January 4, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
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:

The New Jersey Hospital Association (NJHA) represents more than 400 providers across the continuum of care including acute care hospitals, inpatient rehabilitation hospitals, long term care hospitals, home health agencies and skilled nursing facilities. The Health Research and Educational Trust (HRET) is NJHA's 501(c)(3) and has been awarded hospital engagement network contracts with CMS since 2012 to focus on quality improvement initiatives designed, in part, to improve transitions of care through effective discharge planning. We acknowledge that CMS has proposed these changes to implement discharge-related provisions of the Improving Medicare Post-acute Care Transformation (IMPACT) Act of 2014 and that CMS has also proposed changes to the skilled nursing facility requirements for transitions of care and comprehensive person-centered care planning in its proposal issued in July 2015 (42 CFR Parts 405, 431, 447, 482, 483, 485, and 488 [CMS–3260–P] RIN 0938–AR61 Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities; Proposed Rule) that are also designed to implement the discharge-related requirements included in the IMPACT Act.

NJHA believes that discharge planning with a greater focus on patient-centered care is essential to

ongoing improvement in key quality measures including preventable hospitalizations, adherence to medication regimens, falls with injury, infection prevention, pressure ulcer prevention and a range of other measures of concern to the Medicare beneficiary population in particular. Overall, NJHA agrees with CMS' goal for all providers (hospital, SNF and home health agencies) to have a comprehensive, data-driven, interdisciplinary, patient-centered approach to discharge planning. Many of our members across the continuum have already incorporated many of the practices CMS has included in this rule proposal.

In addition, legislation took effect in New Jersey in 2015 (The Caregiver, Record, Enable (CARE) Act) that was the result of collaboration between AARP, the Health Care Quality Institute of NJ, NJHA and the NJ Legislature to improve patients' and caregivers' experiences during hospitalizations and in the process of discharge planning and transitions of care.

NJHA believes that implementation of some aspects of the rule as proposed will require staff education, changes in policies and procedures, modifications of electronic health records systems and potentially the addition of staff. It is essential that all providers, including SNFs, are required to be compliant at the same time once this rule is finalized. Since the SNF requirements will be made effective through the revisions to the SNF conditions of participation proposed in July 2015, NJHA requests that CMS consider an effective date that aligns for all providers. In addition, NJHA respectfully recommends that CMS consider permitting existing State statute governing the acute care discharge planning process to satisfy key elements of the rule once it is finalized so that hospitals under the State statute are not in the position of duplicating effort to meet different state and federal standards.

For example, New Jersey's statute requires general acute care hospitals (not IRFs or LTCHs) to:

- Provide each patient with the opportunity to designate at least one caregiver
- Document the request in the patient's record and, if a caregiver is designated, to record their name, phone and address in the patient's record
- Request written consent to release medical information to a designated caregiver in compliance with federal and state law
- Notify the designated caregiver of a patient's discharge or transfer as soon as possible, and in any event, upon discharge order by a physician. Attempts to contact the designated caregiver must be documented in the patient's record. The lack of contact with the designated caregiver shall not delay discharge.
- Consult with the designated caregiver to develop the discharge plan and provide the discharge plan that describes after-care needs, if any, at the patient's residence. This is not required if the patient is being discharged to a rehabilitation hospital, hospital, SNF, assisted living facility or group home.
- Include in the discharge plan the name and contact information for the caregiver, contact information for any health care, community resources and/or long term services and supports needed and contact information for a hospital employee who can respond to questions after instructions are provided.
- Instruct the designated caregiver in all after-care assistance tasks through in-person or video technology. This is must include a demonstration of the tasks, an opportunity for the caregiver to ask questions and receive answers. The instruction must be documented in the patient's medical record.

