



THE BASICS

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Discharge Planning and Medical Social Services in Fee-for-Service Medicare

This Basic reviews the discharge planning and medical social work services requirements for hospitals, skilled nursing facilities (SNFs), and home health agencies (HHAs) in the Medicare program. Medicare sets minimum health and safety standards known as conditions of participation (COPs) to protect beneficiaries and ensure quality care.¹ Providers such as hospitals, SNFs, and HHAs must satisfy applicable COPs to participate in the Medicare and Medicaid programs. COPs cover many domains, and the specific requirements vary by type of provider. For example, the conditions for some providers require that they provide discharge planning and medical social services to help coordinate care and manage transitions between settings for Medicare beneficiaries who need such services. The payment for these services is not a distinct fee but rather is included in Medicare's fee-for-service payment for certain provider types.

INPATIENT HOSPITAL SERVICES

The Medicare program pays hospitals for qualifying inpatient hospital stays. The payment for each stay is intended to cover all inpatient services needed by the patient, as determined by diagnosis and other patient characteristics. Discharge planning is included in the per-stay payment. Required discharge planning activities relate only to a single hospital stay; overall coordination of a patient's care beyond or unrelated to a hospitalization is not part of the payment and not required.

According to the hospital COPs, the hospital discharge planning process must apply to all patients.² Patients likely to "suffer adverse consequences upon discharge" if there is no discharge plan must be identified by the hospital. The hospital must provide

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such patients with a discharge planning evaluation that assesses (i) the likelihood of the patient needing post-hospital services and of the availability of the services and (ii) the patient's capacity for self care or being cared for in the environment from which he or she entered the hospital. The hospital is required to discuss the results of the evaluation with the patient or a representative acting on his or her behalf and to use the evaluation to establish an appropriate discharge plan. If a patient is determined to need a discharge plan, then a registered nurse, social worker, or other qualified person must develop or supervise the development of a discharge plan. Even if the hospital does not identify the need for a discharge plan, the patient's physician may request one, which the hospital must provide.

The COPs also require the hospital to arrange for the initial implementation of the patient's discharge plan. Specifically, a hospital is required to:

- Counsel patients and family members to prepare them for post-hospital care³
- Supply lists of local Medicare-participating SNFs and HHAs to patients for whom these services are indicated; hospitals may not make recommendations about which facility or provider to use
- Transfer or refer patients, along with appropriate medical records, for follow up and ancillary care as needed
- Reassess its discharge planning process and discharge plans to ensure they are responsive to patients' discharge needs

SKILLED NURSING FACILITY SERVICES

Beneficiaries are eligible for Medicare's SNF benefit if they need short-term skilled nursing care on a daily basis after an inpatient stay of at least three days that occurred no more than 30 days prior to admission to a SNF. SNFs are paid a daily rate that is adjusted to reflect the amount of therapy a patient uses, the need for certain services, the presence of certain conditions, and functional status. The SNF benefit covers skilled nursing care, physical and occupational therapy and speech-language pathology services, and other services and supplies. Payment for medical social services is also included in Medicare's daily rate for SNFs.

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Skilled nursing facilities are required to promote and enhance patients' quality of life through the provision of "medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."⁴ Medical social services are defined as services that contribute meaningfully to the treatment of a patient's condition and "include, but are not limited to:

- Assessment of the social and emotional factors related to the patient's illness, his or her need for care, response to treatment, and adjustment to care in the facility;
- Appropriate action to obtain case work services to assist in resolving problems in these areas; and
- Assessment of the relationship of the patient's medical and nursing requirements to his or her home situation, financial resources, and the community resources available to him or her in making the decision regarding discharge."⁵

Each facility must identify patients' needs and meet those needs using appropriate resources. It is not required that a social worker provide medically-related social services.⁶ However, facilities with more than 120 beds are required to employ a qualified full-time social worker.

When a SNF anticipates that a patient will be discharged, it is also required to perform a discharge summary that includes a summary of the resident's stay and a post-discharge plan of care.⁷ That plan of care must be developed with the participation of the beneficiary and his or her family with the goal of helping the beneficiary "adjust to his or her new living environment."⁸ As with hospital discharge planning, this is not an ongoing service, but related to a single discharge from the skilled nursing facility.

HOME HEALTH AGENCY SERVICES

The Medicare home health benefit provides covered services to beneficiaries needing part-time or intermittent skilled care in their homes. Home health-eligible beneficiaries must be confined to the home, under the care of a physician, receiving services under a plan of care established and periodically reviewed by a physician, in need of skilled nursing care on an intermittent basis

or physical therapy or speech-language pathology, or in continuing need of occupational therapy.⁹

Medicare's home health payment covers 60 days of care.¹⁰ The payment rate is adjusted to reflect a patient's clinical condition, functional status, and use of therapy. Services covered in the home health benefit include skilled nursing care; physical, occupational, and speech therapy; home health aide services; routine and non-routine medical supplies; and medical social services.

If a patient receives medical social services, the services must be given in accordance with the plan of care by a qualified social worker or by a qualified social work assistant.¹¹ Medical social services may be covered under the home health benefit when they are "necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient's medical condition or rate of recovery" and where the plan of care indicates how the required service necessitates "the skills of a qualified social worker or a social work assistant under the supervision of a qualified medical social worker to be performed safely and effectively."¹² When the requirements are met, services of a qualified medical social worker or social work assistants may include:

- "Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care;
- Assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources and availability of community resources;
- Appropriate action to obtain available community resources to assist in resolving the patient's problem;
- Counseling services that are required by the patient; and
- Medical social services furnished to the patient's family member or caregiver on a short-term basis when the HHA can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or to the patient's rate of recovery."¹³

ENDNOTES

1. Compliance with the conditions of participation is monitored through the survey and certification process, conducted at varying intervals for each provider type depending on statutory requirements or policy established by the Centers for Medicare & Medicaid Services (CMS). The survey (or inspection) for this determination is done on behalf of CMS by the individual State Survey Agencies. CMS also deems certain provider types to meet Medicare conditions of participation if they receive accreditation from specified organizations, such as JCAHO, which bestow accreditation based on meeting certain standards.
2. Hospital Conditions of Participation for discharge planning are found at 42 CFR §482.43.
3. CMS provides guidance to patients and caregivers on planning for discharge, "Planning for Your Discharge: a checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting," available at www.medicare.gov/Publications/Pubs/pdf/11376.pdf.
4. 42 CFR §483.15(g)(1), available at http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr483.15.pdf.
5. CMS, *Medicare Benefit Policy Manual*, "Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance," available at www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf.
6. Interpretive Guideline §483.15(g)(1) in CMS, State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, available at www.cms.hhs.gov/CFCsAndCoPs/Downloads/som107ap_pp_guidelines_tcf.pdf.
7. 42 CFR §483.20(l), available at http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr483.20.pdf.
8. 42 CFR §483.20(l)(3), available at http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr483.20.pdf.
9. CMS, *Medicare Benefit Policy Manual*, "Chapter 7 - Home Health Services Section 30 Conditions Patient Must Meet to Qualify for Coverage of Home Health Services," available at www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf.
10. For patients who receive fewer than five visits, home health agencies are paid per visit by type of visit.
11. 42 CFR §484.34, available at http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr484.34.pdf.
12. CMS, *Medicare Benefit Policy Manual*, "Chapter 7 - Home Health Services Section 50.3 Medical Social Services," available at www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf.
13. CMS, *Medicare Benefit Policy Manual*, "Chapter 7:"

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