



American Hospital
Association®

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 eknolle@aha.org.
- ✓ 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 eknolle@aha.org.



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

BACKGROUND

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 (LTCHs), inpatient rehabilitation facilities (IRFs), and psychiatric hospitals), critical access hospitals (CAHs) and home health agencies (HHAs) that participate in the Medicare and Medicaid programs. In addition, the rule implements discharge-related provisions of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 for all three providers. According to CMS, the discharge planning requirements for hospitals have not been updated since 2004. The proposed rule incorporates numerous best practices, stresses the importance of focusing on the needs of psychiatric and behavioral health patients, and emphasizes patient and family/caregiver engagement throughout the discharge planning process.

AT ISSUE

Below we describe the proposed requirements for hospitals and CAHs, which are almost identical. The proposed requirements for HHAs are discussed starting on page six.

Proposed Requirements for Hospitals and CAHs

Discharge plans. In the proposed rule, hospitals and CAHs would be required to create discharge plans for all inpatients as well as some outpatients, including observation patients; same-day patients receiving anesthesia or 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 the hospital's/CAH's discharge planning policies approved by the governing body. The discharge planning process would need to address the patient's goals, needs and treatment preferences, as well as prepare patients and their caregivers to be active partners/participants in post-discharge care. It also would need to focus on ensuring effective transitions and reducing the factors leading to preventable readmissions. CMS emphasizes that providers must take reasonable steps to provide individuals with limited English proficiency or physical, mental, or cognitive and intellectual disabilities "meaningful access to the discharge planning process."

Discharge planning policies. CMS proposes that written discharge planning policies and procedures be developed with input from the medical staff (or for CAHs, the professional health care staff), nursing leadership and other relevant departments. The policies and procedures must be reviewed and approved by the governing body or, for CAHs, either the governing body or responsible individual.

Timing. Hospitals and CAHs would have 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, even for patients who stay less than 24 hours. CMS expects appropriate arrangements for post-hospital care to be made before discharge. The agency notes that emergency-level transfers for patients who require a higher level of care would not need a discharge evaluation and plan, though the hospital/CAH would need to send necessary information with the patient.

Persons involved in the evaluation and development of the plan. A registered nurse, social worker or other personnel qualified in accordance with the hospital's/CAH's discharge planning policies would need to coordinate the discharge needs evaluation and development of the discharge plan. Further, 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/support person also must be involved in the development of the plan and informed of the final plan.

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, and the patient's or caregiver's/support person's capability to perform required care;
- follow-up care from a community-based provider, care from post-acute care facilities, or, in the case of a patient admitted from a long-term care or other residential facility, care in that setting;
- admitting diagnosis or reason for registration;
- relevant co-morbidities and past medical and surgical history;
- anticipated ongoing care needs post-discharge;
- readmission risk;
- relevant psychosocial history;
- communication needs, including language barriers, diminished eyesight and hearing, and self-reported literacy of the patient, patient's representative or caregiver/support person(s), as applicable;
- the patient's access to non-health care services and community-based care providers (such as home modifications, transportation, meal, or household services, and housing services); and
- the patient's goals and treatment preferences.

IMPACT Act provisions. The IMPACT Act of 2014 expanded the reporting requirements for post-acute care (PAC) providers and requires LTCHs, IRFs, skilled nursing facilities (SNFs) and HHAs to report standardized patient assessment data, and quality and resource use measures. The law aims to build a common data-reporting infrastructure for PAC providers and align quality measurement across PAC settings. It also ties data reporting to payment. For more information, please see AHA's [advisory](#) highlighting key aspects of the legislation.

Among the law's requirements, the Department of Health and Human Services (HHS) Secretary must issue regulations that alter the Medicare conditions of participation (CoPs) and related interpretive guidance for PAC providers and general-acute care hospitals and CAHs. Specifically, the CoP changes will require the affected providers "to take into account" in their discharge planning processes the quality, resource use and other measure data mandated by the IMPACT Act.

