PUBLICATION

CMS Revises Discharge Planning Rules, Emphasizing Access to Quality Data, Patient Engagement

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In a long anticipated regulation, the Centers for Medicare & Medicaid Services (CMS) recently updated the hospital, critical access hospital (CAH) and home health agency (HHA) conditions of participation related to the discharge planning process. The final rule on discharge planning was published on September 30, 2019.

Discharging patients and transitioning them from acute care to post-acute care (PAC) is a complex process that is fraught with challenges. There are more than 35 million hospital discharges annually in the United States. Addressing weaknesses in the discharge process has been on the Medicare regulatory agenda for some time. Both Congress, in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, and the Medicare Payment Advisory Commission (MedPAC) have expressed concern about the quality of the post-acute facilities where patients go after a hospital stay. On one hand, patients sometimes remain in the hospital when medical necessity for acute care has ended due to the lack of a suitable alternative setting to provide necessary care. On the other hand, premature discharges, or discharges to settings not capable of meeting patients' needs, are thought to result in hospital readmissions and more intense health care utilization, including emergency department or nursing facility visits.

This new discharge rule seeks to address specific areas of concern noted in the IMPACT Act to overcome barriers to care coordination and, by providing access to more comparative information on providers, empower patients to be more active participants in the discharge planning process.

The final rule requires hospitals to have an effective discharge planning process that focuses on patients' goals and treatment preferences. Facilities must assist patients, their families, or the patients' representatives in selecting a PAC provider by sharing key performance data such as PAC facility quality scores for those downstream providers. The IMPACT Act mandated the collection and reporting of standardized quality data. The current assessment instruments – the Minimum Data Set (MDS) for Skilled Nursing Facilities (SNF), the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), the long term care hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set for LTCHs, and the Outcome and Assessment Information Set (OASIS) for Home Health Agencies (HHA) – allow for the collection of a core set of standardized assessments.

CMS expects providers to factor in these quality measures when assisting patients and families in discharge planning and to document all efforts in the patients' records. Specifically, CMS will require hospitals to provide patients and family caregivers with information about quality measures that may be pertinent to patient decision-making including measures related to the number of pressure ulcers in a given facility, the proportion of falls that lead to injury, and the number of readmissions back to the hospital.

Additionally, the rule calls on providers to reiterate patient data access rights under the HIPAA Privacy Rule. Hospitals are mandated to ensure each patient's right to access his or her medical records in an electronic format. The rule also mandates that information collected by PACs be interoperable, so that hospitals and PAC providers can seamlessly exchange patient data to improve care coordination.

The final rule applies to discharges from:

- hospitals (including long term care hospitals, CAHs, psychiatric hospitals, children's hospitals, and cancer hospitals);
- inpatient rehabilitation facilities;
- HHAs; and
- any PAC setting transitioning a patient to a different PAC setting.

The rule specifically pertains to discharges to patients' own homes or into PACs, including SNFs, nursing facilities, LTCHs, rehabilitation hospitals or units, assisted living centers, substance abuse treatment programs, hospices, or other PAC settings.

The changes are expected to have an effect on how discharge planning departments operate. The Hospital Value-Based Purchasing program, which holds hospitals accountable for the quality of the care patients receive from post-acute care providers, had led some hospitals' to consider narrowing their post-acute networks with the goal of avoiding readmissions. Under the rule, the free exchange of data on all qualified facilities is required and planners will need to document their recommendations for post-acute care. CMS estimates that the final rule will impose $262 million in costs during the first year and $215 million annually thereafter.

The hospital and PAC communities have been waiting some time for this final rule. CMS had published the proposed rule back in November 2015. In November 2018, CMS extended the timeline for publishing the final rule because public comments raised "significant issues." CMS noted that it made numerous changes in the final rule to "avoid any unnecessarily costly and burdensome requirements." CMS dropped a mandatory requirement for providers to access their states' prescription drug monitoring programs while discharge planning. CMS withdrew some of its proposed discharge instruction provisions related to patients discharged home.

The new requirements go into effect November 29, 2019. CMS intends to provide additional sub-regulatory interpretive guidance to facilitate implementation of these requirements.