CMS Proposed Rule:

Revising the Requirements for Discharge Planning

Dec. 3, 2015

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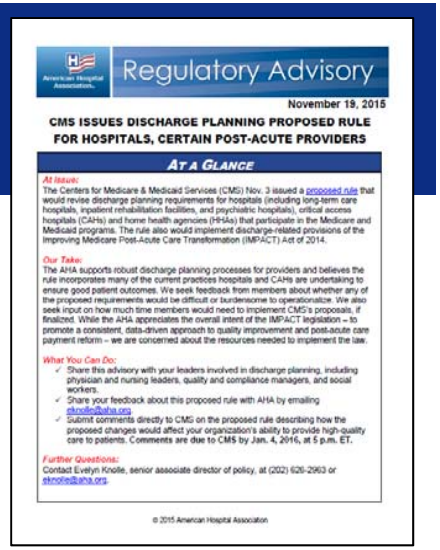
Key Dates and Facts



Regulatory Advisory

November 19, 2015

CMS ISSUES DISCHARGE PLANNING PROPOSED RULE FOR HOSPITALS, CERTAIN POST-ACUTE PROVIDERS

AT A GLANCE

At Issue:
The Centers for Medicare & Medicaid Services (CMS) Nov. 3 issued a proposed rule that would revise discharge planning requirements for hospitals (including long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals), critical access hospitals (CAHs) and home health agencies (HHAs) that participate in the Medicare and Medicaid programs. The rule also would implement discharge-related provisions of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

Our Take:
The AHA supports robust discharge planning processes for providers and believes the rule incorporates many of the current practices hospitals and CAHs are undertaking to ensure good patient outcomes. We seek feedback from members about whether any of the proposed requirements would be difficult or burdensome to operationalize. We also seek input on how much time members would need to implement CMS's proposals, if finalized. While the AHA appreciates the overall intent of the IMPACT legislation – to promote a consistent, data-driven approach to quality improvement and post-acute care payment reform – we are concerned about the resources needed to implement the law.

What You Can Do:
- Share this advisory with your leaders involved in discharge planning, including physician and nursing leaders, quality and compliance managers, and social workers.
- Share your feedback about this proposed rule with AHA by emailing
- Submit comments directly to CMS on the proposed rule describing how the proposed changes would affect your organization's ability to provide high-quality care to patients. Comments are due to CMS by Jan. 4, 2016, at 5 p.m. ET.

Further Questions:
Contact Evelyn Knolle, senior associate director of policy, at (202) 626-2963 or

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CMS published the rule in the *Federal Register* on Nov. 3, 2015.

The proposed rule updates discharge planning requirements for:

- hospitals, including:
  general acute, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals
- critical access hospitals (CAHs), and
- home health agencies (HHAs).

It also implements discharge-related provisions of the IMPACT Act of 2014.

Comments are due by 5 p.m. on Jan. 4, 2016.

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General Goals

CMS proposes that hospitals and CAHs implement effective discharge planning processes that:

- ✓ address the patient's goals, needs and treatment preferences
- ✓ prepare patients and their caregivers to be active partners/participants in post-discharge care
- ✓ promote effective transitions, and
- ✓ reduce the factors that lead to preventable readmissions.

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Discharge Plan Policies

Written discharge planning policies and procedures must be developed with input from . . .

Hospital	CAH
Medical staff	Professional health care staff
Nursing leadership	Nursing leadership
Other relevant departments	Other relevant departments

. . . and reviewed/approved by the governing body or, for CAHs, either the governing body or responsible individual.

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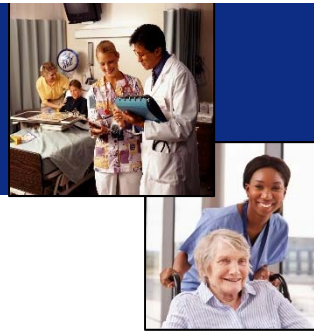
Discharge Plans



Applicability: Hospitals and CAHs would need to create discharge plans for:

- ❑ All inpatients
- ❑ Some outpatients, including
  - observation patients
  - same-day patients receiving anesthesia/moderate sedation
  - emergency department patients identified by emergency department practitioners as needing a discharge plan, and
  - other categories of outpatients recommended by the medical staff and specified in hospital/CAH policy.