The proposed rule would require hospitals and CAHs to assist patients (and others, such as families/caregivers/support persons/representatives) in selecting a post-acute provider by using and sharing relevant data that includes (but is not limited to) the quality and resource use measures for HHAs, SNFs, IRFs and LTCHs. The rule does not propose specific quality measures, but indicates that specific measure data would be addressed in other regulations or issuances. Numerous quality measures to comply with the Impact Act have already been finalized through the fiscal year 2016 and calendar year 2016 payment rules for HHAs, SNFs, IRFs and LTCHs.

CMS expects that the hospital or CAH would be available to discuss and answer questions about a patient's post-discharge options and needs. The agency emphasizes that hospitals and CAHs must consider the IMPACT Act quality measure data in light of the patient's goals and treatment preferences, such as the patient's preferred geographic area or the patient's desire to receive continuing care after discharge at home. CMS also stresses that hospitals and CAHs should not make decisions about post-acute care services on behalf of patients and families.

Discharge to Home. CMS defines the phrase "patients discharged to home" to include at least "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 (PCP) or a specialist; HHAs; hospice services; or any other type of outpatient health care service." The phrase would not include patients transferred to another inpatient acute care hospital, inpatient hospice facility or SNF.

CMS proposes that discharge instructions be provided to patients and/or caregiver/support persons as well as any post-acute care provider, if the patient is referred to post-acute services (or for CAHs, if the patient is referred to community-based services). CMS expects that the instructions would be designed to be easily understood by patients and caregivers and recommends the use of the "teach back" method during discharge planning.

The agency outlines specific elements to be included in discharge instructions, such as:

- instruction on post-discharge care to be used by the patient or the caregiver/support person(s) in the patient's home, as identified in the discharge plan;
- written information on warning signs and symptoms that may indicate the need to seek immediate medical attention. This must include written instructions on what the patient or the caregiver/support person(s) should do and who they should contact if these warning signs or symptoms present;
- prescriptions (and for hospitals, over-the counter medications) that are required after discharge, including the name, indication, and dosage of each drug, along with any significant risks and side effects of each drug as appropriate to the patient;
- reconciliation of all discharge medications with the patient's pre-hospital/CAH admission medications (both prescribed and over-the-counter), *which includes considering how patients will obtain their post-discharge medications*; and
- written instructions regarding the patient's follow-up care, appointments, pending and/or planned diagnostic tests, and pertinent contact information, including telephone numbers, for any practitioners involved in follow-up care or for any providers/suppliers to whom the patient has been referred for follow-up care.

If a follow-up care practitioner is known and identified, the hospital/CAH must send: (1) a copy of the discharge instructions and summary within 48 hours of discharge; (2) pending test results within 24 hours of their availability; and (3) all other necessary information as specified in the section on transfers, below.

Further, hospitals and CAHs would need to establish a post-discharge follow-up process for patients discharged to home, although 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. CMS states in its regulatory impact analysis that, due to the wide variation in patient situations, there may be no likely benefit from follow-up for some patients. CMS does emphasize the importance of ensuring that hospitals follow up "with their most vulnerable patients, including those with behavioral health conditions" and encourages providers to use follow-up procedures they find cost-effective for particular categories of patients.

Transfers. When transferring patients, hospitals and CAHs would be required to provide specific medical information to the receiving facility. This information is intended to be aligned with the common clinical data set specified in the 2015 Edition health information technology certification criteria final rule published last month. CMS does not propose a specific form, format or methodology for this communication.

The information must include:

1. Demographic information, including but not limited to name, sex, date of birth, race, ethnicity and preferred language;
2. Contact information for the practitioner responsible for the care of the patient, and the patient's caregiver(s)/support person(s), if applicable;
3. Advance directive, if applicable;
4. Course of illness/treatment;
5. Procedures;
6. Diagnoses;
7. Laboratory tests and the results of pertinent laboratory and other diagnostic testing;
8. Consultation results;
9. Functional status assessment;
10. Psychosocial assessment, including cognitive status;
11. Social supports;
12. Behavioral health issues;
13. Reconciliation of all discharge medications with the patient's prehospital admission/registration medications (both prescribed and over the counter);
14. All known allergies, including medication allergies;
15. Immunizations;
16. Smoking status;
17. Vital signs;
18. Unique device identifier(s) for a patient's implantable device(s), if any;
19. All special instructions or precautions for ongoing care, as appropriate;
20. Patient's goals and treatment preferences; and
21. 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.

