KUTAKROCK

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CMS FINAL RULE ON DISCHARGE PLANNING REQUIREMENTS

Introduction

On September 26, 2019, the Centers for Medicare and Medicare Services ("*CMS*") released the final rule on discharge planning requirements (the "*Final Rule*") in an effort to empower patients to be active participants in the discharge planning process. The Final Rule complements efforts around interoperability that focus on the seamless exchange of patient information between health care settings.

The Final Rule revises the discharge planning requirements that hospitals, critical access hospitals ("*CAHs*"), and home health agencies ("*HHAs*") must meet in order to participate in the Medicare and Medicaid programs. The Final Rule also implements discharge planning requirements which will give patients and their families access to information that will help them make informed decisions about their post-acute care, while addressing the patients' goals of care and treatment preferences.[1] Finally, the Final Rule updates one provision regarding patient rights in hospitals, which is intended to promote innovation and flexibility in the improvement of patient care and ensures a patient's right to access his or her own medical information from a hospital.[2]

In the Final Rule, the term "hospital" includes acute care hospitals (including related rehabilitation or psychiatric units), long-term care hospitals ("*LTCHs*"), rehabilitation hospitals, psychiatric hospitals, children's hospitals and cancer hospitals. Although the discharge planning requirements apply to psychiatric hospitals, psychiatric hospitals will still be required to meet additional special provisions, special medical record requirements, and special staff requirements that are not discussed in the Final Rule.[3]

CMS is requiring implementation of the requirements outlined in the Final Rule for hospitals, HHAs, and CAHs sixty (60) days after the date of publication of the Final Rule. The Final Rule was published on September 30, 2019 and is available here.[4] Accordingly, the Final Rule will be effective on November 29, 2019.

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[1] Specifically, these informational requirements are being finalized in order to implement the Improving Medicare Post-Acute Care Transformation Act of 2014, Pub. L. 113-185 ("*IMPACT Act*"). The IMPACT Act requires post-acute care providers to report standardized patient assessment data, data on quality measures and data on resource use and other measures and requires the assessment data to be standardized and interoperable to allow for the exchange of data among post-acute care providers and other Medicare participating providers and suppliers.

[2] In the Proposed Rule, CMS encouraged providers to consider using their state's Prescription Drug Monitoring Program ("*PDMP*") during the evaluation of a patient's relevant co-morbidities and past medical and surgical history. CMS solicited comments on whether providers should be required to consult with their state's PDMP and review a patient's risk of non-medical use of controlled substances and substance use disorders as indicated in the PDMP report. In addition, CMS solicited comments on the use of PDMPs in the medication reconciliation process.

After consideration, CMS decided it would be difficult to implement a mandatory requirement for providers to access their state's PDMP during the discharge planning process; therefore, CMS will not require hospitals to consult with their state's PDMP and review a patient's risk on non-medical use of controlled substances and substance use disorders as indicated by the PDMP report, nor will CMS require providers to use or access PDMPs during the medication reconciliation process. However, CMS strongly encourages state PDMP use and notes that some states require practitioners to consult their state's PDMP system.

[3] See 42 CFR §§ 482.60, 482.61, 482.62.

[4] See *Medicare and Medicaid Programs; 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*, 84 Fed. Reg. 51836 (Sept. 30, 2019).

Patients' Rights and Discharge Planning in Hospitals

Patients' Rights to Medical Records

The Final Rule finalizes a proposed rule, with minor modifications, providing patients with the right to access their medical records, including current medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, and within a reasonable time frame.[5]

Hospitals may not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet such requests as quickly as its record keeping system permits.[6]

Conditions of Participation (CoP) –Discharge Planning[7]

Hospitals

CMS is finalizing certain standards for discharge planning for hospitals that outline the discharge planning process, the provision and transmission of the patient's necessary medical information upon discharge, and requirements related to post-acute care ("*PAC*") services.

Specifically, a hospital must identify at an early stage the patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning evaluation. CMS is not including a rigid time frame for the evaluation so as to allow flexibility to accommodate the facts and circumstances of a particular patient's care. The discharge planning evaluation must include an evaluation of the 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. CMS urges hospitals to develop collaborative partnerships with community-based care organizations in their respective areas to improve transitions of care that might support better patient outcomes; however, such a collaboration is not mandated as such a requirement could be overly burdensome for hospitals.

