January 4, 2016

VIA ELECTRONIC SUBMISSION

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8016

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

The Medicare Rights Center (Medicare Rights) is pleased to submit comments on the proposed Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (NPRM).[1] Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over two million Medicare beneficiaries, family caregivers, and professionals.

The following comments are informed by our experience working with Medicare beneficiaries and their families, particularly callers to our national helpline seeking assistance following a hospital inpatient or outpatient stay. We often hear from beneficiaries uninformed or confused about when a hospital discharge will occur, where the beneficiary will be discharged and why, and what care plan follows from a hospital stay.

Given this, we are supportive of the goals and design of the proposed rule. The NPRM updates discharge planning requirements for hospitals, critical access hospitals, and home health agencies, in accordance with the Improving Medicare Post Acute Transformation Act (IMPACT) Act of 2014. We strongly support the proposed rules' emphasis on the following:

- Promoting person-centered care and incorporating patient-directed goals and preferences;
- Providing instructions and information for patients and caregivers at discharge;
- Facilitating access to information for those with diverse language and access needs;
- Strengthening collaborations with community-based organizations; and
- Meeting the psychiatric and behavioral health needs of beneficiaries

We expect that implementing the requirements outlined in the NPRM will require hospitals, critical access hospitals, and home health agencies to spend additional resources. We urge CMS to be sensitive to the varying

[1] Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies [CMS-3317-P] 42 CFR Parts 482 484 485 (referenced hereafter as NPRM)

capacities and financial resources available to these entities and to the potential for competing requirements under CMS demonstration projects or State Medicaid standards. Wherever possible, we urge CMS to ensure consistency among programmatic requirements and to minimize administrative burdens. We believe this sensitivity is necessary to ensure the person-centered discharge planning processes outlined in the NPRM are implemented.

We agree with CMS' assertion that improved discharge planning will benefit people with Medicare, possibly leading to reductions in morbidity and mortality and improved health outcomes. Well-planned and executed discharge procedures may also diminish the potential for hospital readmissions. [2] Among our clients, we can point to examples where a poorly managed discharge contributed to less than ideal outcomes for the beneficiary. As additional data is made available, including that mandated by the IMPACT Act, we encourage CMS to update the discharge planning protocols outlined in the NPRM.

Below we provide detailed comments on specific policies in the proposed rule. For additional information, please contact Casey Schwarz, Senior Counsel for Education and Federal Policy, at CSchwarz@medicarerights.org or 212-204-6271 and Stacy Sanders, Federal Policy Director, at SSanders@medicarerights.org or 202-637-0961. Thank you for the opportunity to provide comments.

Hospital Discharge Planning

1. Design Proposed: The NPRM requires that hospital leadership, medical, nursing, and any other pertinent staff members contribute to the development of a hospital's discharge planning process. We support this proposal as well as the requirement that the process be specified in writing and regularly reviewed.[3]

2. Applicability: The NPRM proposes that the required discharge planning process apply to all inpatients and to patients receiving observation services (outpatients), 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 outpatient category identified by the hospital. We strongly support CMS' proposal to ensure discharge planning procedures apply to hospital inpatients as well as the identified outpatients and the flexibility provided to hospitals to identify at-risk individuals in need of such supports.[4]

3. Discharge Planning Process: We agree with the discharge planning process outlined in the NPRM. In particular, we strongly support the following elements of the discharge planning process:

- Developing a plan that is "tailored to the unique goals, preferences, and needs" of the patient;
- Accommodating patients with diverse language and access needs;
- Ensuring a registered nurse, social worker, or other qualified professional manage the discharge process;
- Identifying patients who require a discharge plan early on during their hospital stay;
- Completing discharge planning before a patient leaves the hospital setting;
- Involving the practitioner responsible for the patient's care in the discharge planning process;
- Encouraging partnerships with community-based organizations; and
- Engaging and informing the patient and informal caregivers about the discharge plan

[2] NPRM, pgs. 68150 - 68151
[3] NPRM, pg. 68130
[4] Id.

In particular, we applaud CMS' expectation that hospitals have knowledge of community-based resources, particularly the services provided by Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and Centers for Independent Living (CILs). We encourage CMS, working alongside the Administration for Community Living (ACL), to provide support and technical assistance to hospitals, critical access hospitals, and home health agencies to develop and reinforce the collaborative partnerships referenced in the proposed rule and to ensure efficient information sharing.

Additionally, we strongly support revised requirements concerning how hospitals engage and inform patients and their informal caregivers in discharge planning. We strongly support CMS' assertion that the discharge plan should incorporate and document the patient's input and goals. Further, we agree that hospitals should assist patients with identifying a post-acute care setting and should reference available resource use and quality measures as part of a documented decision-making process with patients.[5]

4. Discharge to Home: The NPRM proposes to re-designate and revise current requirements to ensure individuals discharged to their home or community residence receive discharge planning services. We agree with the proposed revision. In addition, we agree that discharge instructions should be provided to the patient or caregiver and to the primary care physician, hospice, and/or home health agency if post-acute care services are referred. We also believe these discharge instructions should be provided to, and developed in collaboration with, the individual's managed care organization, particularly one that delivers long-term services and supports in the home.