As noted above, the New Jersey statute does not apply to patients in observation status or to those who are being discharged to an IRF, LTCH, SNF, assisted living facility or group home. NJHA respectfully recommends that CMS reconsider applying the requirement for a full discharge evaluation and plan to outpatients, including those in observation status, same-day patients, emergency department patients. Instead, we would recommend that these patients should receive a complete set of discharge instructions with a standard set of information including: instruction on post-discharge care at home, warning signs for the need to seek immediate care, medications required after discharge, medication reconciliation, and written instructions for follow-up care and referrals. In addition, NJHA believes that since patients who

are being discharged to a facility will be involved in extensive assessment and care planning, hospitals should only need to provide a discharge evaluation and instructions related to the setting of care to which the patient is being discharged, rather than an actual discharge plan as described in the rule proposal. We concur with the American Hospital Association's recommendation related to the standard for discharge planning process, as listed below:

482.43 (c) *Standard: Discharge planning process.* The hospital's discharge planning process must ensure that the discharge goals, preferences, and needs of each patient are identified and result in the development of:

(1) a discharge plan for each inpatient; and
(2) either a discharge plan or discharge instructions, as determined by the practitioner responsible for the care of the patient and in accordance with medical staff policies and procedures, for applicable patients identified in (b)(2) through (b)(5) of this section.

482.43(d)(2):
(d)(2) The discharge instructions must include, but are not limited to, the following:

(i) Instruction on post-hospital care to be used by the patient or the caregiver/support person(s) in the patient's home;

(ii) Written information on warning signs and symptoms that may indicate the need to seek immediate medical attention. This must include written instructions on what the patient or the caregiver/support person(s) should do and who they should contact if these warning signs or symptoms present;

(iii) Prescriptions and over-the counter medications that are required after discharge, including the name, indication, and dosage of each drug, along with any significant risks and side effects of each drug as appropriate to the patient;

(iv) Reconciliation of all discharge medications with the patient's prehospital admission/registration medications (both prescribed and over-the-counter), if applicable; and

(v) If applicable, written instructions in paper and/or electronic format regarding the patient's follow-up care, appointments, pending and/or planned diagnostic tests, and pertinent contact information, including telephone numbers, for any practitioners involved in follow-up care or for any providers/suppliers to whom the patient has been referred for follow-up care.

COMMUNITY RESOURCES

NJHA respectfully requests that CMS clarify in the final rule that compliance with the new standards will be evaluated within the context of a provider's community resources. Successful discharge planning often involves collaboration with or use of community resources, although many communities have limited resources in terms of affordable, appropriate, supportive housing and other services. Our members across the continuum face difficult circumstances when their patients require behavioral health services at the time of discharge. It is especially difficult for hospitals to discharge patients with behavioral health needs to a post-acute care setting.

The rule would likely require hospitals to add social workers to their staffs to handle the increase in the number of patients required to have a discharge plan. CMS recently acknowledged a possible limitation of social workers in its proposed rule updating the requirements for long-term care facilities. CMS must consider these types of shortages as it finalizes the rule for discharge planning. At the very least, CMS should allow for flexibility with regard to the "other personnel" who may coordinate and develop the discharge plan, allowing hospitals to outline the qualifications based on patient needs and knowledge of community resources.

PATIENT-CENTEREDNESS

We agree with CMS' framework for establishing a discharge planning process that focuses on the patient's goals and preferences and prepares patients to be active partners in post-discharge care. This includes, for example, developing discharge plans with the patient's input, discussing the evaluation results with the patient, informing them of the final plan, taking their preferences and needs into account when arranging post-acute care, and more.

We believe that providers will be successful in engaging most patients and incorporating their preferences into a discharge plan. In the final rule, however, we urge CMS to provide clarification about how the agency will expect hospitals and home health agencies to demonstrate the incorporation of the patient's goals and wishes into the plan. In addition, we ask CMS to address the fact that some patients may be reluctant to participate in the process for a variety of reasons. For example, sometimes a patient may leave against medical advice. In addition, many of our hospitals treat undocumented patients who may be guarded as to identity, residence and next of kin. Other times, patients may feel embarrassed to admit they need social services. In these situations, hospitals should try to work with patients as much as possible but should not be penalized if patients prefer more privacy or decline medical or discharge planning assistance. Hospitals must always provide safe care and also treat patients in a way that will not deter them from seeking needed care in the future.