Hospitals must also include a determination of the availability of the appropriate services as well as of the patient's access to those services. The discharge planning evaluation or plan must be developed by, or under the supervision of a registered nurse, social worker, or other appropriately qualified personnel. CMS clarified that providers may use appropriate practitioners (including non-physician practitioners) that they believe will effectively conduct a patient's discharge planning process. For that reason, the discharge planning CoPs do not include requirements specific to individual practitioner categories. The hospital must identify in its discharge planning policy the qualified personnel who will be involved in the discharge planning process and must execute their discharge planning process in accordance with their policies.

The discharge planning process must require regular re-evaluations of the patient's condition to identify changes that may require modification of the discharge plan and all evaluations and plans must be included in the patient's medical record. CMS noted that hospitals and CAHs should also document in the patient's medical record the patient's refusal to participate in the discharge planning process and that such attempts to incorporate the patient and/or patient's caregiver in the discharge planning process were made.

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[5] See *Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care; Proposed Rule*, 81 Fed. Reg. 39448, 39475 (June 16, 2016).

[6] 42 CFR 482.13(d)(2).

[7] 42 CFR § 482.43.

In addition, the hospital must assess its discharge planning process regularly, which includes ongoing periodic review of a representative sample of discharge plans, including patients who were readmitted within thirty (30) days of a previous admission, to ensure that the plans are responsive to patients' post-discharge needs.[8] While no specific timeframe was set, CMS recommends a periodic review take place every two (2) years at a minimum. A hospital must assist patients, their families, or the patient's representative in selecting a PAC provider by using and sharing data that includes, HHA, SNF, inpatient rehabilitation facility ("*IRF*"), or LTCH data on quality measures and data on resource use measures. This data must be relevant and applicable to the patient's goals of care and treatment preferences.

Furthermore, a hospital must discharge the patient, or transfer the patient, if applicable, 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 PAC providers responsible for the patient's follow-up or ancillary care.[9] While CMS is not finalizing a specific list of information to be communicated to the transferring facility, CMS expects certain necessary medical information that is critical to the care of the patient and pertinent to the patient's specific medical status at the time of discharge to be communicated to the receiving facility so as to ensure a safe and effective transition. CMS also did not require hospitals to transmit necessary medical information in a specific manner; however, CMS emphasizes the importance for PAC providers to receive information from hospitals regarding a patient's vital information and encourages the information to be sent prior to discharge. In addition, CMS encourage hospitals to send the information electronically if the PAC provider has the capacity to receive it in that manner.

For patients discharged home and referred for HHA services or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, CMS has set down several additional requirements:

- First, 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 service the geographic area in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. This list is only presented to patients for whom home health care post-hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate. For patients enrolled in managed care, hospitals must ensure such patients are aware of the need to verify which practitioners are in the managed care organization's network.

- Second, the hospital must also inform the patient, or the patient's representative, of their freedom to choose among Medicare providers and suppliers of post-discharge services and must respect the patient's goals of care and treatment preferences, when possible. The hospital may not specify or otherwise limit the qualified providers or suppliers that are available to the patient, though CMS does encourage hospitals to provide any information regarding the PAC providers that provide services that meet the needs of the patient.

- Third, the discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. CMS explained that if a hospital referred patients about to be discharged and in need of post-hospital services only to entities it owned or controlled, the hospital should disclose this information so the patient has all the information needed to choose an appropriate facility.[10]

[8] 42 CFR § 482.43(a)(7).

[9] 42 CFR § 482.43(b).

[10] 42 CFR § 482.43(c).

> The discharge planning rules specify that financial interests that are disclosable are determined in accordance with 42 C.F.R., Part 420, Subpart C.[11] This requires that the hospital disclose any SNF or HHA in which it has a 5% or greater ownership or control interest.[12] CMS appears to intend a hospital to also have to disclose any situation involving a subcontractor to a SNF or HHA in which the hospital as a 5% or greater ownership or control interest in the subcontractor.

CMS provided a significant amount of commentary regarding the requirements that the hospital[13] provide a list of PAC providers and inform the patient, or the patient's representative, of the freedom to choose among these providers. Specifically, commenters requested clarification regarding how providers could choose a PAC provider without improperly steering the patient to certain providers and questioned whether patient choice would be influenced by the patients receiving services or care from a Medicare fee-for-service provider who may be participating in an alternative payment model, such as bundled payment programs shared savings process or full clinical and financial risk payment programs. CMS responded:

