



January 4, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244

Re: CMS 3317-P, Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (Vol. 80, No. 212, Nov. 3, 2015).

Dear Mr. Slavitt:

On behalf of our 71 member hospitals, health systems and other health care organizations, the Arizona Hospital and Healthcare Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that revises hospital, Critical Access Hospital (CAH) and home health agency discharge planning requirements.

AzHHA agrees with CMS's goal that hospitals adopt a comprehensive and multi-disciplinary approach to discharge planning, and we support the intention of the proposed rule. Our members currently utilize many of the practices prescribed by the rule in order to create discharge plans based on patient needs, which also ensure appropriate care transitions and reduce readmissions. While we support the overall intent of the proposed rule, we are concerned that implementation of some of the proposals will prove quite challenging and more costly than estimated in the rulemaking. Our members, for example, report that the rule will require them to add staff, especially during the weekend and evenings. Staff will also need to be trained or retrained. Workflows will need to be revised, and information technology systems altered to align with the proposed standards.

We urge CMS to amend several of the proposed provisions in order to reduce the administrative burden and cost of compliance, as well as clarify some of the requirements. Specifically, we recommend the final rule:

1. Clearly distinguish between discharge instructions and more extensive discharge evaluations and plans, so as to allow hospitals and CAHs to provide one or the other under certain circumstances based on the needs of the patient;

2. Provide flexibility to address the lack of community resources in some instances; and
3. Revisit its cost estimates to reflect the true costs of increasing the discharge planning requirements.

In addition, we strongly recommend that CMS establish an effective date that is two years from the date the rule is finalized. We believe this time is needed for hospitals to make necessary changes that would allow them to come into compliance with the proposed rule. This includes working with vendors to make changes to electronic health record (EHR) systems.

The following outlines our more specific comments on the proposed rule.

APPLICABILITY

1. Discharge Instructions vs. Discharge Plans

We believe the final rule should narrow the range of patients who are required to have a full discharge evaluation and plan, rather than a robust set of discharge instructions. The discharge evaluation that CMS proposes would require hospitals to evaluate patients on at least eight different factors. Although the proposed rule does not define “discharge plan,” we believe the proposal would require hospitals to create a plan for what should happen for the patient after discharge, based on the evaluation. The plan would address any patient needs identified in the evaluation. On the other hand, discharge instructions would include a standard set of information on such things as: (1) post-discharge care at home; (2) medications required after discharge, including medication reconciliation; (3) warning signs for indications of the need to seek immediate care; and (4) written instructions for follow-up care and/or referrals.

In the proposed rule, hospitals and CAHs would be required to create discharge plans for all inpatients as well as certain outpatients, including observation patients; same-day patients receiving anesthesia or moderate sedation; emergency department (ED) patients identified by ED practitioners as needing a discharge plan; and other categories of outpatients recommended by the medical staff and specified in the hospital’s/CAH’s discharge planning policies approved by the governing body, or by the responsible individual in the case of a CAH.

AzHHA agrees that inpatients should be provided a discharge evaluation and plan, as well as some, but not all, observation and same-day patients who receive anesthesia or moderate sedation. However, patients undergoing certain diagnostic procedures such as colonoscopies more likely require a clear, comprehensive set of discharge instructions, but not necessarily a full discharge evaluation and plan. **The practitioners responsible for the care of observation and same-day patients receiving anesthesia or moderate sedation should be able to decide whether the patients need either full discharge evaluations and plans or comprehensive discharge instructions.**

In fact, CMS in the proposed rule states it does not expect every patient to need a comprehensive discharge plan. Rather, the agency suggests the plan should be tailored to the unique goals, preferences and needs of the patient. We agree with this approach, but believe the final rule should more clearly distinguish between discharge instructions and full discharge evaluations and plans. **We believe that hospitals' medical staffs should articulate through their policies and procedures the appropriate level of discharge activities and planning for each type of patient.** We support the recommendation by the American Hospital Association that CMS change the regulatory language to allow hospitals and CAHs more flexibility to tailor the discharge planning activities to the needs of each patient. Not every patient needs a full discharge evaluation as described in 482.43(c)(5), which includes such requirements as an assessment of the patient's psychosocial history and access to social services.

