

A-0823

(Rev. 87, Issued: 07-19-13, Effective: 07-19-13, Implementation: 07-19-13)

§482.43(c)(6) - The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) - This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) - For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations.

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

§482.43(c)(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

§482.43(c)(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.

Interpretative Guidelines §482.43(c)(6), §482.43(c)(7) & §482.43(c)(8)

The hospital must include a list of Medicare-participating home health agencies (HHAs) and skilled nursing facilities (SNFs) in the discharge plan for those patients for whom the plan indicates home health or post-hospital extended care services are required.

- “Extended care services” are defined at sections 1861(h) and (i) of the Social Security Act as items or services furnished in a skilled nursing facility (SNF). SNFs included on the list must be located in a geographic area that the patient or patient’s representative indicated he/she prefers.
- For Home Health Agencies (HHAs) the list must consist of Medicare-participating HHAs that have requested the hospital to be listed and which serve the geographic area where the patient lives. Hospitals may expect the HHA to define its geographic service area when it submits its request to be listed.

During the discharge planning process the hospital must inform the patient of his/her freedom to choose among Medicare-participating post-hospital providers and must not direct the patient to specific provider(s) or otherwise limit which qualified providers the patient may choose among. Hospitals have the flexibility either to develop their own lists or to print a list of skilled nursing facilities and home health agencies in the applicable geographic areas from the CMS websites, Nursing Home Compare (www.medicare.gov/NHcompare) and Home Health Compare (www.medicare.gov/homehealthcompare). If hospitals develop their own lists, they are expected to update them at least annually. (69 FR 49226, August 11, 2004)

For Information – Not Required/Not to be Cited

Hospitals may also refer patients and their families to the Nursing Home Compare and Home Health Compare websites for additional information regarding Medicare-certified skilled nursing facilities and home health agencies, as well as Medicaid-participating nursing facilities.

The data on the Nursing Home Compare website include an overall performance rating,

nursing home characteristics, performance on quality measures, inspection results, and nursing staff information.

Home Health Compare provides details about every Medicare-certified home health agency in the country. Included on the website are quality indicators such as managing daily activities, managing pain and treating symptoms, treating wounds and preventing pressure sores, preventing harm, and preventing unplanned hospital care.

The hospital might also refer the patient and their representatives to individual State agency websites, Long-Term Care Ombudsmen Program, Protection and Advocacy Organizations, Citizen Advocacy Groups, Area Agencies on Aging, Centers for Independent Living, and Aging and Disability Resource Centers for additional information on long term care facilities and other types of providers of post-hospital care. Having access to the information found at these sources may assist in the decision making process regarding post-hospital care options.

If the patient is enrolled in a managed care insurance program that utilizes a network of exclusive or preferred providers, the hospital must make reasonable attempts, based on information from the insurer, to limit the list to HHAs and SNFs that participate in the insurer's network of providers.

If the hospital has a disclosable financial interest in a HHA or SNF on a patient's list, or an HHA or SNF on the list has a disclosable financial interest in the hospital, these facts must also be stated on the list provided to the patient. Surveyors are not expected to know the requirements for a disclosable financial interest under Part 420, Subpart C, but hospitals are expected to know and comply with these requirements, and to identify for the surveyor whether there are such disclosable financial interests between the hospital and any specific HHAs or SNFs to which they refer/transfer patients.

When the patient or the patient's family has expressed a preference, the hospital must attempt to arrange post-hospital care with an HHA or SNF, as applicable, which meets these preferences. If the hospital is unable to make the preferred arrangement, e.g., if there is no bed available in the preferred SNF, it must document the reason the patient's preference could not be fulfilled and must explain that reason to the patient.

Survey Procedures §482.43(c)(6), §482.43(c)(7) & §482.43(c)(8):

- Review a sample of cases of patients discharged to HHAs or SNFs to determine if, when applicable, the hospital provided the patient with lists of Medicare-participating HHAs or SNFs. In making this determination:
 - Is there documentation of a list of multiple HHAs or SNFs being provided (including electronically) to the patient? If not, is there documentation for an acceptable rationale for providing only one option, e.g., the patient's home is included in the service area of only one Medicare-participating HHA that requested to be included on hospital lists, or there is only one Medicare-participating SNF in the area preferred by the patient?
- Ask to see examples of lists of HHAs and SNFs provided to patients prior to discharge.
- Ask the hospital if it has any disclosable financial interests in any HHA or SNF on its lists, or if an HHA or SNF has a disclosable financial interest in the hospital. If yes, is this stated clearly on the lists?
- Interview staff members involved with the discharge planning process. Ask them to

describe how patient preferences are taken into account in the selection of post-hospital HHA or SNF services.

- Ask the hospital to identify current patients for whom HHA or SNF services are planned. Interview the patient or the patient's family to ask them:
 - Were they presented with a list of HHAs or SNFs, as applicable, to choose from?
 - Did the hospital emphasize their freedom of choice?
 - Did the hospital arrange for their referral/transfer to an HHA or SNF reflecting their preferences? If not, did the hospital explain why their choice was not feasible?
 - If applicable, were they made aware of disclosable financial interest?