December 21, 2015

Submitted Electronically

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies proposed rule [CMS-3317-P]

Dear Mr. Slavitt:

LeadingAge appreciates the opportunity to comment on this proposed regulation. The members of LeadingAge and affiliates touch the lives of 4 million individuals, families, employees and volunteers every day. The LeadingAge community (www.LeadingAge.org) includes 6,000 not-for-profit organizations in the United States, 39 state partners, hundreds of businesses, research partners, consumer organizations, foundations and a broad global network of aging services organizations that reach over 30 countries. The work of LeadingAge is focused on advocacy, education, and applied research. We promote home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, continuing care communities, nursing homes as well as technology solutions and person-centered practices that support the overall health and wellbeing of seniors, children, and those with special needs.

LeadingAge is pleased CMS is proposing to revise the current requirement at §482.43(a), that would require the discharge planning process to apply to all inpatients, as well as certain categories of outpatients, including, but not limited to patients receiving observation services, patients who are undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used, emergency department patients who have been identified by a practitioner as needing a discharge plan, and any other category of outpatient as recommended by the medical staff, approved by the governing body and specified in the hospital's discharge planning policies and procedures. To reduce both readmission rates and adverse events, hospitals must improve the effectiveness of transitions of care in which they play a role.

We also support CMS on their proposal to re-designate §482.43(b)(4) as §482.43(c)(5) to require, that as part of identifying the patient's discharge needs, the hospital consider the availability of caregivers and community-based care for each patient, whether through self-care, follow-up care from a community-based providers, care from a caregiver/support person(s), care from post-acute health care facilities or, in the case of a patient admitted from a long-term care or other residential care facility, care in that setting.

LeadingAge is pleased CMS proposes to re-designate and revise the requirements of current § 482.43(c)(6) through (8) at new §482.43(f), "Requirements for post-acute care services" to include that for patients who are enrolled in managed care organizations, the hospital must make the patient aware that they need to verify the participation of HHAs or SNFs in their network. However, we believe the requirement; "If the hospital has information regarding which providers participate in the managed care organization's network, it must share this information with the patient…" does not go quite far enough in assuring adequate discharge information.

RECOMMENDATION: LeadingAge recommends Hospitals be required to provide information to the patient regarding which providers participate in their managed care organization's network.

The patient or their caregiver/support persons must be informed of the patient's freedom to choose among providers and to have their expressed wishes respected, whenever possible. The final component of the retained provision would be the hospital's disclosure of any financial interest in the referred HHA or SNF.

RECOMMENDATION: In order to promote a person-centered discharge plan, it would be advantageous to encourage hospitals to notify patients of specialized programs offered by post-acute providers that may benefit the patient. For example, some home health agencies have specialized programs to care for individuals with CHF, COPD, and wound care. Also, in order to promote a person-centered discharge plan, CMS should encourage hospitals to notify patients of any post-acute providers that have a specific cultural expertise. For example, if a patient only speaks Cantonese, it would benefit the patient if the staff of the post-acute provider had staff that also speak Cantonese, as well as have an understanding of cultural preferences.

We provide comments below on sections of the proposed rule: **Discharge Planning Process (Proposed § 482.43(c)); Discharge Planning Process (Proposed § 484.58(a)); ICRs Regarding Home Health Discharge Planning (§ 484.58)**

ISSUE # 1: CMS anticipates that implementation of this proposed rule will cost HHAs in aggregate $34 million to develop a discharge planning process and $283 million annually to develop and send the discharge summary. CMS estimates that compliance with the Discharge or transfer summary content requirement would require 10 minutes per patient. Of those 10 minutes, CMS estimates that 2 minutes would be covered by a physician, 3 minutes by a social worker ($52/hourly), and 5 minutes by an RN. The average estimated annual cost for an HHA would be approximately $21,710 per HHA.

COMMENT: We do not agree with the estimated implementation costs because of the volume of information proposed at § 484.58(b) in the new standard, "Discharge or transfer summary content. Even though most of this information is currently being collected, it is unrealistic to believe the nurse and social worker will not need to make additional calls to the physician, hospital and family/caregiver that will require more than 10 minutes of additional staff time.