TIMING OF DISCHARGE PLAN EVALUATION AND COMPLETION

CMS proposes that hospitals must begin to identify discharge needs for patients within 24 hours after admission/registration. **We respectfully recommend that CMS consider changing this provision.** We agree that the discharge planning should occur in a timely manner and should be an ongoing process that occurs concurrently with, and not after, the provision of inpatient care. However, while this provision is well-intentioned, we do not support it for the following reasons:

- Some hospitals, especially IRFs and LTCHs, would have trouble meeting this requirement due to staff and resource limitations;
- The 24-hour timeframe does not make sense for patients with longer stays, such as long-term care hospital (LTCH) patients whose average length of stay is 25 days and inpatient rehabilitation facility (IRF) patients, who have an average length of stay of 13 days;
- Certain patients, such as solid organ transplant patients, burn patients or trauma patients, have long stays;
- Occasionally it will be challenging for hospitals to begin discharge planning for certain patients who may arrive unconscious or confused when no caregiver or support person is present; and

- For inpatient psychiatric patients, an interdisciplinary team meeting to coordinate the patient's care may take place soon after a patient is admitted. This team meeting could be the most ideal point in which to begin assessing discharge needs, but it may not take place within 24 hours.

NJHA recommends that CMS finalize the proposed language stating that the discharge planning process should be completed in a timely manner but strike the wording related to a universal 24-hour requirement. Instead, CMS could incorporate this timeframe as a strong expectation in the interpretive guidance and give providers, as well as CMS surveyors, the flexibility to use their best judgment as to what is necessary and practical in a particular case. For example, a hospital compliance survey could include a review of discharges to determine whether the planning process is generally initiated in a timely way or whether the provider's policies and procedures unduly delay patient discharges too often.

We urge CMS to make it easier to comply with this proposed standard by identifying some of the types of activities and information collection that would meet its intent. Specifically, CMS could provide examples in the final rule of efficient mechanisms to collect what it believes are the most relevant types of data. For example, CMS could explain how the identification of discharge needs could begin as part of an initial nursing assessment.

Finally, we ask CMS to clarify in the final rule that, while the discharge planning process must not *unduly* or *unnecessarily* delay a patient's discharge, sometimes the plan does reasonably postpone a patient's discharge. For example, hospitals may need to keep a patient until a bed becomes available in another facility. In addition, an ED practitioner may ask for a discharge plan in accordance with proposed 482.43(b)(4). The practitioner, however, may request the discharge plan at the conclusion of addressing the patient's medical needs, at which point the staff would need time to conduct an evaluation and create a plan. Further, emergency care may be provided in the middle of the night, when coordination with social service agencies may be difficult.

PARTICIPATION OF CAREGIVERS AND SUPPORT PERSONS

We agree with CMS' approach that a patient's caregiver or support person should be involved as much as possible, with the consent of the patient. We ask CMS to clarify in the final rule the following:

- that caregivers and support persons should be involved, *as applicable*, but that CMS is not expecting that all patients will have caregivers and support persons. As mentioned previously, NJ State law requires hospitals to provide patients with an opportunity to name a designated caregiver, but allows for the circumstance in which the patient chooses not to do so, or does not have a caregiver they wish to designate;
- the extent of the involvement of patients and caregivers should be consistent with the patient's wishes and with the Health Insurance Portability and Accountability Act (HIPAA);
- how hospitals and home health agencies will be expected to address situations in which a support person or caregiver is uncooperative. We believe that providers should always place the best interest of the patient first and should have the flexibility to draw appropriate boundaries in terms of another individual's involvement, in the event it is necessary to do so; and
- how hospitals and home health agencies should document the involvement of caregivers and support persons.

INVOLVEMENT OF THE PRACTITIONER RESPONSIBLE FOR THE CARE OF THE PATIENT

NJHA requests clarification regarding the definition of "the practitioner responsible for the care of the patient." The rule states that the practitioner responsible for the care of the patient should be involved in the ongoing process of establishing the patient's goals and treatment preferences. In the case of an ED patient or an observation patient admitted through a hospitalist service, this provision may cause confusion. We ask CMS to clarify whether such practitioners will always be a hospital-based provider or whether he or she also could be the patient's personal physician.

