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### Goals for This Presentation

- Overview of Final Rule on Hospital Discharge Planning
  - Scope
  - Key Provisions Affecting Discharges to Post-Acute Care
- Address Frequently Asked Questions
- Specify Next Steps for Providers

The bottom of the slide contains two logos. On the left is the California Hospital Association logo, and on the right is the HDG Health Dimensions Group logo with the text '© HDG 2019' and the number '1' below it.

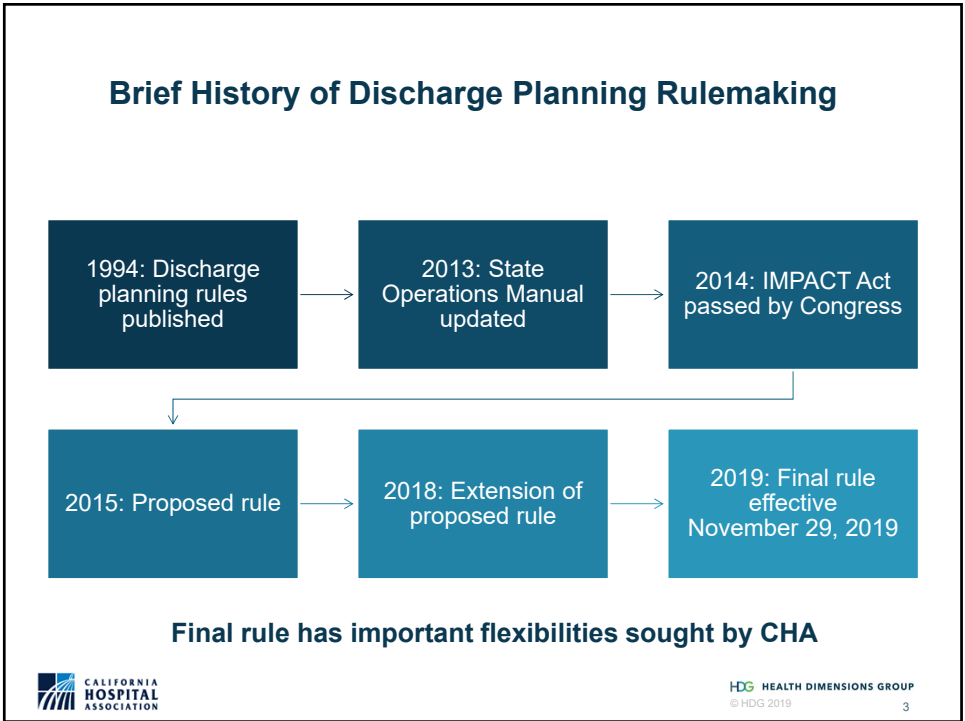
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# Overview of Final Rule

*Brief History*  
*Scope and Key Requirements*

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## Major Aspects of CMS-3317-F: Revisions to Discharge Planning Requirements

- Hospitals must have effective discharge planning process that focuses on patient goals and treatment preferences
- Hospitals need to assist patients, their families, or their caregivers/support persons in selecting post-acute care provider
- Patients can request copy of their medical record, including discharge plan from the hospital, in their requested form and format
- Home health agencies (HHAs) must communicate with all relevant parties, including physicians who are involved in the patient's HHA plan of care, whenever there are revisions related to the plan for patient discharge



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## Basics of Finalized Discharge Planning Process

### A hospital's discharge planning process is to:

- Identify, at early stage of hospitalization, those patients likely to suffer adverse health consequences upon discharge; and,
- Provide discharge planning evaluation for those patients so identified (as well as for other patients upon request of the patient, patient's representative, or patient's physician)

### A discharge planning evaluation must:

- Include evaluation of patient's likely need for appropriate post-hospital services, including, but not limited to, hospice care services, post-hospital extended care services, and home health services
- Such evaluation must also determine availability of those services



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## Discharge Planning Rules Apply to All Hospital Types

- Short-term acute care hospitals
  - Including their IPPS-excluded rehabilitation or psychiatric units
- Psychiatric hospitals
- Long term care hospitals (LTCHs)
- Inpatient rehabilitation facilities (IRFs)
- Children's hospitals
- Cancer hospitals
- Distinct part psychiatric and rehabilitation units in critical access hospitals (CAHs)



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## Since the New Rules Are CoPs, They Generally Apply to All Payors, Unless Exempted

- Discharge planning rules are Medicare Conditions of Participation (CoPs)
- CoPs are generally interpreted to broadly apply to all patients within a Medicare-certified provider, unless there are specific exemptions in law or regulations
- Additional discharge planning requirements can exist for certain hospital types (e.g., psychiatric hospitals)
- Flexibilities provided for observation and certain specified outpatient care



