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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 482, 484, and 485**

**[CMS–3317–F and CMS–3295–F]**

**RIN 0938–AS59**

# 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 in Patient Care

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Final rule.

**SUMMARY:** This final rule empowers patients to be active participants in the discharge planning process and complements efforts around interoperability that focus on the seamless exchange of patient information between health care settings by revising the discharge planning requirements that Hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Rehabilitation Hospitals, Psychiatric Hospitals, Children's Hospitals, and Cancer Hospitals), Critical Access Hospitals (CAHs), and Home Health Agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This final rule also implements discharge planning requirements which will give patients and their families access to information that will help them to make informed decisions about their post-acute care, while addressing their goals of care and treatment preferences, which may ultimately reduce their chances of being re-hospitalized. It also updates one provision regarding patient rights in hospitals, intended to promote innovation and flexibility and to improve patient care.

**DATES:** These regulations are effective on November 29, 2019.

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**SUPPLEMENTARY INFORMATION:**

*Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that website to view public comments.

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## I. Background

### A. Overview

On November 3, 2015, we published a proposed rule that would update the discharge planning requirements for hospitals, critical access hospitals (CAHs), and post-acute care (PAC) settings (80 FR 68126). Discharge planning is an important component of a successful transition from hospitals and PAC settings. The transition may be to a patient's home (with or without PAC services), skilled nursing facility (SNF), nursing facility (NF), long term care hospital (LTCH), rehabilitation hospital or unit, assisted living center, substance abuse treatment program, hospice, or a variety of other settings. While Medicare regulations define ''post-acute care'' providers to include SNFs, LTCHs, inpatient rehabilitation facilities (IRFs) and home health agencies (HHAs), it should be noted that there are other services that can be provided by entities other than PAC providers (that is, LTCHs, IRFs, HHAs, and SNFs), including assisted living facilities, home and community-based services, or primary care providers. The location to which a patient may be discharged should be based on the patient's clinical care requirements, available support network, and patient and caregiver treatment preferences and goals of care.

We also proposed to implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185), that requires hospitals, including, but not limited to, short-term acute care hospitals, CAHs and PAC providers (LTCHs, IRFs, HHAs, and SNFs), to take into account quality measures and resource use measures to assist patients and their families during the discharge planning process in order to encourage patients and their families to become active participants in the planning of their transition to the PAC or other settings (or between such settings).

We published another proposed rule on June 16, 2016 in the **Federal Register**, titled ''Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care'' (81 FR 39448), hereinafter referred to as the ''Hospital Innovation proposed rule'', that proposed to update a number of Conditions of Participation (CoP) requirements that hospitals and CAHs must meet in order to participate in the Medicare and Medicaid programs. One of the proposed hospital CoP revisions in that rule directly addresses the issues

needs, so long as the placement can be reasonably accommodated. One commenter recommended that hospitals review a patient's need for the use of technology and whether or not technology is necessary to maintain a patient's health and safety or individual goals. A few commenters recommended specific revisions to the proposed requirement that the hospital consider the availability of caregivers and community-based care for each patient, including recommendations such as requiring hospitals to consider a patient's socioeconomic condition when identifying and evaluating a patient's anticipated post-discharge needs, and consider patient eligibility for Program of All-Inclusive Care for the Elderly (PACE) and services through the Veterans Administration.

However, other commenters stated that the proposed requirements that a hospital must consider in evaluating a patient's discharge needs are overly prescriptive and overly detailed. A few commenters stated that a requirement to consider a patient's access to non-health care services and community-based care providers would be burdensome for hospitals. One commenter stated that while these services may benefit the patient, hospitals cannot be expected to provide an exhaustive list of services and that the hospital has limited reliable methods to identify non-health care resources in the community.

One commenter disagreed with the use of the term ''consider'' in the proposed requirement, stating that using the term ''consider'' may cause interpretation differences when surveying for compliance. The commenter recommended that CMS clarify that discharge plans can vary, depending on the patient, and that in many cases a patient's discharge instructions could constitute a ''discharge plan.'' The commenter also recommended that CMS coordinate with AOs to develop mutually agreed upon interpretive guidelines, which all surveyors would use when assessing compliance with this provision.

*Response:* We agree that the proposed list could be burdensome, and, therefore, we are not finalizing it in this final rule. We are instead finalizing a requirement at § 482.43(a)(2) that a discharge planning evaluation include an evaluation of a patient's likely need for appropriate post-hospital services, including, but not limited to, hospice care services, post-hospital extended care services, home health services, and non-health care services and community based care providers, and that the evaluation must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.