We agree with CMS that hospitals should carefully develop the discharge instructions and employ best practices, such as the referenced "teach-back" method, to ensure that beneficiaries understand the instructions. Further, we support the elements that CMS suggests must be included, including care instructions, warning signs and symptoms, prescriptions and medication information, medication reconciliation, and follow-up appointments.[6]

These revisions are in accordance with the Caregiver Advise, Record and Enable (CARE) Act (2015), recently enacted legislation in New York that requires hospitals to allow an individual to formally designate a caregiver before he or she is discharged home or to another facility.[7] The CARE Act also requires hospital workers to provide the designated caregiver with instruction or training on how to perform tasks for the individual at home. Similar laws have passed in several states, including California, Connecticut, Maine, and Virginia, and we are supportive of revisions that reflect CARE Act laws.

Finally, we support the proposed requirement that hospitals develop a post-discharge follow-up process, utilizing low-cost technology (like telephone call programs) and other tools. We appreciate that CMS is allowing hospitals flexibility to tailor these post-discharge follow-up processes to meet specific patient needs, though we agree that hospitals should necessarily engage in a follow-up process with their most vulnerable patients.

To the extent that these requirements, conversations, and plans duplicate existing plans created by the beneficiary, their family members and their primary care and other community providers, we encourage CMS to provide hospitals with the flexibility to supplement and support these existing plans, rather than replacing them.

5. Transfer of Patients to Another Healthcare Facility: Like CMS, we believe that a transfer from a hospital to another care facility represents a critical moment in the trajectory of a patient's care and, when mismanaged, may

[5] NPRM, pg. 68130-68133
[6] NPRM, pg. 68133
[7] S.676B/A.1323B, available at https://www.nysenate.gov/legislation/bills/2015/s676

result in beneficiary harms and/or poor outcomes. As such, we support the minimum information requirements outlined by CMS in the NPRM for hospitals to provide when a patient is transferred. We encourage CMS to also ensure that hospital patients being transferred (and their caregivers) have ready access to information on how to contact their State Health Insurance Assistance Program (SHIP), the Medicare Ombudsman, and local legal services and other community-based resources.

6. Requirements for Post-Acute Care Services: We strongly support CMS' proposal to ensure that hospitals communicate with managed care enrollees about the need to verify that their post-acute provider is in-network. Also, we applaud CMS for requiring that hospitals provide beneficiaries with a list of in-network post-acute providers when that list is "readily available" to the hospital. We encourage CMS to define "readily available" to ensure that, for example, availability on plan websites is considered "readily available."

It is our understanding that, in some cases, managed care organizations, including Medicare Advantage plans and Medicaid managed care plans, may be in the best position to provide up-to-date information on the network status of post-acute providers or facilities. As such, we would also support CMS' exploration of strategies that would facilitate information sharing between hospitals and managed care plans in these instances.

Additionally, we encourage CMS to ensure that hospitals, community-based providers, and managed care organizations work together to create a seamless transition as individuals are discharged from the hospital to a post-acute care setting. Some managed care organizations, in particular those that manage care for dually eligible individuals, receive a capitated payment to perform care coordination and case management. As such, managed care organizations must be an integral part of the discharge planning process; hospitals should contact an individual's health plan and ensure that the plan is involved in the discharge planning process.

<u>Home Health Agency (HHA) Discharge Planning</u>

1. Discharge Planning Process: We agree with the discharge planning process outlined in the NPRM. In particular, we strongly support the following elements of the discharge planning process:

- Identifying "goals, preferences, and needs" as part of each patient's discharge plan;
- Accommodating patients with diverse language and access needs;
- Considering patient capacity and the availability of informal caregivers;
- Involving the physician responsible for the home health care plan in the discharge planning process; and
- Using resource use and quality measures in decision-making about transfers to another HHA or facility

2. Discharge or Transfer Summary Content: We support the minimum information requirements outlined in the NPRM for HHAs to provide when a patient is transferred. As noted above, we also encourage CMS to ensure that patients transferred from HHAs (and their caregivers) have ready access to information on how to contact their SHIP, the Medicare Ombudsman, and local legal services and other community-based resources. Additionally, as patients are transferred from HHAs to other settings, we encourage CMS to ensure that HHAs coordinate with managed care organizations, particularly those that deliver long-term services and supports through Medicaid.

<u>Critical Access Hospital (CAH) Discharge Planning</u>

We support the establishment of discharge planning rules as a Condition of Participation (CoP) for CAHs. The general requirements, as consistent with our comments above, are ones we support. Given existing burdens and

resource constraints on CAHs, however, we encourage CMS to work closely with CAHs and consumer advocates who serve rural areas to develop the detailed rules and processes for implementation.