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CMS finalizes rules to improve patient experience with discharge planning and reduce administrative burdens for providers

By Harsh P. Parikh, Megan McGovern, Meghan Hopkins, Jacalyn Smith and Gabriela Illa

Earlier this week, on September 30th, the Centers for Medicare & Medicaid Services (CMS) published two rules that will impact a wide array of Medicare and Medicaid providers: (1) the Revisions to Requirements for Discharge Planning, 84 Fed. Reg. 51836 (Discharge Planning Rule), and (2) the Omnibus Burden Reduction Final Rule, 84 Fed. Reg. 51732 (Burden Reduction Rule).

The Discharge Planning Rule makes key revisions to Medicare conditions of participation (CoP) that hospitals and home health agencies must comply with in order to participate in Medicare and Medicaid. Many of the new regulations implement the 2014 Improving Medicare Post-Acute Care Transformation Act's (IMPACT's) discharge planning requirements. Other regulations seek to improve transition of care, increase a patient's ability to access their health care information, and complement efforts to improve interoperability across the care continuum.

The Burden Reduction Rule purports to eliminate CoPs that CMS views as unnecessary, obsolete, or excessively burdensome to providers. CMS estimates that within the first year of implementation, the Burden Reduction Rule will save providers and suppliers an estimated 4.4 million hours previously spent on paperwork and roughly $800M or $8B over the next ten years—with the largest savings for psychiatric hospitals.

Empowering patients for discharge planning

CMS finalized the Discharging Planning Rule, amending CoPs for hospitals, critical access hospitals (CAHs), and home health agencies (HHAs). CMS aims to allow patients to play a greater role in the discharge planning process. Discharge planning refers to the time when patients are discharged from facilities, often hospitals, into post-acute care (PAC). PAC is often provided by:

- long-term care hospitals;
- inpatient rehabilitation facilities;
- inpatient psychiatric facilities;
- children's hospitals;

- cancer hospitals;
- CAHs; and
- HHAs.

The discharge planning process must focus on patient goals and treatment preferences and include patient caregivers/support person(s) as active partners in the planning. The Discharge Planning Rule requires hospitals and PAC providers to collaborate with patients about their treatment options. Hospitals and HHAs must discharge the patient from acute-care by transitioning or referring the patient to an appropriate PAC provider and transferring any necessary medical information about the patient to both the PAC provider and any other outpatient facility, practitioner, or agency that participates in the patient's follow up care.

The new regulations require hospitals and HHAs to assist patients, their families, or their representative in selecting a PAC service provider that best reflects the patient's treatment preferences. Hospitals and HHAs must share relevant and applicable data about PACs with the patient, including quality and resource metrics. Providers must make reasonable efforts to use the PAC data that is currently available to them until all the measures stipulated in the IMPACT Act are finalized and publicly reported. CMS will publish sub-regulatory interpretive guidance to assist providers in complying with these new requirements.

Notably, the finalized regulations are less onerous than the agency's initial proposal. For instance, CMS had initially proposed to require a discharge plan for all inpatients and many categories of outpatients, including all patients with same-day surgeries where anesthesia or moderate sedation was used. Instead, CMS chose to give providers significant flexibility in designing their discharge planning process. Under the final rule, a hospital's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning. The hospital must provide a discharge planning evaluation for patients with a discharge need, at the request of a patient or patient representative and at the request of a patient's physician.

The Discharge Planning Rule also requires hospitals to provide patients access to their medical records, including electronic records, upon an oral or written request. Hospitals must produce records in the requested form and format if it is readily producible in such form and format. The new CoP mandate that the hospital "must not frustrate the legitimate efforts of individuals to gain access to their own medical records." Rather, the hospital "must actively seek to meet these requests as quickly as its record-keeping system permits."

Patients over paperwork—eliminating administrative burdens for Medicare providers and suppliers

As part of CMS's "Patients Over Paperwork" initiative, the Burden Reduction Rule finalizes the provisions of three distinct proposed rules (the Proposed Rules).[1] Each of the Proposed Rules included reforms to remove CoP that were identified as unnecessary, obsolete, or excessively burdensome on hospitals and other participating health care providers. For administrative

[1] Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, 83 Fed. Reg. 47686 (Sept. 20, 2018); Fire Safety Requirements for Certain Dialysis Facilities, 81 Fed. Reg. 76899 (Nov. 4, 2016); Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, 81 Fed. Reg. 39447 (June 16, 2016).

efficiency and to promote transparency, CMS combined the three separate Proposed Rules into the singular Burden Reduction Rule.