For HHAs, CMS would require that the physician responsible for the home health plan of care be involved in the ongoing process of establishing the discharge plan. **We ask CMS to clarify in the final rule that one way HHAs may demonstrate compliance with this provision is by documenting any outreach to the physician to coordinate his or her involvement.** The physician's level of involvement is ultimately up to the physician, and cannot be enforced or controlled by the home health agency.

IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT

The proposed rule would require hospitals and HHAs to assist patients (and others, such as families/caregivers/support persons/representatives) in selecting a post-acute provider by using and sharing relevant data that includes (but is not limited to) the quality and resource use measures for HHAs, skilled nursing facilities (SNFs), IRFs and LTCHs. As this provision is a new statutory requirement, in the final rule NJHA respectfully recommends that CMS should:

- **Clarify the exact data that hospitals and HHAs will be expected to use; identify where these data will be available; and explain what additional data about post-acute care providers may also be furnished to patients (such as marketing materials).** CMS has already finalized numerous IMPACT Act quality measures for SNFs, IRFs, LTCHs and HHAs. However, we are unsure of whether data collection and public reporting for these measures will be complete by the discharge planning final rule's effective date. CMS should identify what data should be used in the interim.

- **Provide guidelines for discussions with patients as hospitals and HHAs share the quality measure and resource use data.** Specifically, CMS should provide concise, consumer-friendly information on each measure and how performance of a particular measure should be used to evaluate whether a specific post-acute provider is appropriate for a patient. Some patients may not understand the relevance of a Medicare Spending Per Beneficiary measure to their decision-making or how to consider the relevance of disparate measures that label different providers as high quality.

- **Provide clarification on how hospitals and HHAs may assist patients in choosing a post-acute care provider without raising concerns about improperly steering patients to particular providers.** Our understanding of CMS' goal is to ensure that consumers have objective information to inform their choice of post-acute providers. Such information would include factors such as quality and resource use measure performance; the patient's goals, needs and treatment preferences; bed availability; and cost/insurance network status. We believe hospitals should be able to make recommendations to patients based on these factors, especially when the patient asks for the hospital's opinion.

In addition, hospitals and HHAs also should be allowed to identify post-acute care providers with which they have agreements to facilitate care coordination between sites of service and promote better outcomes. Specifically, CMS should align its clarification in this area with CMS's final rule for the Comprehensive Care for Joint Replacement (CJR) bundled payment initiative, as well as with CMS' policies related to Bundled Payment for Care Improvement (BPCI) models 2 through 4. In the CJR rule, the agency agreed that hospitals should be allowed to identify preferred providers and suppliers. In the discharge planning rule, too, hospitals and HHAs should be able to identify providers and suppliers who best contribute to improved efficiency and better outcomes, as long as the ultimate choice is left up to the patient and any financial dealings that could create a conflict of interest are disclosed to the patient.

DISCHARGE TO HOME

Discharge instructions. We agree that that discharge instructions should be provided to patients and/or caregiver/support persons designated by the patient in accordance with NJ law, as well as any post-acute care provider, if the patient is referred to post-acute services. We also agree with the proposed content of the discharge instructions, if they are modified slightly as illustrated above. Given the abundance of paperwork required at discharge, we seek ways to help our members reduce information overload for their patients.

Forwarding information to a follow-up care practitioner. If a follow-up care practitioner is known and identified, the rule would require a hospital to send: (1) a copy of the discharge instructions and summary within 48 hours of discharge; (2) pending test results within 24 hours of their availability; and (3) all other necessary information, as specified in the proposed section on transfers. NJHA respectfully requests that **CMS consider making several revisions to these proposed requirements.**

With regard to the requirement to provide a copy of the discharge instructions and discharge summary within 48 hours, CMS should provide flexibility to ensure the transmission of information is the most efficient and effective. If a follow-up care practitioner is known, hospitals should be allowed to contact the follow-up practitioner within two business days to coordinate the transmission of the information. Otherwise, providers may need to send the information via a less effective route (i.e. mail rather than fax or electronic means). In addition, contacting the next care provider alerts that provider that the information is forthcoming and reduces the chance that it will get lost prior to a follow-up appointment.

