

***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 to Patient Care***  
***Final Rule***

[Final Rule](#)

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**Background:**

On September 30, 2019 CMS issued a final rule to revise the discharge planning conditions of participation (CoPs) for hospitals, critical access hospitals and home health agencies and would also implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT Act) of 2014.

**Who's Impacted:**

The final rule applies to all classification of hospitals: **short-term care hospitals (and their inpatient prospective payment system-excluded rehabilitation or psychiatric units), psychiatric hospitals, LTCHs, rehabilitation hospitals, critical access hospitals, children's hospitals and cancer hospitals. Home health agencies will be impacted as well.**

**Summary**

CMS believes the rule “empowers patients to make informed decisions about their care as they are discharged from acute care into post-acute care (PAC)... In addition to improving quality by improving these care transitions, **today's rule supports CMS' interoperability efforts by promoting the seamless exchange of patient information between health care settings and ensuring that a patient's health care information follows them after discharge from a hospital or PAC provider.**”

The final rule requires hospitals to:

- Have an effective discharge planning process that:
  - Focuses on the patient's goals and treatment preferences
  - Includes the patient and his or her caregivers/support persons as active partners in discharge planning for post-discharge care
- Ensure patients have the right to access their own medical records upon oral and written request, in the form and format requested by the individual (including electronically, if readily producible format) and within a reasonable timeframe
- Provide a discharge planning evaluation:
  - Allow for timely arrangement of post-hospital care prior to discharge;
  - Include evaluation of the likely need for, availability of, and patient access to non-health care services and community-based care providers; and
  - Provide patients and their caregivers with assistance selecting a PAC provider, including the sharing of HHA, SNF, IRF or LTCH data on quality and resource use measures relevant to the patient's goals of care and treatment preferences.

**For patients discharged and referred for HHA services, or for patients transferred to a SNF, IRF or LTCH, hospitals must also:**

- Include in the discharge plan a list of Medicare-participating HHAs, SNFs, IRFs or LTCHs that are available and serve the patient's geographic area. The hospital must document in the patient's medical record that the list was provided;
- For patients enrolled in managed care organizations, the hospital must share information it has about the providers and suppliers that are in the managed care organization's network and must make the patient aware of the need to verify that providers and suppliers are in network;
- Inform the patient or the patient's representative of the freedom to choose among participating Medicare providers and suppliers of post-discharge services. The hospital must not specify or otherwise limit the qualified providers or suppliers available to the patient; and
- Identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as well as any HHA or SNF that has a disclosable financial interest in the hospital.

**HHA Discharge Planning Requirements**

The Final Rule requires HHAs to:

- Develop and implement an effective discharge planning process;
- For patients transferred to another HHA or discharged to a PAC, provide patients and their caregivers assistance in PAC provider selection, including the sharing of HHA, SNF, IRF or LTCH data on quality and resource use measures;
- Provide all necessary medical information pertaining to the HHA patient to the receiving PAC, facility or health care practitioner; and
- Comply with requests for additional clinical information made by the receiving facility or health care practitioner.

The rule goes into effect Friday November 29, 2019.

**Notable Comments, Responses & Final Decisions**

Comment 1: Several commenters were concerned that durable medical equipment (DME) requirements were not specifically required in the discharge planning proposed rule. The commenters explained that providers should address and document a patient's DME needs during the discharge planning process. A few commenters also noted that DME was not addressed in the Meaningful Use Stage 3 requirements (80 FR 62761, which is discussed in our response here), and thus is still largely in paper format. (Pg 4)

Response: We agree that **considering a patient's DME needs when planning for a patient's post-hospital care is a best practice. While we are not mandating that providers include information on a patient's DME needs in the patient's discharge instructions at this time,**

**we encourage providers to do so where appropriate. However, comments regarding specific Stage 3 Meaningful Use requirements are not within the purview of these CoPs.**

Comment 2: We received a large number of comments in response to our solicitation for comments on the use of PDMPs during the discharge planning process. A majority of commenters strongly disagreed with establishing a requirement for providers to consult with their state's PDMP, with most stating that such a requirement would be burdensome and time consuming for providers and their prescribing practitioners during the discharge planning process. A few commenters expressed specific concerns about the burden of such a requirement on CAH providers. One commenter expressed concern about the applicability of this requirement to pediatric patients and recommended that this requirement be optional for pediatric patients under the age of 12. Many commenters agreed that PDMPs could potentially be useful, if the many challenges that currently exist within the PDMP systems are resolved. In addition, some commenters stated that PDMPs could work if there were a national or standardized PDMP database.... Several commenters agreed that many PDMPs still encounter legal, policy, and technical challenges.

