

MEMORANDUM

**To:** AAPM&R  
**From:** Peter Thomas and Joe Nahra  
**Date:** October 9, 2019  
**Re:** Summary and Analysis of Final Rule on Hospital and Post-Acute Care Discharge Planning

On September 30, 2019, the Centers for Medicare and Medicaid Services (CMS) released a final rule entitled *Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care*. This final rule revises the discharge planning requirements with which these settings must conform in order to participate in the Medicare and Medicaid programs, following a proposed rule issued in November 2015<sup>1</sup>. The regulations will go into effect on November 29, 2019. The final rule also includes an update to current regulations regarding patient rights in hospitals, intended to promote innovation and flexibility and to improve patient care.

The full text of the rule can be found [here](#), and a CMS fact sheet summarizing the major provisions in the rule can be found [here](#).

**Overview of the Final Rule**

The final rule implements discharge planning requirements mandated under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) by modifying the Medicare Conditions of Participation (CoPs)<sup>2</sup> for hospitals, including acute care hospitals, long-term care hospitals (LTCHs), inpatient rehabilitation hospitals and units (IRFs), psychiatric hospitals, children’s hospitals, and cancer hospitals, as well as critical access hospitals (CAHs) and home health agencies (HHAs).<sup>3</sup>

CMS emphasizes in the final rule the importance of discharge planning to successfully transition from hospitals to post-acute care (PAC) settings. It states that the location to which a patient may be discharged should be based on the patient’s clinical care requirements, available support network, patient and caregiver treatment preferences, and goals of care. The regulation also suggests that

<sup>1</sup> Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, 80 Fed. Reg. 68,126 (Nov. 3, 2015).

<sup>2</sup> The Medicare CoPs set the federal health and safety standards that providers and suppliers must satisfy to participate in the Medicare and Medicaid programs.

<sup>3</sup> CMS addressed discharge planning requirements for skilled nursing facilities (SNFs) in an October 2016 final rule entitled *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*.

providers should take into account quality and resource use measures to assist patients and their families during the discharge planning process in order to encourage patients and caregivers to become active participants in their transition to PAC or other settings.

## **CMS' Revisions to Hospitals' Discharge Planning Requirements**

The proposed rule set forth six standards for discharge planning in the Conditions of Participation. CMS has finalized significant modifications to the proposed standards in light of stakeholder comments regarding burdensome requirements in the proposed rule. The final rule states that hospitals must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and their caregivers/support person(s) as active partners in the discharge planning process for PAC. The discharge planning process must ensure an effective transition from hospital to PAC settings, and work to reduce the factors leading to preventable hospital readmissions.

1. **Standard: Design** – CMS proposed to establish a new standard titled “Design” requiring hospital medical staff, nursing leadership, and other pertinent service providers to provide input in the development of the discharge planning process and requiring the process for each hospital to be specified in writing and reviewed by the hospital's governing body. In response to stakeholder comments stating that the proposal was too process-oriented and prescriptive, *CMS is not finalizing any of the proposed requirements relating to the proposed “Design” standard.* The final rule does include a requirement for a hospital or CAH to assess its discharge planning process on a regular basis, but does not establish a specific timeframe requirement.
2. **Standard: Applicability** – CMS proposed to require that the discharge planning process apply to all inpatients, as well as specific categories of outpatients. In response to stakeholder concerns, however, CMS is scaling back this requirement's scope. The final rule requires that a hospital's discharge planning process must identify “at an early stage of hospitalization” those patients who are likely to suffer adverse health consequences upon discharge without adequate discharge planning and provide a discharge planning evaluation for those patients, as well as for other patients upon request of the patient, patient's representative, or patient's physician.
3. **Standard: Discharge Planning Process** – CMS proposed 10 specific elements to be addressed in the discharge planning process, detailing an extensive list of requirements for identifying each patient's anticipated post-discharge goals, preferences, and needs, and for developing an appropriate discharge plan for patients. CMS has significantly revised the proposed requirements to focus less on specific processes and prescriptive elements and focus more on overall outcomes and flexibilities for hospitals. The final regulations require the following:
  - Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge.

- *Note: CMS removed the proposed requirement establishing a specific timeframe of 24 hours after admission or registration for beginning to identify anticipated discharge needs for each applicable patient.*
  - A discharge planning evaluation must include an evaluation of a patient’s likely need for appropriate post-hospital services, including, but not limited to, hospice care services, *post-hospital extended care services, home health services, and non-health care services and community-based care providers, and must also include a determination of the availability of these services as well as the patient’s access to these services.*
  - The discharge planning evaluation must be included in the patient’s medical record and the results of the evaluation must be discussed with the patient or patient’s representative.
  - Any discharge planning evaluation or plan must be developed by, or under the supervision of, a registered nurse, social worker, or other qualified personnel.
    - *Note: CMS removed the proposed requirement that the practitioner responsible for the patient’s care be involved in establishing the patient’s goals of care and treatment preferences that inform the discharge plan.*
  - A hospital’s discharge planning process must require regular re-evaluation of the patient’s condition to identify changes that require modification of the discharge plan. The discharge plan must be updated as needed to reflect these changes.
  - As required by the IMPACT Act, hospitals must take into account PAC providers’ data on quality measures and resource use during the discharge planning process. The rule finalizes the provisions in the proposed rule requiring that hospitals must consider this data in light of the patient’s goals of care and treatment preferences. Hospitals should use this quality data to assist patients and their families in selecting a PAC provider. This requirement is finalized without modification from the proposed rule.
4. **Standards: Discharge to Home/Transfer of Patients to Another Healthcare Facility** – CMS proposed to redefine “discharge to home” in the Medicare CoPs to include those patients returning to their residence (or to the community if they do not have a residence) who require follow-up with their primary care provider, home health agency, hospice service, or any other type of outpatient healthcare service. CMS also proposed to detail the minimum information a discharging hospital must provide to the patient (if discharged to home) or to a receiving facility, but in response to stakeholder comments, *the agency has removed the majority of the proposed requirements and revised the remaining requirements.* Instead, the agency has finalized a singular requirement entitled “Discharge and transfer of the patient and transmission of the patient’s necessary medical information.”