We believe that a requirement to send pending test results within 24 hours of their availability is too burdensome in some instances. Critical test results should be sent within 24-36 hours; other test results should be sent within 3-5 business days. For all results to be dictated and sent within 24 hours could be a significant burden on physicians.

POST-DISCHARGE FOLLOW-UP PROCESS.

We agree that hospitals should have the flexibility to decide the scope and mechanism of follow-up programs. In the rule, hospitals would need to establish a post-discharge follow-up process for patients discharged to home, although CMS does not specify the mechanism or timing of follow-up programs. Instead, CMS says it would defer to hospitals to determine how best to meet the needs of their patient populations.

We agree with this approach. Hospitals should have the flexibility to determine the mechanism, timing and scope of follow-up programs. However, we welcome the opportunity to work with CMS to identify

various best practices that can be incorporated into the interpretive guidance as suggestions or examples of effective programs.

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPS)

We believe a requirement for providers to consult PDMPs in the discharge planning or medication reconciliation processes would conflict with New Jersey PDMP law. New Jersey's law governing prescription drug monitoring only covers controlled dangerous substances dispensed by a pharmacist in an outpatient setting. Only licensed practitioners authorized to prescribe, dispense or administer and pharmacists authorized to dispense controlled dangerous substances can obtain information from the program. The New Jersey Division of Law and Public Safety has proposed implementing regulations that are currently in the public comment phase.

CMS specifically asks for comments on: (1) whether providers, in evaluating patient discharge needs, should be required to consult with their state's PDMP to review a patient's risk of non-medical use of controlled substances and substance use disorders; and (2) whether PDMPs should be used in the medication reconciliation process.

We understand CMS' desire to capitalize on a resource that has the potential to better inform the discharge planning process for some patients**.** However, New Jersey's PDMP statute was not enacted primarily to assist in discharge planning and thus have not been designed with that function in mind.

> As CMS finalizes the proposed rule, the agency should examine the various state PDMP law limitations, as well as any potential restrictions of privacy regulations such as 42 CFR to ensure the final standards are legally permissible.

COST ESTIMATES

NJHA agrees that hospitals and HHAs should have strong patient safety standards that are consistent across the country. However, the cost of implementing new and more robust standards may be difficult for some providers to bear.

The rule anticipates that the per-facility cost of the rule will be approximately $22,000 annually for hospitals, and $ 23,721 for HHAs. However, these figures greatly underestimate the cost of implementation. A key area of cost for this rule relates to staff. The proposed rule would mean that some hospitals and home health agencies would have to hire additional staff, including clerical staff, social workers, and RNs, to accommodate the increased number of discharge plans required.

In addition to the need to hire additional staff, hospitals and HHAs also would need to implement changes to EHRs to build in the needed elements of the initial assessment, incorporate the elements of the evaluation and the transfer criteria, and possibly align the records with a modified clinician workflow. Further, hospitals and HHAs will need to ensure that EHR vendors will be able to make needed changes before the effective date of the final rule. The rule also does not take into account the labor, training, and workflow changes that will be required to implement the discharge-related provisions of the IMPACT Act.

APPLICABILITY OF THE FINAL RULE

In the final rule, we urge CMS to clearly specify all of the providers the final rule would affect. As with all conditions of participation (CoP)-related changes, CMS should clarify the rule's applicability to: general acute care hospitals, psychiatric hospitals, LTCHs, IRFs inpatient prospective payment system exempt units, Veterans hospitals, incarcerated patients and Department of Defense facilities. In addition, CMS should clarify in the final rule that the CoPs apply to all patients, not just Medicare patients.

DEVELOPMENT OF INTERPRETIVE GUIDANCE

We urge CMS to use an open and transparent process for developing the interpretive guidance for the finalized regulations. CMS could, for example, post the draft guidance electronically for a period of 30 to 60 days and provide an email address for stakeholders to offer comments. We appreciate the fact that CMS provides flexibility with regard to many of the proposed standards and believe that interpretive guidance will be important in terms of defining adequate compliance with those requirements.

Once again, NJHA appreciates the opportunity to offer our comments. If you have any questions or need more information, please feel free to contact Theresa Edelstein at tedelstein@njha.com or Aline Holmes at aholmes@njha.com.

Sincerely

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