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Health Care ADVISORY ■

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CMS Releases Final Rule on Revisions to Requirements for Discharge Planning

Late last month, the Centers for Medicare & Medicaid Services (CMS) finalized a rule mandating new discharge planning requirements for hospitals, critical access hospitals (CAHs), and home health agencies (HHAs). This Final Rule came nearly four years after CMS first proposed discharge planning improvements under the previous Administration, on October 29, 2015 (80 FR 68126). CMS delayed the release of its Final Rule (originally slated for 2018) to make significant revisions suggested by 299 commenters. The final discharge planning requirements are substantially less burdensome than those proposed since CMS revised requirements "to focus less on prescriptive and burdensome process details, and more on patient outcomes and treatment preferences."

Nonetheless, hospitals, CAHs, and HHAs will need to update or create new discharge planning processes by November 29, 2019 to comply with new conditions of participation under the Final Rule. Updated discharge planning processes will need to: (1) focus on patient goals and treatment preferences; (2) increase patient access to health care information; and (3) ensure necessary medical information is shared with receiving providers.

Additionally, the Final Rule implements requirements outlined in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 related to using and sharing data on quality measures and resource use measures during the discharge planning process. According to CMS, the IMPACT Act requires providers to employ standardized data elements to facilitate coordinated post-acute care and "to assist patients and their families during the discharge planning process."

Key Changes to Discharge Planning Requirements

Discharge planning evaluations and discharge plans (applicable to hospitals and CAHs)

While Medicare and Medicaid Conditions of Participation (CoPs) previously required hospitals to have discharge planning processes in place, the Final Rule extends this requirement to CAHs and makes several significant changes applicable to both hospitals and CAHs. Among other requirements, hospitals and CAHs will now be required to implement the following as a part of the discharge planning process:

- **Person-centered approach:** Take into account each patient's goals and treatment preferences and include the patient as well as his or her caregivers as active partners in the discharge planning process.

- **Discharge planning evaluation:** Identify, early in the hospitalization process, those *patients likely to suffer adverse health consequences after discharge in the absence of adequate discharge planning*. The hospital or CAH must provide a discharge planning evaluation for those patients (as well as any other patient upon request). Discharge planning evaluations are required to include an assessment of the patient's need for post-hospital services (such as hospice or home health services), determine the availability of the appropriate services, and evaluate the patient's access to necessary services.
  - The Proposed Rule initially required hospitals to apply their discharge planning process to *all inpatients and certain categories of outpatients*, including patients receiving observation services, patients undergoing surgery or other same-day procedures when anesthesia or moderate sedation was used, and emergency department patients that a practitioner deemed needed a discharge plan. In the Final Rule, however, CMS scaled back the reach of the discharge planning requirements, noting that the initial proposal "could potentially have the unintended consequence of shifting hospital resources away from those patients most in need of a discharge plan."
- **Develop discharge plan:** Use the discharge evaluation to develop a discharge plan for identified patients.
  - CMS declined to finalize many of the more specific requirements it had proposed, such as a requirement that affected entities begin to identify anticipated discharge needs within 24 hours of admission or registration. CMS remarked that numerous changes to discharge planning requirements included in the Proposed Rule were stripped from the Final Rule in an effort to "avoid any unnecessarily costly and burdensome requirements."
- **Share PAC data:** Share data on quality and resource use measures from available post-acute care (PAC) providers with patients—such as the proportion of falls at a certain facility that lead to injury, or the number of readmissions from a facility back to the hospital—to help patients select a PAC provider that aligns with their goals of care and treatment preferences.
- **Document:** Document all discharge planning evaluations and discharge plans in the patient's medical record.
- **Share information with receiving provider:** Send all "necessary medical information" (which is defined as a "patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences") pertaining to the patient to the receiving facility or health care practitioner and comply with requests for additional clinical information made by the receiving facility or health care practitioner.
- **Periodic assessment of process:** Periodically assess the discharge planning process. This evaluation should include "ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs."

Requirements for HHAs

The Final Rule also creates a new discharge planning CoP for HHAs. While these new discharge planning requirements are less specific than those imposed on hospitals and CAHs—and significantly less onerous than those initially proposed in 2015—the Final Rule requires HHAs to:

- **Develop a discharge planning process:** Develop and implement an effective discharge planning process.

- **Share PAC data:** Assist patients, when necessary, with selecting a PAC provider that aligns with the patient's goals of care and treatment preferences by using and sharing data on quality and resource use measures for available PAC providers.
- **Share information with receiving provider:** Send all "necessary medical information" (which is defined as a "patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences") pertaining to the patient to the receiving facility or health care practitioner and comply with requests for additional clinical information made by the receiving facility or health care practitioner.

CMS reduced the potential burden on HHAs by withdrawing a majority of its proposed discharge planning requirements (with the exception of those required by the IMPACT Act). Additionally, CMS did not finalize a provision in the Proposed Rule that would have required physicians responsible for a patient's home health plan of care to be involved in the ongoing process of establishing the discharge plan because this requirement duplicated a recently enacted HHA CoP (42 CFR 484.60(c)(3)(ii)) addressing physician involvement in the HHA discharge planning process. CMS stated that it is "committed to working with stakeholders to identify specific needs and concerns regarding discharge planning in the HHA care setting … and to explore all options for achieving positive patient outcomes."

Proposed Provisions Related to Prescription Drug Monitoring Programs Not Implemented

A proposed requirement that hospitals, HHAs, and CAHs consult with their states' Prescription Drug Monitoring Programs (PDMPs) and review a patient's risk of non-medical use of controlled substances and substance use disorders was not implemented as part of the Final Rule. CMS likewise did not finalize a proposed requirement that providers use or access PDMPs during the medication reconciliation process.

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