Hospital requirements for PAC services. For hospitals only, CMS would retain, but slightly revise, language related to post-discharge services. For patients discharged home and referred for HHA services, or for those transferred to a SNF, IRF or LTCH, the following requirements would apply:

- The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs 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, IRF, or LTCH, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.
- This list must be presented only to patients for whom home health care post-hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate. The hospital must document in the patient's

medical record that the list was presented to the patient or to the patient's representative.

- For patients enrolled in managed care organizations, the hospital would need to remind patients to verify which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.
- The hospital must inform the patient/patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services, and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.
- 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 HHS Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

Review of discharge planning process. The rule states that hospitals and CAHs would need to regularly assess their discharge planning processes. This includes ongoing periodic review of a sample of discharge plans, including patients readmitted within 30 days of a previous admission. For CAHs, this assessment would need to take place at least annually.

Prescription drug monitoring programs (PDMPs). CMS specifically asks for comments on: (1) whether providers, in evaluating patient discharge needs, should be required to consult with their state's PDMP to review a patient's risk of non-medical use of controlled substances and substance use disorders; and (2) whether PDMPs should be used in the medication reconciliation process.

Home Health Agencies

For HHAs, the proposed rule would withdraw and replace the discharge planning proposals included in a previous proposed rule issued in October 2014. In the November 2015 rule, CMS proposes that HHAs develop and implement effective discharge planning processes that prepare patients to be active partners in post-discharge care; promote effective transitions to post-HHA care; and reduce the factors that lead to preventable readmissions. CMS's new discharge planning proposals would require HHAs to: develop a discharge plan for each patient that addresses his or her goals, needs, and treatment preferences; involve patients and caregivers in the development of the plan; and update the plans as needed.

Among the proposed provisions, CMS would require the following:

Development of the plan. The physician responsible for the home health plan of care would need to be involved in the ongoing process of establishing the discharge plan. The patient and caregiver(s) must be involved in the development of the discharge plan and informed of the final plan. The HHA must consider caregiver/support person availability, and the patient's or caregiver's capability to perform required care, as part of the identification of discharge needs.

IMPACT Act provisions. For patients transferred to another HHA or discharged to a SNF, IRF, or LTCH, HHAs would be required to follow the same procedures outlined above for hospitals and CAHs, as it relates to IMPACT Act implementation.

Completion of the discharge plan. The evaluation of the patient's discharge needs and the discharge plan must be documented, completed on a timely basis and included in the clinical record. The results of the evaluation must be discussed with the patient or patient's representative.

Discharge or transfer summary content. The HHA must send necessary medical information to a receiving facility or health care practitioner. Necessary medical information must include criteria nearly identical to #1-18 for hospitals and CAHs outlined above, as well as:

- Recommendations, instructions or precautions for ongoing care, as appropriate;
- Patient's goals of care and treatment preferences;
- The patient's current plan of care, including goals, instructions and the latest physician orders; and
- Any other information necessary to ensure a safe and effective transition of care that supports the post-discharge goals for the patient.

CMS notes that some of the proposed medical information components in this provision may not apply to patients. Therefore, HHAs would need to use "N/A" or another appropriate notation for non-applicable elements.

NEXT STEPS

The AHA will submit comments to CMS and encourages members to submit their own letters to CMS. Comments are due by Jan. 4, 2016 at 5 p.m. ET and may be submitted electronically at <http://www.regulations.gov>. **Please refer to file code CMS-3317-P.**

To develop our comment letter, we seek member feedback on CMS's proposals. We are concerned about the resources that may be required to implement all of the changes for all providers, and we ask for your input on the following questions:

1. How closely do the agency's proposals for discharge planning resemble what you are already doing? What are the main differences?

2. Would the proposed requirements create additional administrative burden or necessitate an increase in your organization's workforce?
3. What timeframe would you need to implement CMS's proposals, if they are finalized?
4. Do you think providers should consult PDMPs in the discharge planning process? Why or why not?

To reply or if you have further questions, contact Evelyn Knolle, senior associate director of policy, at (202) 626-2963 or eknolle@aha.org.