The new standard requires the hospital to discharge the patient, along with “all necessary medical information pertaining to the patient’s current course of illness and treatment, post-discharge goals of care, and treatment preferences” at the time of discharge, to the

appropriate post-acute care service providers responsible for the patient's follow-up or ancillary care.

5. **Standard: Requirements for Post-Acute Care Services** – CMS finalized the proposed requirements for PAC services without modification. *Hospitals must include in the discharge plan a list of Medicare-participating PAC providers (including HHAs, SNFs, LTCHs, or IRFs) that serve the geographic area of the patient for whom home health or PAC services are indicated. (Previous requirements omitted IRFs from this list.)* For patients enrolled in managed care organizations, the hospital must alert the patient of the need to verify the HHAs or SNFs within the hospital's provider network. To the extent that the hospital has information as to which facilities/providers participate in the managed care organization's network, it must share this information with the patient. Additionally, *the hospital must document in the patient's medical record that it presented a list of options to the patient. The patient, or their caregiver/support person, must be informed of the patient's freedom to choose among PAC providers.* Lastly, the hospital must disclose any financial interest it may have in the referred HHA or SNF.

(Note: The preambles in both the proposed and final rule state that the final component of this standard, the hospital's disclosure of any financial interest in the referred PAC provider, is intended to be revised to include IRFs and LTCHs, in addition to HHAs and SNFs. However, the actual regulatory text included in the final rule states only that the disclosure requirement applies to "any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest." It is unclear whether this is an unintended omission in the final regulatory language, and may require additional clarification from CMS.)

The proposed rule also addressed discharge planning modifications for CAHs and HHAs. For CAHs, CMS is replicating the finalized regulations it applies to other discharging hospitals (as described above). For HHAs, CMS proposed a slightly simplified process entailing the content and timing requirements for discharge or transfer summaries from HHAs. However, after consideration of stakeholder comments, *CMS is not finalizing the proposed discharge planning process requirements for HHAs, with the exception of those required by the IMPACT Act* (mirroring the regulations outlined above in the process standard for hospitals).

As with the requirements for discharge to home/another healthcare facility, CMS is not finalizing the proposed specified list of information to include with an HHA discharge, but will require the HHA to send "necessary medical information" pertaining to the patient's treatment, goals, and preferences. HHAs are also required to comply with requests for additional clinical information by the receiving facility or health care practitioner as may be necessary for the patient's treatment.

The proposed rule also solicited comments on requiring the use of state's Prescription Drug Monitoring Programs (PDMPs), which are state-run electronic databases used to track prescribing and dispensing of controlled prescription drugs to patients. CMS did not finalize any requirement that hospitals consult with their state's PDMPs to review a patient's risk of non-medical use of

controlled substances or substance use disorders, nor will the agency require providers to use or access PDMPs during the medication reconciliation process. However, the final rule “strongly encourages” providers to use strategies and tools, including PDMPs, at their disposal to help reduce prescription drug abuse.

Lastly, the final rule also includes one additional provision stemming from a June 2016 Hospital Innovation proposed rule<sup>4</sup>, which ensures a patient’s right to access his or her own medical information from a hospital, in the form or format that the patient requests (as long as it is readily producible in such form) within a reasonable time frame. This is the only provision of that rule that CMS is finalizing here.

## **Commentary**

The final rule comes four years after the proposed rule was issued by the Obama Administration. While many of the proposed rule’s provisions have not been adopted in the final rule due to stakeholder comments concerned about regulatory burdens, the final rule offers several improvements to the current discharge planning process that should benefit patients in need of post-acute care and the full array of PAC providers. The fact is that, for certain patients, the discharge plan from the acute care hospital must include choices within each category of post-acute care, as well as resources for extended care services and even non-medical services in the community setting.

These new discharge planning procedures will likely improve transitions from acute to PAC services, decreasing readmissions to the acute care hospital and potentially improving access to traditional and non-traditional PAC services, especially for individuals with disabilities and chronic conditions. The requirement to produce hospital medical records to patients upon request within a reasonable period of time is designed to increase transparency, but may very well lead to an increase in medical malpractice lawsuits against hospitals of all kinds.

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<sup>4</sup> Medicare and Medicaid Programs; Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, 81 Fed. Reg. 39,448 (June 16, 2016).