We acknowledge that patients and families seeking post-hospital non-health care services, as well as the discharge planning staff of hospitals assisting them with this process, frequently find themselves confronted with what can be an overwhelming number of organizations and requirements. This search occurs at a time of vulnerability or crisis, and can result in patients, families, and caregivers making decisions based on incomplete, and sometimes inaccurate, information about their options. In partnership with the Veterans Health Administration and the Administration for Community Living (ACL) within HHS, CMS is working collaboratively with states to streamline access to long-term services and supports (LTSS) through a network of organizations, including Aging & Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), and Centers for Independent Living (CILs)) that make up a statewide No Wrong Door (NWD) system. We expect that CILs, AAAs, and ADRCs would assist patients in accessing LTSS, and would have staff trained to help patients and their families exercise their choice and control over the types of LTSS that work best for them in their lives. Along with the U.S. Department of Veterans Affairs, CMS formally recognized the importance of state ADRC/NWD systems by publishing the NWD System Medicaid Administrative Guidance (*https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/no-wrong-door-guidance.pdf*) and the ''Expanded Access to Non-VA Care Through the Veterans Choice Program Rule'' interim final rule (80 FR 674991, December 1, 2015.)

We therefore urge hospitals to develop collaborative partnerships with these community based care organizations in their respective areas to improve transitions of care that might support better patient outcomes. Regarding hospital expectations, hospitals are required to comply with all applicable Federal laws, including the Americans with Disabilities Act (ADA). It is our expectation that hospitals would administer their services, programs, and activities in the most integrated setting appropriate to individuals with disabilities, in compliance with the ADA. For further information on ADA compliance, we recommend that readers visit *https://www.ada.gov/.* For further information about other nondiscrimination laws see *http://www.hhs.gov/civil-rights.* We expect hospitals to develop collaborative relationships with their area and state ADRCs, AAAs, and CILs that are knowledgeable of the availability of these services in the community and would be able to help connect patients as well as their families, friends, and caregivers to these resources. We would also expect that these hospital efforts to collaborate and to connect patients with these types of community-based care organizations will be documented in the medical record. It is for this reason that we urge hospitals to develop ongoing and collaborative partnerships with ADRCs, AAAs, and CILs. We remind hospitals that they can find more information on community-based services and community-based organizations at *http://www.acl.gov/.*

Considerations must also be made for those patients whose personal homes have been adversely impacted due to an emergency or disaster. We note that the Emergency Preparedness final rule requires health care facilities to communicate with state and local officials during a disaster (81 FR 63860, September 16, 2016). Therefore, in the event of such an emergency, we would expect that patients that are determined for safe discharge to a personal home that may have been adversely impacted should not be directed to shelters without prior consultation with public health and emergency management officials overseeing those shelters. Additionally, we would expect that patients that are anticipated to be discharged to another inpatient facility that may be adversely impacted should not be sent to a shelter without prior consultation with public health and emergency management officials overseeing those shelters and with health care coalitions, where available, that may know of other inpatient facility options. In addition, we refer readers to guidance from Office for Civil Rights on emergency preparedness and ensuring at risk individuals have access to emergency services at the following link: *https://www.hhs.gov/civil-rights/for-individuals/special-topics/emergency-preparedness/index.html.*

*Comment:* We received several comments regarding community based care organizations. Comments included the following recommendations:

- Mandate that providers collaborate and coordinate with community based organizations on the availability of community supports at discharge.
- Include specific references to CILs, ADRCs, and AAAs in the regulation and provide patient instructions on their use.

• Clarify how collaboration between hospitals and community based organizations would be encouraged and funded, including requiring Medicare and Medicaid reimbursement of AAAs and community-based organizations.
• Require that community based providers be included in the early stages of planning for a patient's discharge.
• Clarify how a hospital would know what facility or agency a patient would use before discharge.
• Clarify timelines for considering the availability of, and access to, non-health care services for patients, specifically in instances where the post-acute care provider had a physical accessibility issue.

*Response:* As we have already stated in this final rule, we believe that community based care organizations, including CILs, ADRCs, and AAAs, play an important part in helping individuals, who are returning home or who want to avoid institutionalization, by connecting them to community services and supports. Currently, many of these organizations already help older adults and people with disabilities with transitions across settings, from hospitals and PAC settings back to home. Because of the important role that community based organizations play, we strongly encourage hospitals to develop collaborative partnerships with providers of community-based services. We believe that such collaboration will help with successful patient transitions.