> We understand the commenter's concerns regarding patient steering. However, we believe compliance with the revised CoP and the fraud and abuse laws, including the physician self-referral law and Federal anti-kickback statute, is achievable. We believe that hospitals, HHAs and CAHs will be in compliance with this requirement if they present objective data on quality and resource use measures specifically applicable to the patient's goals of care and treatment preferences, taking care to include data on all available PAC providers, and allowing patients and/or their caregivers the freedom to select a PAC provider of their choice. Providers will have to document all such interactions in the medical record. In addition, we expect hospitals to comply with requirements in 482.43(c) and inform the patient and/or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services, while not specifying or otherwise limiting the qualified providers or suppliers that are available to the patient.[14]

In response to different comments regarding a similar issue, CMS provides the following additional thoughts:

> While hospitals may have working relationships with some PAC providers, hospitals are expected to present patients with a list of providers that meet the proposed requirements of 482.43(f)(1). We expect discharge planning to facilitate patient choice in any post hospital extended care services, even though the statute does not require a specific list beyond HHAs, SNFs, IRFs, and LTCHs. The proposed requirement at 482.43(f)(2) is also important because it requires the hospital, as part of the discharge planning process, to inform the patient or the patient's representative of their freedom to choose among participating Medicare providers

[11] The provisions are Part 420, Subpart C requires Medicare providers and suppliers to disclose a number of items, including hiring of intermediary's former employees, principals convicted of a program-related crime, business transaction information and persons having an ownership, financial or control interest. We assume that CMS intends for the HHA/SNF financial interest disclosure requirements to comply with this last set of disclosure requirements.

[12] The term "*ownership or control interest*" means the hospital meets one of the following criteria: (i) it has an ownership interest totaling 5% or more in the SNF/HHA, (ii) it has an indirect ownership interest equal to 5% or more in the SNF/HHA, (iii) it has a combination of direct and indirect ownership interests equal to 5% or more in a SNF/HHA, (iv) it owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the SNF/HHA if that interest equals at least 5% of the value of the property or assets of the SNF/HHA, (v) it is an officer or director of a SNF/HHA that is organized as a corporation; or (vi) it is a partner in a SNF/HHA that is organized as a partnership. The term "*ownership interest*" means the possession of equity in the capital, the stock, or the profits of the SNF/HHA. The term "*indirect ownership interest*" means any ownership interest in an entity that has an ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

[13] The term "*subcontractor*" means either:

- An individual, agency, or organization to which a SNF/HHA has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which an intermediary or carrier has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicare agreement.

[14] *See* 84 Fed. Reg. at 51845.

> and suppliers of post discharge service sand 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. We do encourage hospitals to provide any information regarding PAC providers that provide services that meet the needs of the patient.[15]

HHAs

Home health services are covered under Medicare for qualifying beneficiaries who are covered for Medicare Part A and/or Part B. These services include skilled nursing care; physical, occupational, and/or speech therapy; medical social work; and home health aides. Such services must be furnished by or under an arrangement with an HHA that participates in the Medicare program and must be in the beneficiary's home.

Under the Final Rule, HHAs are also required to develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF, or LTCH, the HHA must assist patients and their caregivers in selecting a PAC provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. Such data must be relevant and applicable to the patient's goals of care and treatment preferences.[16]

CMS initially proposed several other requirements for HHAs to implement in the discharge planning process; however, many of these areas were subsequently addressed in the 2017 Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies final rule.[17] As such, the proposed requirements involving HHA and physician communication regarding discharge are no longer necessary.

However, CMS is still making changes to HHAs discharge or transfer summary content. CMS is not finalizing a list of requirements related to the content of discharge summary, but CMS is finalizing the requirements that an HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure safe and effective transition of care.[18] CMS has left the requirement broad and flexible so as to allow the HHA to tailor the exchange of information to the exact circumstances and needs of the care transition in order to support the patients' post-discharge goals.

Finally, HHAs must comply with requests for additional clinical information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner. This should ensure that receiving facilities and practitioners have access to information as needed, while not overburdening HHAs to preemptively provide such a potentially large volume of information that may not be helpful to receiving practitioners and facilities.

CAHs[19]

Given the IMPACT Act mandate, CMS is also requiring certain CAH discharge planning requirements. CMS requires a CAH to have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregiver as active partners in the discharge planning for post-discharge care. That discharge planning process and discharge plan must be consistent with the patient's

[15] *See* 84 Fed. Reg. at 51861.

[16] 42 CFR § 484.58(a).

[17] See *Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies,* 82 Fed. Reg. 4504 (Jan. 13, 2017).

[18] 42 CFR §484.58(b).

[19] 42 CFR § 485.642.

goals for care and his or her treatment preferences, ensure an effective transition of the patient from the CAH to post-discharge care, and reduce factors leading to preventable CAH and hospital readmissions.