Taking into consideration there are 18 million annual HHA patient discharges, the anticipated cost of implementation is too low.

RECOMMENDATION
LeadingAge recommend CMS revisit and revise their estimated implementation costs to reflect the additional time that will be needed to be in compliance with this regulation.

ISSUE #2 Discharge Planning Process (Proposed § 482.43(c)) CMS proposes a new requirement at § 482.43(c)(8) to require that hospitals assist patients, their families, or their caregiver's/support persons in selecting a PAC provider by using and sharing data that includes but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. Furthermore, the hospital would have to ensure that the PAC data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. CMS also expects the hospital to document in the medical record that the PAC data on quality measures and resource use measures were shared with the patient and used to assist the patient during the discharge planning process.

CMS notes that quality measures are defined in the IMPACT Act as measures relating to at least the following domains: Standardized patient assessments, including functional status, cognitive function, skin integrity, and medication reconciliation; by contrast, resource use measures are defined as including total estimated Medicare spending per individual, discharge to community, and measures to reflect all-condition risk-adjusted preventable hospital readmission rates. Accordingly, this proposed rule does not address or include further definition of these terms, which will be addressed and established in forthcoming regulations or other issuances. However, CMS advises providers to use other sources for information on PAC quality and resource use data, such as the data provided through the Nursing Home Compare and Home Health Compare Web sites, until the measures stipulated in the IMPACT Act are finalized. Once these measures are finalized, providers will be required to use the measures as directed by the appropriate regulations and issuances.

COMMENT: 45 statewide health data organizations collect all-payer hospital data, and six communities have aggregated data from multiple sources for the Centers for Medicare & Medicaid Services (CMS) Better Quality Information project. There are no standardized resource use measurement that could be used. Little is known about the validity of resource use measures or the advantages and disadvantages of different measures. Only a few resource use measures (length of stay and readmission measures) have been endorsed by the National Quality Forum (NQF). Charges or estimated costs associated with specific services are sometimes presented as resource use measures, although these measures may be distorted by cost shifting, anticompetitive behavior, differences in quality, and a variety of other manifestations of market failure.[1]

[1] Selecting Quality and Resource Use Measures: A Decision Guide for Community Quality Collaboratives Prepared for: Agency for Healthcare Research and Quality U.S. Department of Health and Human Services, p. 44-47. Online

LeadingAge recognizes there are no specifications related to resource use measurement, but has significant concerns as to how such would be determined for post-acute providers, including Home Health. Specific information related to risk adjustment, and avoidance of "double counting" services will be critical to ensure valid data collection.

RECOMMENDATION
LeadingAge recommends the requirement to include resource use measures be postponed until accessible, accurate data is available to acute and post- acute providers.

We also recommend CMS instruct hospitals to provide the patient with PAC data on quality measures that are relevant and applicable to the patient's goals of care and treatment preferences, and not just give the SNF or Home Health Star rating.

ISSUE #3 Discharge Planning Process (Proposed § 484.58(a)) For those patients transferred to another HHA or who are discharged to a SNF, IRF, or LTCH, CMS proposes to require the HHA assist patients and their caregivers in selecting a PAC provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. CMS would expect the HHA would be available to discuss and answer patient and caregiver's questions about post-discharge options and needs. Furthermore, the HHA must ensure the PAC data on quality measures and data on resource use measures are relevant and applicable to the patient's goals of care and treatment preferences.

COMMENT: We understand the IMPACT Act requires HHAs to take into account data on quality measures and resource use measures during the discharge planning process. It is important to note that individuals who are dually eligible for Medicare and Medicaid may benefit from long-term services and supports, such as adult day services, home care, and meal programs that are, in many states, included in Medicaid waivers for service In most states, there is no available public quality data on these types of services.

RECOMMENDATION
LeadingAge recommends CMS not include the requirement to provide data on quality measures and data on resource use measures for non-PAC providers at this time.

