# CMS Announces New Discharge Planning Requirements for Hospitals and HHAs with Implications for PAC Providers

H. Carol Saul and Charmaine A. Mech

On September 26, 2019, the Centers for Medicare & Medicaid Services (CMS) announced a new Final Rule, Revisions to Discharge Planning Requirements (CMS-3317-F) in a bid to "improve engagement, choice and continuity of care across hospital settings."[1] The Final Rule requires the Medicare Conditions of Participation to implement more comprehensive discharge planning requirements for hospitals, including critical access hospitals (CAHs), and home health agencies (HHAs).

Hospitals and CAHs will be impacted the most by the new discharge planning requirements. Under the revised Conditions of Participation, hospitals and CAHs must provide expanded discharge planning to patients likely to suffer adverse health consequences upon discharge without adequate discharge planning as well as for other patients upon the request of the patient, patient's representative, or physician. Hospitals and CAHs must perform and document timely and regular discharge planning evaluations, which assess the patient's need for post-hospital services, determine the availability of the appropriate services, and evaluate the patient's access to necessary services. These discharge evaluations and discharge plans must be developed by or under the supervision of a registered nurse, social worker, or other qualified personnel.

The Revisions to Discharge Planning Requirements also require hospitals and CAHs to assist patients being discharged to post-acute care (PAC) providers with selecting a PAC provider using key performance data including quality metrics on available HHAs, skilled nursing facilities (SNFs), inpatient rehab facilities (IRFs), or long-term care hospitals (LTCHs). In this way the new regulations utilize requirements from the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, which requires LTCHs, SNFs, HHAs and IRFs to submit standardized data to CMS and provide quality measures to consumers.[2]

Hospitals also must provide patients with a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, participate in Medicare, and serve the applicable geographic area, and they must educate the patient on their freedom to choose. The hospital may not specify or otherwise limit the qualified providers available to a patient and must note any HHAs or SNFs with which the hospital has a disclosable financial interest under Medicare (as defined in 42 C.F.R. 420, Subpart C). In addition, if patients are enrolled in a managed care organization, the hospital must educate patients on the need to verify in-network providers and share information regarding in-network providers.

The revisions to the HHA discharge planning requirements are less specific than the requirements imposed on hospitals and CAHs. HHAs are only required to develop effective discharge planning processes which assist patients being discharged to SNFs, IRFs, or LTCHs to select a PAC provider using data on quality measures and resource use measures.

Upon a patient's discharge, to ensure the most effective transition, hospitals, CAHs, and HHAs alike must provide the receiving facility necessary medical information on the patient's illness,

1 *CMS's Discharge Planning Rule Supports Interoperability and Patient Preferences,* (Sep. 26, 2019), www.cms.gov/newsroom/press-releases/cms-discharge-planning-rule-supports-interoperability-and-patient-preferences.
2 *IMPACT Act of 2014 Data Standardization & Cross Setting Measures,* (*last modi ied* Dec. 11, 2018), www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures.html.

treatment, and post-discharge goals. In addition, the Final Rule implements revisions to the Medicare hospital Conditions of Participation addressing patient's rights, requiring hospitals to provide patients copies of their medical records within a reasonable timeframe and in any readily producible format, including electronic format, upon oral or written request. Patients' medical records must include all discharge planning documents.

When addressing the implementation costs of the new regulations, CMS noted that many hospitals already counsel patients on discharge choices, and all providers affected by the rule already have access to quality information from the CMS websites Hospital Compare, Nursing Home Compare, and Home Health Compare, as well as other public and private websites and their own knowledge of local providers. To comply with the new discharge planning requirements, CMS estimates there will be a total one-time cost of approximately $17.7 million for all hospitals, approximately $10.8 million for all HHAs, and approximately $1.9 million for all CAHs.

The Final Rule was officially published in the Federal Register on September 30, 2019, and the new requirements will become effective on November 29, 2019, giving hospitals and HHAs just sixty days to ensure compliance. CMS, state agencies, and accrediting organizations will monitor compliance through surveys.

To read the Final Rule, click here.

## Authors and Contributors

**H. Carol Saul**
Partner, Atlanta Office
404.873.8694
carol.saul@agg.com

**Charmaine A. Mech**
Associate, Atlanta Office
404.873.7018
charmaine.mech@agg.com

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