Illinois Health and Hospital Association

October 25, 2019

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

SUBJECT: Revised Discharge Planning Requirements for Hospitals, Critical Access Hospitals, and Home Health Agencies, Final rule

On Sept. 30, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (FR) a final rule modifying discharge process requirements as a condition of participation for hospitals, critical access hospitals (CAHs) and home health agencies (HHAs). CMS' stated goal with this final rule is to promote active patient participation in the discharge planning process and the seamless exchange of patient information between healthcare settings through discharge planning requirements. The requirements in this final rule are effective Nov. 29, 2019.

Hospitals and CAHs

Discharge Planning Requirements

Hospitals and CAHs are required to create a discharge plan for patients that the hospital identifies as likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning. A discharge plan must also be developed for any patient upon request from the patient, the patient's representative, or the patient's physician. The planning process must include an evaluation of the patient's need for post-hospital services and the availability of those services. Additionally, the patient and caregiver[1]/support person(s), as applicable, must be involved in the development of the discharge plan, and informed of the final plan to prepare them for post-hospital or CAH care.

Per the final rule, hospitals and CAHs must begin to identify discharge needs for applicable patients at an early stage of hospitalization. The patient's condition must be regularly monitored and re-evaluated to identify any necessary modifications to the discharge plan, and the discharge planning process must be completed in a timely manner, prior to discharge or transfer. CMS notes that these requirements do not pertain to emergency-level transfers for patients who require a higher level of care. CMS plans to issue sub-regulatory guidance discussing the circumstances of when a discharge or transfer summary would be expected at the time of discharge versus when it would not be appropriate to delay an emergency transfer as a result of waiting on the availability of a discharge summary.

[1] Illinois Public Act 99-0222 outlines state requirements on the designation, informing, and training of caregivers for hospital inpatients.

A registered nurse, social worker, or other personnel qualified in accordance with the hospital or CAH's discharge planning policies must coordinate the timely administration of a discharge needs evaluation and development of the discharge plan. The planning process should identify anticipated post-discharge goals, preferences, and needs of the patient, and the practitioner responsible for the care of the patient must be involved in the ongoing process of establishing a discharge plan that includes these elements.

In an effort to provide hospitals and CAHs with flexibility in discharge planning, CMS did not finalize specific factors to be considered in the discharge needs evaluation. Instead, CMS requires that discharge needs evaluations assess the patient's likely need for post-hospital services. CMS urges hospitals and CAHs to consider: hospice care, post-hospital extended care services, home health services, and non-health care services and community-based care providers. Hospitals and CAHs are also required to determine the availability of and the patient's access to those services as part of the discharge needs evaluation.

In Illinois, a hospital must notify the designated Care Coordination Unit (CCU) at least 24 hours prior to a patient's pending discharge to a skilled nursing facility, so the CCU can perform the Choice for Care assessment (prescreening) (Hospital Licensing Act). The prescreening is to inform the patient and family of all available community services or resources in order to prevent premature and/or unnecessary institutionalization, and failure to provide 24-hour notice to the CCU may result in delay of patient discharge.

Note – these discharge planning requirements also apply to patients who move from the acute inpatient setting to swing bed services. Additionally, should a hospital refer a patient to a home health, home services or home nursing agency, that agency must be licensed in the state of Illinois under the Home Health, Home Services, and Home Nursing Agency Licensing Act.

Patient Access to Medical Records

Hospitals and CAHs must ensure that patients have access to their medical records upon verbal or written request. Medical records must be made available in the form or format requested by the patient, so long as that form or format is made readily available by the provider. The Office for Civil Rights states that medical records must be sent within 30 days (or 60 days if an extension is applicable) of request. Please note, hospitals may still charge a reasonable fee for providing patient medical records upon request.

IMPACT Act Requirements

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the submission of standardized data by HHAs, Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Skilled Nursing Facilities (SNFs). These standardized data include quality measures, standardized patient assessment data elements and resource use measures (found here). The intent of the IMPACT Act is to allow for data exchange between post-acute care (PAC) providers and other providers, such as hospitals and CAHs. This data exchange

allows for better Medicare beneficiaries outcomes through enhanced care coordination and discharge planning.

Hospitals and CAHs are required to assist patients, their families, or their caregiver/support person(s) in selecting a PAC provider by using and sharing data that includes, but is not limited to, HHA, IRF, LTCH and SNF data on quality and resource use measures collected under the IMPACT Act. Furthermore, the hospital or CAH must ensure that the PAC data on quality and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

CMS expects hospitals and CAHs to be available to discuss and answer patients' and their caregiver's questions about their post-discharge options and needs. Additionally, hospitals and CAHs are expected to document in the medical record that the PAC data on quality and resource use measures were shared with the patient and used to assist the patient during the discharge planning process. CMS stressed that hospitals and CAHs should not make decisions on PAC services on behalf of patients and their families/caregivers.