The CAH discharge planning requirements are intentionally similar to those of the hospital discharge planning requirements; however, there are some necessary differences as a result of some of the challenges unique to CAHs, including their rural location, small size, and limited resources.

While CAHs are not required to include in their discharge plan a list of HHAs, SNFs, URFs, or LTCHs, they are required to, like hospitals, assist patients, their families, or their caregivers in selecting a PAC provider. CAHs must do so by using and sharing data that includes but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and resource use measures. CMS clarifies that, although CAHs are not required to include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs, there is nothing prohibiting them from doing so.

CMS is requiring CAH's discharge planning process to identify at an early stage of hospitalization those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning, and to provide a discharge planning evaluation for those patients so identified, as well as for other patients upon the request of the patient, patient's representative, or patient's physician.[20] A discharge evaluation must be made on a timely basis to ensure that appropriate arrangements for post-CAH care will be made before discharge and to avoid unnecessary delays in discharge.

A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-CAH services, including, but not limited to, hospice care services, post-CAH extended care services, home health services, and non-health care services and community-based care providers. The evaluation must also determine the availability of those services as well as the patient's access to those services.

As is required for hospitals, the discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results must be discussed with the patient. Upon the request of the patient's physician, the CAH must arrange for the development and initial implementation of a discharge plan for the patient, and any discharge planning evaluation or discharge plan must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.

Furthermore, the CAH discharge planning process must require regular re-evaluation of the patient's condition to identify changes that would require modification of the discharge plan, and the CAH must assist patients and their families in selecting a PAC provider by using and sharing the data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data resource use measures. The CAH must ensure that the PAC data on quality measures and data on resource use measures is relevant and applicable to the patients' goals of care and treatment preferences.

As with hospitals, CAHs are also required to assess their discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within thirty (30) days of a previous admission, to ensure that that plans are responsive to patient post-discharge needs.

CMS has also implemented requirements regarding patient transfers from CAHs. When a patient is transferred to another facility (another CAH, hospital, or a PAC provider), the CAH must discharge the patient and also transfer or refer the patient, where applicable, along with all necessary medical information pertaining to the patient's current course of illness, treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient services providers and practitioners responsible for the patient's follow-up or ancillary care. As with hospitals, there is not a specific list of medical information finalized that CAHs are required to send to

[20] 42 CFR §485.642(a).

the receiving facility, but CMS again emphasizes the importance in including all necessary medical information relevant to the patient's care and treatment.[21]

Application to "PAC Provider Networks"

While there are many nuances and applications to the finalized discharge planning requirements, the discharge planning requirements provide insight to hospital providers that are engaged in alternative payment model programs or other efforts to manage the post-discharge care of their patients (e.g., through creating a PAC provider network that adopt certain treatment protocols to reduce hospital readmission rates or otherwise improve quality, decrease costs or improve patient experience and/or health).

CMS makes clear that providers may not limit patients to only those providers within the "PAC provider network." Rather, the hospital must include a list of all of the PAC providers that are available to the patient, that are participating in the Medicare program and that service the area in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. Additionally, the hospital must inform the patient that the patient has the freedom to choose any provider on the list.

That said, the hospital can provide information to the patient or the patient's representative relating to quality and resource use measures specifically applicable to the patient's goals of care and treatment preferences, taking care to include data on all available PAC providers, and can also provide information regarding PAC providers that provide services that meet the needs of the patient.

Hospitals will also need to be identify any SNFs and HHAs in which the hospital has a financial interest, as described above, and ensure it implements processes to ensure that it meets the financial interest disclosure requirements relative to such SNFs and HHAs and any other PAC provider to which it wants to voluntarily extend the disclosure policy.

Given this commentary, a hospital that has relationships with PAC providers for purposes of alternative payment models or creating a "PAC provider network" will need to carefully consider processes in complying with the discharge planning requirements with respect to the provision of lists of PAC providers, ensuring patient freedom of choice and disclosing financial interests in PAC providers, where applicable. This will include processes and content used to describe any PAC providers with which the hospital has entered into relationships for purposes of alternative payment models and/or other efforts to manage the post-discharge care of their patients for purposes designed to improve quality, control costs and improve patient satisfaction.

Additional Information

For further information or questions about the Final Rule, please contact any member of Kutak Rock's National Healthcare Practice Group. For more information regarding our practices, please visit us at www.KutakRock.com.

[21] 42 CFR § 485.642(b).