While we encourage, and even urge, collaboration with organizations such as CILs, AAAs, and ADRCs to assist patients with access to LTSS, we believe that mandating a collaborative relationship could be overly burdensome for hospitals. In order to demonstrate compliance with a proof of collaboration requirement like the one recommended here by some commenters, hospitals would need to provide extensive documentation solely for Medicare certification and participation purposes. Such an approach runs counter to current CMS initiatives to place patients over paperwork. Hospitals should be afforded the flexibility to provide information about these organizations and collaborate with these entities as is appropriate for the patient and based on the patient's goals of care and treatment preferences. We expect that hospitals would be responsive to the patient regarding his or her needs and provide information to the patient about these organizations as well as form collaborative relationships with these entities as appropriate.

This final rule does not mandate a specific methodology for how collaboration between hospitals and community based providers should be conducted nor does it mandate that hospitals (when developing a patient discharge plan) must consider a patient's eligibility for community based services, any patient wait lists for services, or any time frames established by community based providers for the initiation of services. We believe that such detailed mandates would be overly burdensome for hospitals and inappropriate for these regulations. However, as we stated above, we are finalizing a requirement at § 482.43(a)(2) that a hospital include an evaluation of a patient's likely need for appropriate non-health care services and community based care providers, and must also include a determination of the availability of, and the patient's access to, those services as part of the patient's discharge planning evaluation. We encourage hospital personnel to be knowledgeable about the services that are provided by their local community based organizations and expect hospital personnel to be able to offer their patients guidance on how to connect with their local community based organizations. Once a patient is discharged, we would not expect hospitals and CAHs to be responsible for ensuring that a patient has received non-health care services (including home modifications), as this would be outside the scope of a hospital's or CAH's responsibility. Once a patient is connected with a community based organization, such as an ADRC, AAA, or CIL, the responsibility for ensuring that the patient is actually receiving non-health care services, including home modifications, becomes that of the community based organization and the community provider of the services and supports. We also do not believe that hospitals and CAHs should hold patients until physical accessibility issues are resolved, although we understand that sometimes hospitals hold patients until a bed is available at a corresponding PAC facility. Hospitals and CAHs can provide patients with resources regarding supportive housing and home and physical environment modifications including assistive technologies and, where appropriate, medical equipment and supplies, including back-up batteries. We refer readers to further guidance that can be found in the previously provided web links in the discussion on the proposed requirements for § 482.43(c)(5) and on the final requirements for § 482.43(a)(2) of this final rule.

Finally, comments regarding funding for community based organizations are outside the scope of this rule.

*Comment:* Many commenters supported the proposal to require that the discharge plan address the patient's goals of care and treatment preferences. A few commenters asked for clarification on how hospitals will be expected to demonstrate the incorporation of the patient's goals and wishes into the plan. The commenters gave specific examples of instances where patients may leave against medical advice, may be undocumented and not as forthcoming about information, or patients who may be embarrassed about needing social services. The commenters noted that hospitals should try to work with the patients as much as possible and should not be penalized if patients decline medical or discharge planning assistance. One commenter stated that sometimes patient goals and preferences are not consistent with the clinical needs of the patient or the resources available to the patient post-discharge. Therefore, the commenter concluded that the patient's goals and preferences cannot be fully accommodated in the final discharge plan. The commenter recommended that CMS modify the language used in the rule and clarify that the patient's goals and preferences must be considered during the discharge planning process, but that it is ultimately the decision of the practitioner responsible for the care of the patient whether the goals and preferences can be incorporated into the discharge plan.

*Response:* While we are modifying this proposal by finalizing it in the introductory paragraph at § 482.43, we note that we still expect that the patient's goals of care and treatment preferences would be included in the patient's medical records. Similarly, we understand that situations may arise where patients may be uncooperative or may refuse to participate in the discharge planning process. We also expect hospitals and CAHs to document the patient's refusal to participate in the discharge planning process, and that such attempts to incorporate the patient and/or the patient's caregiver in the discharge planning process were made, in the medical record. While we understand the commenter's concerns that a patient's goals of care and treatment preferences might not always align with the practitioner's recommended medical care, we continue to believe that it is important for hospitals and CAHs to develop and implement an effective discharge planning process that focuses on and,