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Discharge Plans

Timing. Hospitals and CAHs would need to:

- begin to identify discharge needs for patients within 24 hours after admission/registration
- regularly re-evaluate a patient's condition to identify necessary modifications of the discharge plan, and
- complete the discharge planning process in a timely manner, prior to discharge or transfer. The process must not unduly delay the patient's discharge or transfer.

**There are exceptions for emergency-level transfers.*

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Discharge Plans

People involved in the development of discharge plans:

Person	Role
A registered nurse, social worker or other personnel qualified in accordance with the hospital's/CAH's discharge planning policies . . .	coordinates the discharge needs evaluation and development of the discharge plan.
The practitioner responsible for the care of the patient . . .	must be involved in the ongoing process of establishing the patient's goals and treatment preferences that inform the discharge plan.
The patient and caregiver or support person . . .	must be involved in the development of the plan and informed of the final plan.

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Discharge Plans

Criteria for the evaluation of discharge needs. CMS outlines numerous factors that must be considered in evaluating discharge needs, such as:

- caregiver/support person and community-based care availability
- the patient's or caregiver's capability to perform required care
- relevant co-morbidities and past medical and surgical history
- admitting diagnosis or reason for registration
- the patient's goals and treatment preferences
- the patient's access to non-health care services
- communication needs
- relevant psychosocial history, and
- anticipated ongoing care needs and readmission risk.

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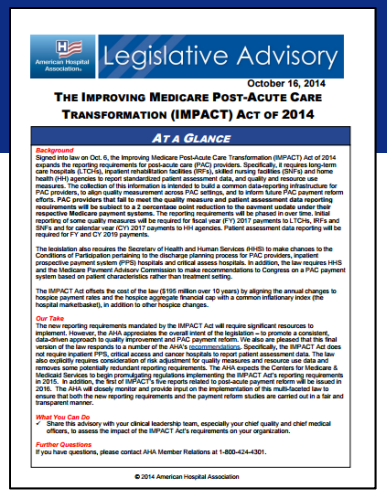
IMPACT Act of 2014



Legislative Advisory

October 16, 2014

THE IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT OF 2014

AT A GLANCE

Background

Signed into law on Oct. 6, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 expands the reporting requirements for post-acute care (PAC) providers. Specifically, it requires long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health (HH) agencies to report standardized patient assessment data, and quality and resource use measures. The collection of this information is intended to build a common data-reporting infrastructure for PAC providers, to align quality measurement across PAC settings, and to inform future PAC payment reform efforts. PAC providers that fail to meet the quality measure and patient assessment data reporting requirements will be subject to a 2 percentage point reduction to the payment update under their respective Medicare payment systems. The reporting requirements will be phased in over time. Initial reporting of some quality measures will be required for fiscal year (FY) 2017 payments to LTCHs, IRFs and SNFs and for calendar year (CY) 2017 payments to HH agencies. Patient assessment data reporting will be required for FY and CY 2019 payments.

The legislation also requires the Secretary of Health and Human Services (HHS) to make changes to the Conditions of Participation pertaining to the discharge planning process for PAC providers, inpatient prospective payment system (IPPS) hospitals and critical assess hospitals. In addition, the law requires HHS and the Medicare Payment Advisory Commission to make recommendations to Congress on a PAC payment system based on patient characteristics rather than treatment setting.

The IMPACT Act offsets the cost of the law ($195 million over 10 years) by aligning the annual changes to hospice payment rates and the hospice aggregate financial cap with a common inflationary index (the hospital marketbasket), in addition to other hospice changes.

Our Take

The new reporting requirements mandated by the IMPACT Act will require significant resources to implement. However, the AHA appreciates the overall intent of the legislation – to promote a consistent, data-driven approach to quality improvement and PAC payment reform. We also are pleased that this final version of the law responds to a number of the AHA's recommendations. Specifically, the IMPACT Act does not require inpatient PPS, critical access and cancer hospitals to report patient assessment data. The law also explicitly requires consideration of risk adjustment for quality measures and resource use data and removes some potentially redundant reporting requirements. The AHA expects the Centers for Medicare & Medicaid Services to begin promulgating regulations implementing the IMPACT Act's reporting requirements in 2015. In addition, the first of IMPACT's five reports related to post-acute payment reform will be issued in 2015. The AHA will closely monitor and provide input on the implementation of this multi-faceted law to ensure that both the new reporting requirements and the payment reform studies are carried out in a fair and transparent manner.