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## Key Requirements of Discharge Planning Rule as They Impact Hospital-PAC Relationship



Provide list of facilities for post-acute care (PAC) discharges



Assist managed care enrollees to verify in-network providers



Assist in selecting PAC provider



Preserve freedom of choice



Disclose financial interest



Source: 42 CFR Section 482.43



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## Provide List of Medicare Participating Providers for Post-Acute Discharges

- Hospital must include in discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that:
  - Are available to the patient;
  - Participate in the Medicare program; and,
  - Serve geographic area (as defined by HHA) in which the patient resides; or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient
- HHAs must request to be listed by the hospital as available
- CMS provides flexibility in meeting this requirement; hospitals may use most recent information from [www.medicare.gov](http://www.medicare.gov) or develop their own list
- Hospital must document in patient's medical record that the list was presented to the patient or to the patient's representative



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## Flexibility Provided for Managed Care Enrollees

- Hospital must make patient aware of need to verify with their managed care organization which practitioners, providers, or certified suppliers are in the managed care organization's network
- If hospital has information on which practitioners, providers, or certified suppliers are in the network of patient's managed care organization, it must share this with the patient or the patient's representative



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## CMS Guidance About Managed Care Enrollees

- Discharge planning requirements do not prohibit providers from giving patients information regarding coverage of a selected PAC by the patient's insurance or specifics on out-of-pocket costs for PAC providers
  - Providers may give this information to patients *if they choose*
- CMS does not expect providers to have definitive knowledge of the terms of a patient's insurance coverage or eligibility for post-acute care, or for Medicaid coverage, but encourage providers to be generally aware of patient's insurance status



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## Requirement to Assist Patients in Selecting PAC

Hospital must:

- Assist patients, their families, or patient's representative in selecting PAC provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality and resource use measures
- Ensure that PAC data on quality and resource use measures is relevant and applicable to patient's goals of care and treatment preferences



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## Can Hospitals Supplement Publicly Available Information on PAC?

Hospitals can use additional available information to assist patients as they select a PAC provider, so long as the hospital:

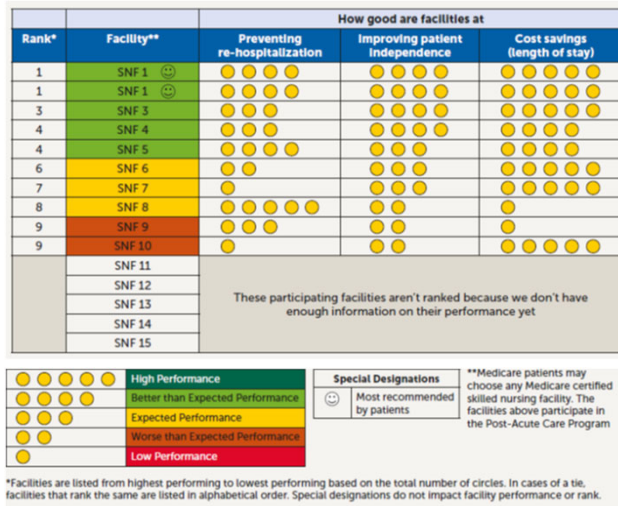
1. Presents **objective** data on quality and resource use measures **specifically applicable** to patient's goals of care and treatment preferences;
2. Takes care to include data on all available PAC providers; and
3. Allows patients and/or their caregivers the freedom to select a PAC provider of their choice

Providers will have to document all such interactions in the medical record



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### Specific Example of Quality and Resource Use Data Shared for Skilled Nursing Facilities



Source: CMS, Care Coordination Toolkit, March 2019

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## Frequently Asked Questions

- Level of Detail Required*
- Preferred Network Designations*
- Patient Steering & Specialized Services*
- Patient Refusal for Discharge*
- English Proficiency*

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## How Detailed Should Hospitals Get in Sharing Information with Patients?

### CMS' goal is to maximize patient's ability to make well-informed choice about care

CMS does NOT expect hospitals to:

- Give overly detailed and complex analyses of PAC quality and resource use data, which may only serve to confuse patients and/or their caregivers
- Attempt to provide patients and their caregivers with data that do not exist regarding PAC facilities

CMS expects hospitals to:

- Put forth their best effort to answer patient questions regarding the data



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## Can Hospitals Add Preferred Provider Designation to PAC Quality & Resource Data Shared with Patient?

In order to share preferred provider status, hospital must meet three prongs:

All PAC providers presented to patient must meet patient's needs and preferences

All PAC providers presented to patient must have quality and resource data that are relevant and applicable to patient's treatment preferences

Given 1 and 2 above, acceptable to identify certain PAC providers as "preferred provider," as long as list provided to patients not exclusively comprised of those preferred providers



Source: Email from CMS dated November 26, 2019



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## What About Patient Steering and Specialized Services?

