

Discharge planning evaluations required for Medicare Advantage inpatient authorization requests, starting Nov. 9

Effective discharge planning is an important component of a safe and successful transition from an inpatient hospital stay to the appropriate post-discharge setting. Discharge planning should begin early in the hospitalization, preferably upon admission, and be reassessed as the member's clinical condition and post-discharge needs change.

Starting Nov. 9, 2026, providers submitting an authorization request for an acute inpatient medical and surgical (non-behavioral health) admission for a Medicare Plus BlueSM or BCN AdvantageSM member will be required to include the member's discharge planning evaluation along with the clinical information required for the request.

A discharge planning evaluation typically includes:

- Anticipated discharge disposition and date
- Clinical needs: Medications, therapies, equipment and follow-up care
- Functional needs: Impairments, mobility, ADLs and caregiver support
- Social needs: Home environment/modifications, safety, community resources and transportation
- Service availability: Assessment of post-acute services, local providers and access barriers

For additional information, refer to the Centers for Medicare & Medicaid Services hospital Conditions of Participation [42 CFR § 482.43, Condition of Participation: Discharge Planning](#).

Our provider manuals and the document [Submitting acute inpatient authorization requests - Frequently asked questions for providers](#) will be updated to reflect this change.

[Subscribe](#) to Provider Alerts Weekly, a weekly email with a list of links to the previous week's provider alerts.