---

at http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/perfmeasguide/perfmeas.pdf

ISSUE # 4 Discharge Planning Process (Proposed §482.43(c)) "CMS proposes to re-designate §482.43(b)(4) as §482.43(c)(5) to require, that as part of identifying the patient's discharge needs, the hospital consider the availability of caregivers and community-based care for each patient, whether through self-care, follow-up care from a community-based providers, care from a caregiver/support person(s), care from post-acute health care facilities or, in the case of a patient admitted from a long-term care or other residential care facility, care in that setting."

COMMENT: LeadingAge is pleased CMS is requiring hospitals to identify the availability of caregivers and community-based care. The supply of family caregivers is unlikely to keep pace with demand to assist the growing number of frail older people in the future. We believe CMS needs to work closely with the Administration for Community Living to improve the quality of information on long term services and support options available in the community. Hospitals should be required to give contact information that includes the local Aging and Disability Resource Center, and Area Agency on Aging to patients being discharged. Many states have waiting lists for Medicaid services, so it is important for hospitals to provide information on other possible sources of long-term services and supports, such as the Veterans Health Administration long term care services for adult day services, home health and nursing homes, as well as services provided through Older Americans Act programs and State funded long term services and supports. A patient on Medicare and Medicaid that continues to require comprehensive skilled care may benefit from a Program of All Inclusive Care for the Elderly. It would be important for the hospital to provide information on PACE. Hospitals need to identify individuals eligible for Medicaid and Medicaid long term services and supports.

RECOMMENDATION
LeadingAge recommends that CMS expand the requirements for hospitals to identify the availability of caregivers and community based providers to include eligibility for Medicaid and Medicaid services, PACE and services through the Veterans Administration.

ISSUE #5 Transfer of Patients to Another Health Care Facility (Proposed § 482.43(e))
Electronic health records could simplify the process of extracting necessary information when a resident is transferred to a nursing home and electronic Continuity of Care documents provide a standardized way to exchange critical information between providers. CMS is saying that using certified health IT, facilities can ensure that hospitals are transmitting interoperable data that can be used by other settings, supporting a more robust care coordination and higher quality of care for patients.

COMMENT: On pages 68136 – 68137 of the Preamble, CMS stresses the importance of electronic health records to simplify the process of extracting necessary information when a resident is transferred to a nursing home.

LeadingAge agrees that EHRs and the use of Certified Health IT support better transitions of care and facilitate the process of providing standardized documentation and the exchange of critical information to meet post-hospitalization goals, support continuity in care, and reduce the likelihood of hospital readmission. CMS also maintains that facilities electronically capturing information should be doing so using certified health IT that will enable real time electronic

exchange with the receiving provider and advises that the Agency intends to align the required data elements with the common clinical data set published in the ‘‘2015 Edition of Health Information Technology (Health IT) Certification Criteria, Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications’’ October 16, 2015 Final Rule. CMS’ stated intent is to “…recognize the advent of electronic health information technology and to accommodate and support adoption of ONC certified health IT and interoperability standards.”

While CMS is not requiring a certain form or format for the exchange of critical information, we remind CMS that the existing certification programs are geared to Meaningful Use incentives for eligible hospitals and eligible providers. Thus we encourage HHS to accelerate the development of a modular certification program for long-term and post-acute care providers. We also would like to point out that increased use of EHRs eligible providers, as well as non-eligible providers who have the resources and invested in this technology, puts smaller, non-affiliated and particularly rural providers at a significant disadvantage. We urge CMS and ONC to consider ways to encourage the adoption and use of these tools by such providers to prevent this digital gap from further increasing.

RECOMMENDATION

LeadingAge recommends accelerating the development of a modular certification program for long-term and post-acute care providers. We also recommend CMS consider ways to encourage the adoption and use of these tools by rural and frontier providers to prevent this digital gap from further increasing.

Again, LeadingAge appreciates the opportunity to comment on this proposed rule. We look forward to our continued work with you on this and related issues.

Sincerely,

Cheryl Phillips, MD

Senior VP Public Policy and Advocacy