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# Final Discharge Planning Rule Drops 'Onerous' Provisions; Some Outpatients Won't Need It

By Nina Youngstrom

In its final regulation on discharge planning, CMS backed off from some of the demands of its 2015 proposed regulation. Hospitals don't have to do discharge plans for all outpatients who receive sedation and observation patients, or always start the process within 24 hours of registration or admission, and they have more flexibility with the medical information sent to post-acute care (PAC) providers, according to the final regulation, which was announced Sept. 25. A freer hand with discharge planning, however, may make hospitals more vulnerable during surveys for compliance with the Medicare Conditions of Participation (CoPs), an attorney says.

CMS said it revised and simplified the proposed regulation in response to concerns expressed by commenters, and to focus more on outcomes than on "prescriptive" processes.

"It's pretty crazy the drastic difference between the two," says Ronald Hirsch, M.D., vice president of R1 RCM. "For the past four years, case management departments have been on edge, wondering whether they would need to drastically increase the number of outpatients who would formally need a discharge plan. They were concerned that the requirement to start a discharge plan in 24 hours would lead them to have staffing problems, so it was a potential disaster for hospitals that had to comply with some of those proposals. So that's a big message: the onerous requirements were not adopted."

CMS also emphasized patient and caregiver participation in discharge planning, says attorney Judy Waltz, with Foley & Lardner in San Francisco. The final regulation stuck with a requirement for "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."

In the final regulation, CMS made changes to some of the 10 elements that it said should be addressed in the discharge planning process. It ditched some and finalized others, sometimes with revisions. Most of the provisions come from a 2015 proposed regulation to update discharge planning requirements, but CMS also included measures from a 2016 regulation to implement the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 and the Hospital Innovation proposed rule.

One of the most significant changes relates to the information that hospitals communicate when transferring patients to PAC providers and other facilities. Hospitals will now have more leeway to decide what information to include. "The most onerous part of the proposed rule was the requirement to send a regimented 20+ data set within 48 hours of discharge to PAC providers and outpatient providers. CMS has relaxed the prescriptive nature of the data set, and removed the 48-hour hard stop," says Edward Hu, M.D., system executive director of physician advisor services at UNC Health Care in North Carolina. "Instead, CMS focused on allowing hospitals to specify the relevant information to transmit and expects that information to be available when those providers need it."

## 'A Lot Will Be Left to Enforcement Discretion'

The data set in the proposed regulation included demographic information, diagnoses, course of illness/treatment, social supports, behavioral health assessments and a lot more, including the patient's discharge instructions and discharge summary "to ensure a safe and effective transition of care that supports the post-discharge goals." The final rule abandons the list while keeping the same goals in mind: "A hospital must discharge the patient, and also 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 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."

The change reflects a broader theme in the regulation, which favors flexibility, Waltz says. "I get they are trying to reduce the burden by not requiring such specifics in some of the things in the proposed regulations, but I'm not sure it necessarily reduced the burden," she says. When there are 10 items to check off a list, hospitals check them off and probably won't get dinged if one is missing when state surveyors are evaluating their compliance with the Medicare CoPs. But with the vaguer standard of "medical information," hospitals have less certainty about how they will be judged, she notes. Similarly, the final regulation requires hospitals to review and update discharge plans "as needed," but it set no definitive time frame. "We would recommend" that a hospital or critical access hospital review them every two years at least, CMS said. Waltz worries where that leaves hospitals. "What does it mean if you recommend something? Will you get cited by surveyors who think there should have been more, or something different? A lot of this will be left to the enforcement discretion of the surveyors, and that is a scary place to be," Waltz says.

## CMS Expands Patient Choice Requirement

The final regulation also ditched a proposal to identify "anticipated discharge needs for each applicable patient within 24 hours after admission or registration." CMS opted for a more customized approach. "A hospital's discharge planning process must identify, at an early stage of hospitalization (ideally when the patient is admitted as an inpatient, or shortly thereafter), those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified, as well as for other patients upon the request of the patient, patient's representative, or patient's physician."

Patient choice is another feature of the final regulation. Hospitals have always had to give appropriate patients a list at discharge of home health agencies (HHAs) and skilled nursing facilities, but CMS has expanded the requirement to long-term acute care hospitals (LTACHs) and inpatient rehabilitation hospitals (IRFs). That way, patients have options for all of these PAC providers, along with information about quality and resource use, as required by the IMPACT Act.

"What's interesting about that is in many cities there are plenty of SNFs and HHAs, but with IRFs and LTACHs, that is not the case, so hospitals will have to figure out how to define their geographic region and who to include on their list. If there is an IRF in town but the next closest one is 20 miles away, are they obligated to list that for the patient? CMS gave no guidance," Hirsch says. To comply with the IMPACT Act quality and resource use data requirements, hospitals probably will defer to CMS's SNF, IRF and other Compare databases, he says. "The problem is that there is no way to easily access quality and resource use data on IRFs or LTACHs. When I tried to produce an IRF list for Chicago, the list would be 48 pages. What patient will find that useful?"

## CMS Punted on Potential Steering

Several commenters on the proposed regulation expressed concern that hospitals would illegally steer patients to

PAC providers within their health system. CMS said while it understands the concerns, "we believe compliance with the revised CoP and the fraud and abuse laws, including the physician self-referral law and Federal anti-kickback statute, is achievable. We believe that hospitals, HHAs and [critical access hospitals] will be in compliance with this requirement 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," CMS said. If providers are worried about conflicts, they can look to guidance on the Office of Inspector General and CMS websites. "We remind providers that compliance with these requirements will be assessed through on-site surveys by CMS, state survey agencies, and [accrediting organizations] and that purposeful patient steering (that is, directing patients and/or their caregivers to PAC providers that do not align with the patient's goals of care and treatment preferences) could lead to a determination of provider noncompliance with the requirements in this rule."

## Another Proposal Was Killed

That's not exactly guidance on what could be considered steering, Waltz says. Another section of the regulation states that hospitals must identify which HHAs they have a financial interest in, but otherwise, CMS again just briefly mentions the Stark Law and CoPs, and refers hospitals to the CMS website. "I don't know how much comfort providers can take with this kind of ambiguity and with design of their own processes to meet the discharge requirements without violating the fraud and abuse rules," she notes.

The final regulation also disposes of the requirement that the practitioner responsible for the care of the patient be involved in "the ongoing process of establishing the patient's goals of care and treatment preferences that inform the discharge plan."

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View the regulation at http://bit.ly/2lyi8Ge.