

HFMA
Discharge Planning Final Rule
Executive Summary

On September 26, 2019, the Centers for Medicare & Medicaid Services published its long-awaited discharge planning [rule](#). The rule applies to a wide variety of providers and, though not as extensive in scope and requirements as the proposed rule, makes multiple changes to the Medicare conditions of participation related to discharge planning. Below are key takeaways from the rule. A detailed summary will be posted [here](#) shortly in the compliance section.

- 1) **Effective Date**: The new regulations are effective on November 29, 2019.
- 2) **Impacted Providers**: The rule applies to hospitals (including short-term acute-care hospitals, long-term care hospitals [LTCHs], rehabilitation hospitals, psychiatric hospitals, children’s hospitals, and cancer hospitals), critical access hospitals (CAHs), and home health agencies (HHAs). The must meet the new requirements in order to participate in the Medicare and Medicaid programs.
- 3) **Data to Inform Choice of Post-Acute Care Provider (PAC)**: The final rule requires providers to use quality and resource use data¹ to assist patients in choosing a PAC provider that aligns with the patient’s goals of care and treatment preferences. CMS expects providers to document all efforts regarding this requirement in the patient’s medical record.

However, CMS does not expect providers to give overly detailed and complex analyses of the quality and resource use data, which may only serve to confuse patients and/or their caregivers; nor does CMS expect providers to attempt to provide patients and their caregivers with data that do not exist regarding PAC facilities. The final rule states CMS expects providers to put forth their best effort to answer patient questions regarding the data.

The final rule further states that hospitals will not be in violation of fraud and abuse laws 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. Hospitals are expected to 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.

¹ Although the rule does not mandate the use of specific sources, it notes that the various “Compare” websites provide data on quality and utilization. It also states that additional sources of quality data will be available in the near future, as mandated by the IMPACT Act, and expects that providers will use sources that are “currently” available to them.

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- 4) *Patient Access to Medical Records*: The final rule states that patients have the right to access their medical records in the form and format they request, if it is readily producible in such form and format. The medical record must include any discharge planning documents, so it is not necessary for this requirement to specify any specific part of the medical. If the records are not readily producible in the form or format requested by the patient, the hospital must provide the records in a readable hard copy form or such other form and format as agreed to by the facility and the individual.

- 5) *Discharge Planning Process*: The final rule requires that hospitals must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions. The specific elements finalized are significantly reduced from the proposed rule and included in Exhibit 1.

- 6) *Transfer to Another Facility*: The final rule requires that when a patient is transferred or referred to another facility, all necessary medical information that pertains to the patient's current course of illness and treatment, post-discharge goals of care and treatment preferences should be provided to the appropriate providers and practitioners responsible for the patient's follow-up or ancillary care. CMS will issue sub-regulatory guidance describing the circumstances of when a discharge or transfer summary would be expected at the time of discharge versus when it would not be appropriate to delay an emergency transfer pending the availability of a discharge summary. CMS opted not to finalize its far more prescriptive proposal, which specified the data elements that were to be included in transfer documentation.

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Exhibit 1: Finalized Discharge Planning Elements

- Any discharge planning evaluation or discharge plan required by regulation must be developed by, or under the supervision of, a registered nurse, social worker or other appropriately qualified personnel.
- The hospital must identify, at an early stage of hospitalization, all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. The hospital must provide a discharge planning evaluation for those patients so identified, as well as for other patients upon the request of the patient, the patient's representative or patient's physician.
- The discharge plan should be updated to reflect any changes in the patient's condition that would necessitate changes in the discharge plan.
- 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, and home health services, and non-healthcare services and community-based care providers, and must also determine the availability of the appropriate services as well as of the patient's access to those services.
- The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).
- Hospitals must have an effective discharge planning process that focuses on the patient's goals and preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.
- The hospital must assist patients and their families in selecting a post-acute care provider by using and sharing data on quality and resource use measures, as may be relevant and applicable to the patient's goals of care and treatment preferences.
- 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 and to avoid unnecessary delays in discharge.

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- Hospitals must assess their discharge planning processes on a regular basis, including ongoing review of a representative sample of discharge plans, including patients who were readmitted within 30 days of a previous admission, to ensure that they are responsive to patient discharge needs.