What You Can Do

✓ Share this advisory with your clinical leadership team, especially your chief quality and chief medical officers, to assess the impact of the IMPACT Act's requirements on your organization.

Further Questions

If you have questions, please contact AHA Member Relations at 1-800-424-4301.

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The IMPACT Act:

- expanded quality and resource use data reporting requirements for post-acute providers, and
- requires certain providers "to take into account" quality, resource use and other data in discharge planning.

The proposed rule would require hospitals and CAHs to:

✓ assist patients/support persons in selecting a post-acute provider by sharing relevant data that includes the quality and resource use measures for HHAs, SNFs, IRFs and LTCHs

✓ be available to discuss and answer questions about a patient's post-discharge options and needs, and

✓ consider the IMPACT Act quality measure data in light of the patient's goals and treatment preferences.

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Discharge to Home

Discharge Instructions. CMS proposes that discharge instructions be provided to patients and/or caregiver/support persons as well as any post-acute care providers. Components include:

- instruction on post-discharge care
- written information on warning signs and symptoms that may indicate the need to seek immediate medical attention
- prescriptions (and for hospitals, over-the counter medications)
- reconciliation of all discharge medications with the patient's pre-hospital/CAH admission medications, and
- written instructions regarding the patient's follow-up care.

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Post-Discharge Follow-Up Process

Post-Discharge Follow-up. CMS proposes that hospitals and CAHs establish a post-discharge follow-up process for patients discharged to home. However:

- CMS does not specify the mechanism or timing of follow-up programs.
- The rule also is unclear as to whether the process would apply to *all* patients discharged to home.

Question: What would be reasonable in terms of follow-up processes for hospitals and CAHs?

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Transfers

Transfers. When transferring patients, hospitals and CAHs would be required to provide the following specific medical information to the receiving facility. *Note – no specified format.*

- Demographic information
- Contact information for the practitioner responsible for the care of the patient, and the patient's caregiver(s)/support person(s), if applicable
- Advance directive, if applicable
- Course of illness/treatment
- Procedures, diagnoses, and laboratory tests, and the results of pertinent laboratory and other diagnostic testing
- Consultation results
- Functional status assessment
- Psychosocial assessment, including cognitive status
- Social supports

(Cont'd)

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Transfers

- Behavioral health issues
- Reconciliation of all discharge medications with the patient's prehospital admission/registration medications
- All known allergies, including medication allergies
- Immunizations
- Smoking status
- Vital signs
- Unique device identifier(s) for a patient's implantable device(s)
- All special instructions or precautions for ongoing care
- Patient's goals and treatment preferences; and
- All other necessary information, including a copy of the patient's discharge instructions, the discharge summary and any other documentation as applicable, to ensure a safe and effective transition of care that supports the post-discharge goals for the patient.

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Other Hospital Requirements

For hospitals, when referring patients for post-acute care:

- include a list of post-acute care providers in discharge plan
  - ⇒ notify patients in managed care organizations to check networks, or share that data if hospital has it
- inform patient of freedom to choose among Medicare providers
- discharge plan must identify any HHA or SNF to which the patient is referred in which hospital has disclosable financial interest.

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PDMPs

Prescription drug monitoring programs.

CMS asks:

1. Should providers, in evaluating patient discharge needs, consult with their state's PDMP?

2. Should PDMPs be used in the medication reconciliation process?

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Behavioral Health Focus

Improving focus on Behavioral Health. CMS wants hospitals and critical access hospitals (CAHs) to improve their focus on psychiatric and behavioral health patients.

CMS does not propose, but mentions its expectations, that hospitals and CAHs must:

- identify the types of services needed upon discharge, including options for tele-behavioral health services as available/appropriate
- identify organizations offering community services in the psychiatric hospital or unit's community, and try to establish partnerships
- arrange, as applicable, for the development and implementation of a specific psychiatric discharge plan for the patient as part of the patient's overall discharge plan, and
- coordinate with the patient for referral for post-acute psychiatric or behavioral health care.