2. Emergency-level transfers.

We support the proposal that hospitals not be required to conduct discharge evaluations and create discharge plans for emergency-level transfers for patients who require a higher level of care, though the hospital/CAH should send necessary information with the patient.

COMMUNITY RESOURCES & PATIENT ENGAGEMENT

AzHHA urges CMS to clarify in the final rule that compliance with the new standards will be evaluated within the context of a provider's community resources. We agree that successful discharge planning often requires collaboration with community partners and connecting patients with community resources. However, many communities in Arizona have limited resources with respect to supportive housing and other social support services. The state has a shortage of behavioral health workers, and the availability of social workers is limited in many areas of the state. We urge CMS to 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 and CAHs to outline the qualifications based on patient needs and knowledge of community resources.**

We support CMS's goal of having a discharge planning process focused on patient goals and preferences and that engages patients in their post-discharge care. We believe this process will prove successful in most instances, leading to better outcomes. However, some patients may be reluctant to participate in the discharge planning process for a number of reasons. Many of our hospitals treat undocumented patients who are reluctant to share personal information, including their ability to access to community resources upon discharge. Some patients also leave against medical advice, while others simply may not wish to admit they need social services. We would expect hospitals to work with patients as much as possible in these instances, but they should not be penalized if patients prefer privacy or decline medical or discharge planning assistance.

We urge CMS to clarify how it will expect hospitals and CAHs to demonstrate the incorporation of the patient's goals and wishes into the

plan. In addition, we ask CMS to address the fact that that some patients may be reluctant to participate in the process for a variety of reasons.

DISCHARGE PLAN EVALUATION – TIMING

The proposed rule requires hospitals and CAHs to begin identifying discharge needs for patients within 24 hours after admission or registration. We agree that discharge planning should occur in a timely manner and be an ongoing process that occurs alongside the provision of inpatient care. And while we support the intent of the “24 hour provision,” we do not believe it is practical for all patients and urge CMS to revise it.

For example, the 24-hour timeframe does not make sense for patients with longer stays, such as long term acute care hospital patients whose average length of stay is 25 days and inpatient rehabilitation facility patients, who have an average length of stay of 13 days. It will also be difficult at times for hospitals to begin discharge planning for patients who arrive unconscious or confused, such as those that are unaccompanied by a caregiver or support person. And, some small and rural hospitals will have trouble meeting this requirement due to staff and resource limitations. **With this in mind, AzHHA urges CMS to finalize the proposed language stating that the discharge planning process should be completed in a timely manner but strike the wording related to a 24-hour requirement.** (CMS could incorporate this timeframe as an 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.)

COST ESTIMATES

The rule anticipates that the per-facility cost of the rule will be approximately \$22,000 annually for hospitals, and \$6,400 for CAHs. **We believe these figures underestimate the cost of implementation, and we recommend CMS revisit the cost estimate.** A key area of cost for this rule relates to staff. The proposed rule would require hospitals and CAHs to hire additional staff, including clerical staff, social workers, and nurses to accommodate the increased number of discharge plans required. Some hospitals have indicated they would need to double the staff who coordinate discharge plans in order to meet the rule’s proposed requirements. We are especially concerned about the additional staff requirements for CAHs, some of which do not have social workers on duty 24/7.

In addition to the need to hire staff, hospitals and CAHs would need to make changes to EHR systems to address all the required elements of the initial assessment, incorporate the elements of the evaluation and the transfer criteria, and possibly align the records with modified workflows. And, hospitals and CAHs will need to ensure that 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.)

We believe a more accurate cost estimate is imperative given the fact that so many of our hospitals have negative operating margins. Based on monthly data reported by 78

percent of Arizona hospitals to AzHHA, 48 percent of Arizona hospitals incurred an operating loss in October of 2015—the latest month for which we have data. And, the statewide operating margin for these hospitals for the twelve months ending October 31, 2015 is 1.6 percent.

IMPLEMENTATION DATE

We urge CMS to set an effective date that is two years from the date of the final rule. As stated previously, we believe this time is needed for hospitals to make necessary changes that would allow them to come into compliance with the proposed rule. This includes working with vendors to make changes to EHR systems.

Thank you for your consideration of our comments. If you have any questions, please feel free to contact me at 602-445-4300 or djohnston@azhha.org.

Sincerely,



Debbie Johnston
Senior Vice President, Policy Development