Hospital-Specific Requirements for PAC Services
CMS finalized language related to post-discharge services specific to hospitals. These requirements are for patients discharged to home and referred for HHA services, or for patients transferred to an IRF, LTCH or SNF.

Specifically, the hospital must include in the discharge plan a list of Medicare-participating HHAs, IRFs, LTCHs or SNFs. Listed HHAs must serve the geographic area (as defined by the HHA) in which the patient resides, and listed IRFs, LTCHs or SNFs must be in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available. This list may only be presented to those patients for whom home healthcare post-hospital extended care services, IRF, LTCH or SNF LTCH services are indicated and appropriate as determined by the patient's discharge plan.

If the patient is enrolled in a managed care organization (MCO), the hospital must inform the patient that they need to verify with their MCO which practitioners, providers or certified suppliers are in the MCO's network. If the hospital has this information, it must share it with the patient or the patient's representative. The hospital must document in the patient's medical record that the list was presented to the patient or to the patient's representative.

As part of the discharge planning process, the hospital must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services. The hospital must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital may not specify or otherwise limit the qualified providers or suppliers that are available to the patient.

Finally, the hospital must disclose any financial interests they may have with any HHA or SNF on the provided list or to whom a patient is referred, as specified by the U.S. Department of Health & Human Services Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

Discharge to Home

CMS did not finalize the majority of proposed requirements for discharging a patient to the home, which includes patients returning to their residence (or the community if they do not have a residence), who require follow-up with their primary care provider or a specialist, HHAs, hospice services, or any other type of outpatient healthcare service. CMS explained that it believes the overall involvement of the patient and caregivers in the discharge planning process, in addition to the already established practice of providing discharge instructions specific to each patient, will ensure appropriate communication between providers, patients and caregivers throughout the discharge planning process. When the follow-up care practitioner is known and identified, the hospital or CAH must send:

- A copy of the discharge instructions and summary;
- Completed and pending test results; and
- All other necessary information as specified in the section on transfers (below).

When a patient is referred to an HHA, the HHA must be Medicare-participating and serving the geographic area (as defined by the HHA) in which the patient resides. CMS expects patients to be referred to HHAs that can meet their clinical needs as indicated in the patient's discharge plan.

Transferring Patients to Other Healthcare Facilities

When a patient is transferred from a hospital or CAH to another facility (CAH, hospital, or PAC provider), the patient must be transferred 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. This information must be provided 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.

Internal Review of Discharge Planning Process

CMS did not mandate a specific frequency requirement for the internal review of a hospital or CAH's discharge planning process. However, CMS did state that hospitals and CAHs need to assess their discharge planning process regularly. This assessment must include ongoing periodic review of a sample of discharge plans, including plans of patients that were readmitted within 30 days, to ensure that the process is responsive to patient post-discharge needs. CMS recommends that hospitals and CAHs review their discharge planning process at least every two years.

Home Health Agencies

IMPACT Act Requirements

For those patients who are transferred to another HHA or who are discharged to an IRF, LTCH or SNF, the HHA must assist patients and their caregivers in selecting a PAC provider by using and sharing data that includes, but is not limited to, data on quality and resource use measures. HHAs must take these data into account during the discharge planning process, and these data must be relevant to the patient's goals of care and treatment preferences.

Discharge or Transfer Summary Content

HHAs must send necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences to the receiving facility or healthcare practitioner to ensure the safe and effective transition of care. Additionally, HHAs must comply with requests for additional necessary clinical information made by the receiving facility or healthcare practitioner, which may include items such as a copy of the patient's current plan of care or latest physicians' orders.

Prescription Drug Monitoring Programs (PDMP)

CMS requested comment on potentially requiring providers to consult patient reports in their state's PDMP and using PDMPs in the medication reconciliation process during the discharge process. Due to implementation concerns, CMS is not requiring hospitals, LTCHs, IRFs, HHAs or CAHs to interface with PDMPs during discharge at this time. However, they strongly encourage providers to utilize PDMPs or similar tools to help reduce prescription drug misuse. CMS notes that there may be state laws that require practitioners to consult with their state's PDMP system. Illinois does have a prescription monitoring program, and there are specific requirements for providers when an initial prescription for Schedule II narcotics, such as opioids, are written. More about Illinois' prescription monitoring program requirements can be found on IHA's website.