- **Steering:** “The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient. We do encourage hospitals to provide any information regarding PAC providers that provide services that meet the needs of the patient.”
- **Specialized services and needs:** “If the hospital has information regarding a PAC provider’s specialized services, we encourage that this information be provided to the patient as well as any culturally specific needs that the PAC providers are able to address (for example, the patient’s foreign language needs, and their cultural dietary needs or restrictions).”



Source: Page 51861 of preamble to final rule on discharge planning

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## How Should Refusal to be Discharged Be Treated?

- **Question:** *Please clarify the protocols that providers would be expected to follow if a patient refused to agree to be discharged to a PAC facility chosen on the basis of the supplied quality data and/or family preferences, especially when no other safe options exist in the area.*
- **Answer:** We expect hospitals, HHAs, and CAHs to document the patient’s refusal in the medical records and continue to make reasonable efforts to work with the patient and/or the patient’s caregiver to find appropriate substitutions.

**Existing policy about Hospital-Issued Notice of Non-Coverage (HINN) is not affected by the final rule on discharge planning**



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## Guidelines for Providing Information to Persons with Limited English Proficiency or Disabilities

- CMS recommends providers **follow National Standards for Culturally and Linguistically Appropriate Services (CLAS)** in Health and Health Care: <https://www.thinkculturalhealth.hhs.gov/clas/standards>
  - Provides guidance on providing instructions in culturally and linguistically appropriate manner
- CMS reminds providers of their obligations **take reasonable steps to provide meaningful access to individuals with limited English proficiency** in accordance with Title VI of the Civil Rights Act of 1964 and section 1557 of the Affordable Care Act)
- Providers reminded to take appropriate steps to **ensure effective communication with individuals with disabilities**, including provision of auxiliary aids and services, in accordance with section 504 of Rehabilitation Act, Americans with Disabilities Act, and section 1557 of Affordable Care Act



Source: Page 51840 of final rule



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## Next Steps for Providers

*Further Guidance*

*Implementation Steps for Now*

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## Further Guidance Is Forthcoming

- Sub-regulatory interpretive guidance still being developed (expected 1Q 2020)
- Further information regarding specific measures mandated by IMPACT Act will be available in forthcoming regulations



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## Important Implementation Steps for Now

- Carefully review entire final rule, including requirements for access to records
- Provide comprehensive lists of PAC providers that are relevant to patient needs and geography
- Develop simple and clear PAC quality and resource use metrics, starting from compare sites and augmenting the information only if additional data meets criteria identified herein
- Document PAC provider conversation in the record, as well as efforts directed at preserving freedom of choice
- Carefully review sub-regulatory guidance when issued



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## For More Information



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## Appendix

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## IMPACT Act of 2014 Requires HHS to Issue Regulations to Address Discharge Planning Policy

i) USE OF STANDARDIZED ASSESSMENT DATA, QUALITY MEASURES, AND RESOURCE USE AND OTHER MEASURES TO INFORM DISCHARGE PLANNING AND INCORPORATE MEDICARE BENEFICIARY PREFERENCE.—

- “(1) IN GENERAL.—Not later than January 1, 2016, and periodically thereafter (but not less frequently than once every 5 years), the Secretary shall promulgate regulations to modify conditions of participation and subsequent interpretive guidance applicable to PAC providers, hospitals, and critical access hospitals. Such regulations and interpretive guidance shall require such providers to take into account quality, resource use, and other measures under the applicable reporting provisions (which, as available, shall include measures specified under subsections (c) and (d), and other relevant measures) in the discharge planning process. Specifically, such regulations and interpretive guidance shall address the settings to which a patient may be discharged in order to assist such PAC providers, patients, and families of such patients with discharge planning from inpatient settings, including subsection (d) hospitals, critical access hospitals, and hospitals described in section 1886(d)(1)(B)(v), and from PAC provider settings. In addition, such regulations and interpretive guidance shall include procedures to address—
  - “(A) treatment preferences of patients; and
  - “(B) goals of care of patients.
- “(2) DISCHARGE PLANNING.—All requirements applied pursuant to paragraph (1) shall be used to help inform and mandate the discharge planning process.
- “(3) CLARIFICATION.—Such regulations shall not require an individual to be provided post-acute care by a specific type of PAC provider in order for such care to be eligible for payment under this title.



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## Compare Websites

- <https://www.medicare.gov/inpatientrehabilitationfacilitycompare/>
- <https://www.medicare.gov/homehealthcompare/search.html>
- <https://www.medicare.gov/nursinghomecompare/search.html>
- <https://www.medicare.gov/longtermcarehospitalcompare/>



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