Generally, the Burden Reduction Rule focuses on improving patient care, eliminating burdensome rules, and eradicating duplicative regulations. For instance, the final rule eliminates the onerous data submission requirements associated with Medicare re-approval for organ transplant centers, which CMS found resulted in some transplant programs potentially avoiding performing transplants for certain patients, causing some organs to be discarded.

The Burden Reduction Rule also permits multi-hospital systems to have unified and integrated Quality Assessment and Performance Improvement (QAPI) and infection control and antibiotic stewardship programs for all of their member hospitals, in contrast to the current regulations that require each Medicare-certified hospital to develop and maintain such programs individually. According to CMS, such changes to the regulations will make it easier for hospitals to implement best practices across facilities, resulting in quicker improvements to quality of care, in addition to allowing rural hospitals to draw from the resources and clinical expertise of a larger hospital system. The Burden Reduction Rule also removes the requirement that a hospital's medical staff must attempt to secure autopsies in all cases of unusual deaths and deaths of medical-legal and educational interest. In addition, under the final rule, hospitals (and other facilities with the exception of longer-term care facilities) are required to review their emergency preparedness plans on a biannual basis, rather than the current annual requirement.

For psychiatric hospitals, CMS is also clarifying that the use of non-physician practitioners and doctors of medicine or osteopathy (MD or DO) are permitted to document progress notes for patients receiving services in a psychiatric hospital.

Further, the Burden Reduction Rule reduces the frequency with which providers are required to review their policies and evaluate their facilities. For instance, the requirement for rural health clinics (RHCs) and federally qualified health centers (FQHCs) to conduct an annual review of patient care policies and facility evaluations has been reduced to every two years. The final rule also lessens the reporting burden of community mental health centers by requiring that they maintain 30-day comprehensive assessments only for those patients who receive partial hospitalization services, as opposed to all patients. According to CMS, this change will increase the amount of time clinicians are able to spend with patients and thereby improve health outcomes.

With respect to ambulatory surgical centers (ASCs), the Burden Reduction Rule removes the requirement that all ASCs either have a written transfer agreement in place with a hospital that meets certain Medicare requirements or ensure that all physicians performing surgery in the ASC have admitting privileges at a hospital that meets certain Medicare requirements. While ASCs will still be required to maintain effective procedures for immediate transfers of patients requiring emergency care beyond its capabilities, periodic notice to a local hospital that outlines the ASC's operations and patient population, as opposed to a formal written transfer agreement, will meet the regulatory requirements set forth in the Burden Reduction Rule. In addition, the final rule removes the current requirement that ASCs perform a comprehensive medical history and physical assessment (H&P) on all patients no more than 30 days prior to a scheduled surgery. Under the amended regulations, ASCs will be permitted to establish and implement a policy that identifies the types of patients that require an H&P prior to surgery.

The Burden Reduction Rule also purports to reduce the administrative burden for home health agencies, hospices, comprehensive outpatient rehabilitation facilities, portable x-ray services, critical access hospitals, dialysis facilities, and religious nonmedical health care institutions.

The changes implemented by the two rules become effective on November 29, 2019.

For more information on the content of this alert, please contact your Nixon Peabody attorney or:

- Harsh Parikh at **hparikh@nixonpeabody.com** or 213-629-6108
- Megan McGovern at **mmcgovern@nixonpeabody.com** or 617-345-1179
- Meghan Hopkins at **mhopkins@nixonpeabody.com** or 401-454-1047
- Rebecca Simone at **rsimone@nixonpeabody.com** or 516-832-7524
- Valerie Breslin Montague at **vbmontague@nixonpeabody.com** or 312-977-4485
- Jill H. Gordon at **jgordon@nixonpeabody.com** or 213-629-6175
- Stephen D. Zubiago at **szubiago@nixonpeabody.com** or 401-454-1017
- Philip Rosenberg at **prosenberg@nixonpeabody.com** or 518-427-2709