PUBLICATION

CMS Proposes Significant Revisions to Hospital Discharge Planning Process: How Patient Choice May be Impacted [Ober|Kaler]

November 12, 2015

On November 3, 2015, CMS released a proposed rule [PDF] revising existing discharge planning requirements for hospitals, critical access hospitals (CAHs) and home health agencies (HHA). CMS stated impetus for doing so is to both "modernize" the discharge planning process and to meet the discharge planning requirements set forth in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act).

1. Emphasis on Establishing Formal Discharge Planning Procedures, while Engaging Patients

The proposed rule places a heavy emphasis not only on establishing a more formal, standardized discharge planning process for hospitals, CAHs, and HHAs alike, but also on empowering patients and their caregivers in the discharge planning process. For example, to the extent patients are discharged to the home from a hospital or CAH, CMS now proposes to require specific elements to be included in the discharge instructions, such as instructions on post-hospital care to be used by the patient or the caregiver/support person in the patient's home, prescriptions and over the counter medications that are required after discharge (including a reconciliation of such medications), warning signs and symptoms that may indicate a need to seek immediate medical attention, and written instructions regarding the patient's follow-up care. Similarly, in the event a patient is transferred from a hospital or CAH to another health care facility, CMS is now seeking to require that the hospital or CAH send specific medical information to the receiving facility.

Furthermore, hospitals and CAHs would be required to consider the discharge planning process and patient goals early on – within 24 hours of admission or registration (with exceptions for emergency level transfers). The discharge planning process would apply not only to all inpatients, but to certain outpatient categories, e.g., patients receiving observation services, patients who are undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used, and certain emergency department patients.

With respect to HHAs, CMS is proposing to institute similar policies to those for hospitals and CAHs. While HHAs are currently required to prepare a discharge summary, CMS is now proposing to require HHAs to develop and implement an "effective discharge planning process" with patients as active partners. CMS is also proposing to mandate that HHAs send all necessary medical information to a patient's receiving facility or health care practitioner when a patient is transferred or discharged.

2. Implications for Hospitals & Patient Choice

As outlined above, CMS is proposing significant changes to the discharge planning process, a proposal that if implemented would undoubtedly impose on hospitals, CAHs, and HHAs additional responsibility, time, and documentation requirements. However, and of import, the proposed rule may also ultimately allow health care providers, particularly hospitals, to be more transparent with patients in post-acute care discharge planning discussions.

Specifically, and in furtherance of the IMPACT Act requirements, CMS is proposing a new requirement for hospitals – that they "assist patients, their families, or their caregivers/support persons in *selecting a PAC [post-acute care] 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." Pending finalization of the IMPACT Act's definition of "quality measures," CMS advises providers to "use other sources for information on PAC quality and resources use data, such as the data provided through the Nursing Home Compare and Home Health Compare websites." CMS' proposal, if finalized, may signal CMS' increasing recognition of the importance of (a) the use of objective quality data in the post-acute care discharge planning process and (b) educating and empowering patients to make smart, informed decisions with respect to their post-acute care needs.