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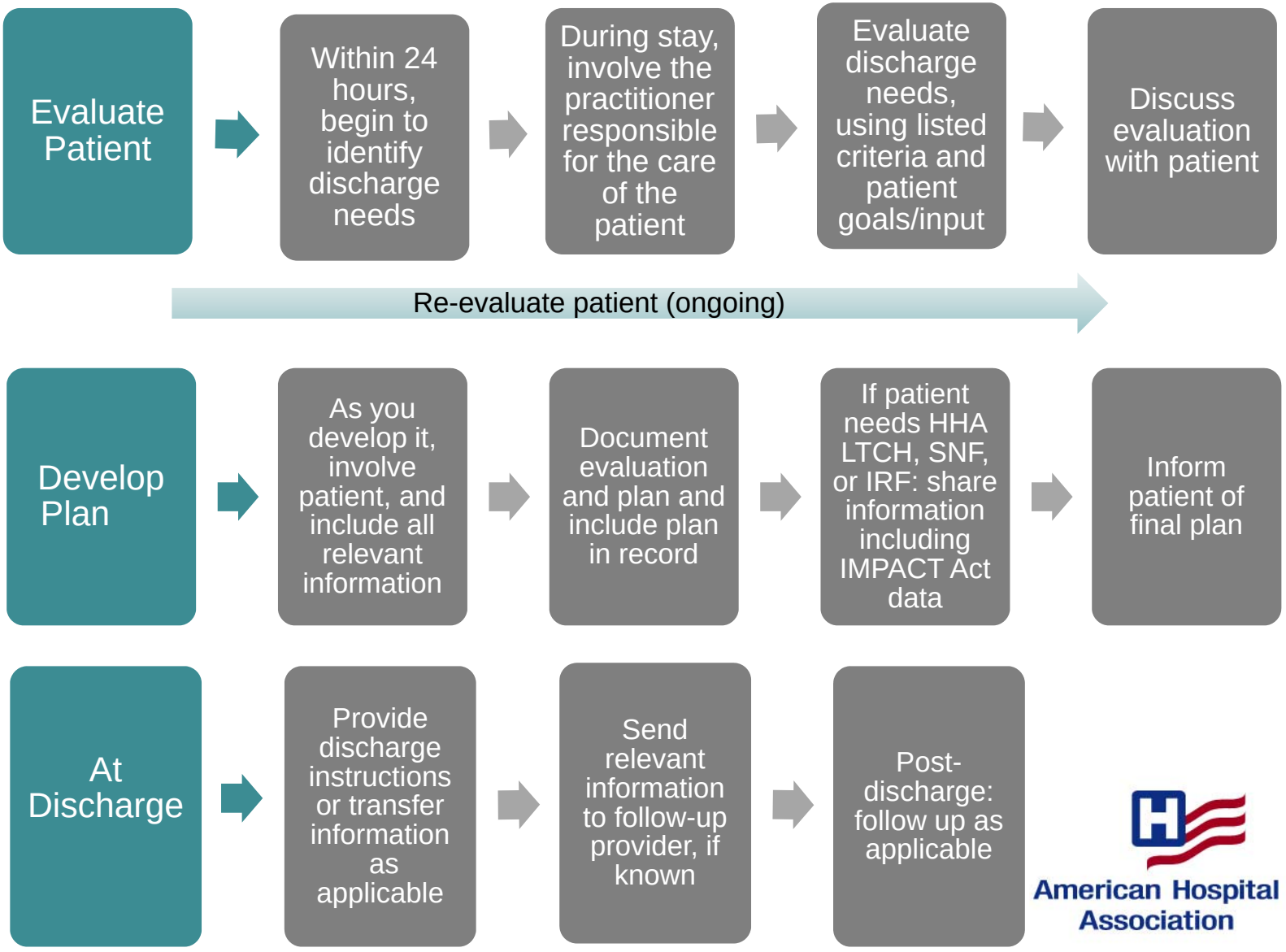
Key Steps



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