hospital’s discharge decision and

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2. See Alfred J. Chiplin, *Medicare Discharge Planning Regulations: An Advocacy Tool for Beneficiaries*, 29 CLEARINGHOUSE REV. 152–61 (1995) (now the J. POVERTY L. & POL’Y).

3. See Medicare Modernization Act of 2003, Pub. L. No. 108-173, § 201(a), 117 Stat. 2176, 2176.

4. See 42 C.F.R. § 422.620(a)(i)–(ii) (2004).

appeal rights.<sup>5</sup> An enrollee is entitled to coverage until at least noon of the day after notice is provided.<sup>6</sup>

If the beneficiary requests immediate Quality Improvement Organization (QIO) review of non-coverage of inpatient hospital care, coverage is extended as authorized by that section provided that the enrollee submits a request for immediate review to the QIO that has an agreement with the hospital.<sup>7</sup> The QIO must make a determination and notify the enrollee, the hospital, and the MCO by close of business of the first working day after it receives all necessary information from the hospital, the organization, or both.<sup>8</sup>

Before providing a notice of non-coverage, the entity making the non-coverage/discharge determination must obtain the concurrence of the physician who is responsible for the beneficiary's inpatient care.<sup>9</sup> Written notice of non-coverage must be issued no later than the day before hospital coverage ends.<sup>10</sup> The written notice must include: "(1) the reason why inpatient hospital care is no longer needed; (2) the effective date and time of the enrollee's liability for continued inpatient care; (3) the enrollee's appeal rights; and (4) additional information specified by CMS."<sup>11</sup>

## 2. HOSPITAL NOTICE

Persons in the traditional Medicare fee-for-service program are also entitled to notice when their Medicare-participating hospital determines that the hospital stay is no longer medically necessary and the hospital intends to charge them for any continued stay.<sup>12</sup> An inpatient of a Medicare participating hospital also has a right to an appeal to the QIO of a hospital's notice of non-coverage.<sup>13</sup>

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5. *Id.* § 422.620(a)(1)(i).

6. *Id.* § 422.620(a)(2).

7. *Id.*

8. *Id.* § 422.620(b).

9. *Id.*

10. *Id.* § 422.620(c).

11. *Id.*

12. *Id.* § 412.42(c)(1)–(4) (2004).

13. *Id.* § 478.32 (2004). As to liability for payment, recent regulations provide that if a beneficiary receives a notice of non-coverage under 42 C.F.R., the patient may remain in the hospital without any additional financial liability until a decision has been made by the QIO if the beneficiary requests an expedited determination by the QIO and the beneficiary meets the conditions of § 1879(a)(2) of the Social Security Act, 42 U.S.C. § 1395pp(a)(2) (West 2003), which provide that if the individual did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under Part A or Part B.