Response & Final Decision: We thank the commenters for their feedback. We received many comments that stated that we had proposed PDMP requirements for providers and many of these comments recommended that we not finalize, or delay finalization, of this proposal... We will not require that hospitals, including LTCHs and IRFs, HHAs or CAHs consult with their state's PDMP and review a patient's risk of nonmedical use of controlled substances and substance use disorders as indicated by the PDMP report, nor will we require providers to use or access PDMPs during the medication reconciliation process. However, as discussed in the proposed rule, we strongly encourage practitioners to utilize strategies and tools, such as PDMPs, to the extent permissible under the HIPAA Privacy Rule and state law, to help to reduce prescription drug misuse.

Comment 3: Most commenters supported the proposed requirement that hospitals send a copy of the discharge instructions and the discharge summary, pending test results, and other necessary information to the practitioner(s) responsible for follow-up care, if the practitioner is known and has been clearly identified, and cited the importance of this information for these practitioners. However, most commenters stated that the required timeframes were overly prescriptive and requested more flexibility pertaining to these timeframes. Several commenters noted the challenges that the lack of adoption of interoperable health IT among follow-up practitioners poses for hospitals. Two commenters requested that, instead of sending test results, hospitals instead be required to make such test results available or accessible to the follow-up practitioner(s). (pg 21)

Response: We are (CMS is) revising the requirements for hospitals and CAHs to send information to the practitioner(s) responsible for follow-up care prior to the patient's first follow-up visit with the practitioner(s). We further (they have) note that we are finalizing a requirement that hospitals and CAHs must **discharge the patient, and transfer or refer the**

**patient where 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 practitioners responsible for the patient's follow-up or ancillary care at § 482.43(b).** We refer readers to section II.E.7 of this final rule for a more detailed discussion of this requirement. We are not proposing a specific form, format, or methodology for the communication of this information; however, by using certified health IT, facilities can ensure that they are transmitting interoperable data that can be used by other settings, supporting a more robust care coordination and higher quality of care for patients. While pending test results clearly would be included as part of a patient's necessary medical information that we are requiring be sent upon discharge to facilities and practitioners providing PAC and follow-up services to the patient, we also recognize that the very nature of these test results being "pending" precludes them from being sent at that time and hospitals would not be held accountable for sending information that they simply do not have at the time of discharge. We encourage hospitals and CAHs to find their own innovative and unique solutions to solve this issue, including any means that would ensure that these pending results are available and accessible to the appropriate facilities and practitioners at the appropriate time.

*Comment 4:* Many comments were submitted regarding the requirement to provide discharge information to the practitioner(s) responsible for follow up care. One commenter stated that the list of information may be duplicative and, in some cases, excessive. The commenters added that for patients following up with their primary care provider, many of the preventive and baseline medical history items, as well as a psychosocial assessment, would already be known to the provider. Two commenters recommended that CMS require hospitals to provide the required necessary medical information, to dialysis facilities, dialysis units, or nephrologists within 48 hours of discharge. A few commenters questioned how the hospital would monitor the information sent by the hospital to the practitioner(s) responsible for follow-up care of the patient who is being discharged to their home. (Pg 21)

*Response:* We have revised this requirement to remove a number of items that were proposed to be included as part of what many commenters described as an overly and unnecessarily prescriptive list of patient medical information that was to be sent. In this final rule, the hospital is now only required to provide certain necessary medical information that we believe allows a hospital the flexibility to effectively determine and align the pertinent patient information with a specific patient based on the clinical judgment of the practitioners responsible for the care of the patient since they are the practitioners who know the patient best while he or she is receiving care in the hospital. As many commenters noted, and with which we agree, a more flexible regulatory approach, such as we are finalizing here, allowing for the determination and transfer of a particular patient's necessary medical information will provide a more thoughtful and effective means to ensure better continuity of care for a patient being discharged. However this requirement as finalized in this rule will not limit the types and amount of patient information that can be shared with practitioners responsible for the patient's follow-up or ancillary care, but will also allow the inclusion of any additional clinically relevant information that the hospital's or CAH's practitioners believe would be beneficial for the patient's transition from one care setting

to another. Similarly, this requirement that a patient's necessary medical information must be transferred at the time of discharge (and transfer or referral as applicable) to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care would also include dialysis facilities, dialysis units, and nephrologists for those patients where this is relevant and appropriate. Furthermore, we believe that providing pertinent information such as specialized assessments and information regarding DME needs is a valuable piece of necessary medical information.