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CMS Issues Final Rule for Hospitals & Home Health Agencies for Patient Discharge Planning

Insight — 10/28/2019

On September 26, 2019, the Centers for Medicare and Medicaid Services and Department of Health and Human Services published commentary and its final rule affecting how hospitals, including critical access hospitals ("CAHs"), and home health agencies ("HHAs") must plan and document the discharge of patients in order to avoid re-admissions.[1] CMS published this new rule with commentary in the Federal Register on September 30, 2019.[2]

In order to "empower patients to make informed decisions about their care as they are discharged"[3] from hospitals or transferred from HHAs to the post-acute care ("PAC") setting, CMS adopted this final rule under the Improving Medicare Post-Acute Care Transformation Act ("IMPACT Act") of 2014. CMS's final rule is predicated on hospitals, CAHs and HHAs using the quality and resource use information CMS gathers from HHAs, skilled nursing facilities ("SNFs"), inpatient rehabilitation facilities ("IRFs"), and long-term care hospitals ("LTCHs") under the IMPACT Act. Hospitals, CAHs, and HHAs must now provide this information to patients and their caregivers so that they may consider it when selecting the PAC provider or services they will utilize to continue their treatment.

The final rule focuses on the act of planning for a patient's transition to the PAC setting, establishing certain patient rights related to medical record access,[4] and requiring hospitals, CAHs, and HHAs to provide a plan for patients' future care and goals. Hospitals, CAHs, and HHAs must provide this plan to both the patient and PAC that will provide further care to the discharged patient. CMS has codified these changes within its conditions of participation ("CoPs") for Medicare, which are enforced by state surveying agencies and other accrediting organizations.[5]

The obligations created by this final rule will primarily affect hospitals and CAHs. Under the CoPs changed by the final rule, hospitals and CAHs must engage in an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers as active participants in the process.[6] As part of the planning process, the hospital or CAH must consider all of the PAC settings that may be appropriate for the patient's continued care, including SNFs, IRFs, LTCHs, HHAs, and non-health care services and community based providers.[7] Upon the patient's discharge, the hospital or CAH must provide the PAC service or provider that will be responsible for the

patient's continued care with all medical information relating to the patient's care, including the patient's discharge plan.[8]

Specific to hospitals, the final rule modifies several requirements pertaining to the list of PAC providers that must accompany the discharge plan of patients that are referred for HHA services, or discharged to SNF, IRF, or LTCH facilities. Now, hospitals must include IRFs and LTCHs on these lists in addition to HHAs and SNFs. Additionally, for patients enrolled in managed care programs, hospitals must educate the patient about the need to verify whether a PAC provider or supplier is a network participant.[9]

HHAs are also required to provide discharge plans to patients and their caregivers, including the quality and resource use measures for SNFs, IRFs, LTCHs, and other HHAs to which the patient may be discharged.[10] Like hospitals and CAHs, HHAs must provide all necessary information to the PAC where the patient's treatment will continue.[11] Within a newly created CoP for HHAs, though, CMS requires that the HHA provide additional information to the PAC or health care provider rendering ongoing care to the patient.[12]

CMS's final rule and revisions to conditions of participation take effect on November 29, 2019,[13] allowing limited time for hospitals, CAHs, and HHAs to comply. CMS anticipates its final rule to impose a one-time cost of compliance of $17.7 million onto hospitals, with $1.9 million specifically for CAHs, and $10.8 million for HHAs.[14] Holland & Hart LLP presented a webinar on this new discharge planning rule on October 22, 2019. You can view a recording here.

For questions regarding this update, please contact:
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[1]CMS-3317-F and CMS-3295-F.
[2]84 Fed. Reg. 51836 (Sept. 30, 2019).

[3]*CMS' Discharge Planning Rule Supports Interoperability and Patient Preferences*, https://www.cms.gov/newsroom/fact-sheets/cms-discharge-planning-rule-supports-interoperability-and-patient-preferences (Sept. 29, 2019).
[4]42 C.F.R. § 482.13(d)(2).
[5]*See, e.g., id.* at § 482.11(b)(2).
[6]42 C.F.R. §§ 482.43, 485.642.
[7]*Id.*
[8]*Id.*
[9]*Id.* at § 482.43(c)(1)(ii).
[10]*Id.* at § 484.58.
[11]*Id.* at § 484.58(a).
[12]*Id.* at § 484.58(b).
[13]84 Fed. Reg. at 51836.
[14]*Id.* at 51879.

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