



January 4, 2016

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3317-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Sir/Madam:

The Home Care Association of New York State (HCA) appreciates the opportunity to provide comments on the proposed rule that would revise the discharge planning requirements for hospitals, critical access hospitals and home health agencies (HHAs).

HCA is a statewide association representing nearly 400 health care providers, organizations and individuals involved in the delivery of home care services to over 300,000 Medicare and Medicaid patients in New York State. HCA's members include Certified Home Health Agencies (CHHAs), Long Term Home Health Care Program (LTHHCP) providers, Licensed Home Care Services Agencies (LHCSAs), providers of various waiver programs, Managed Long Term Care plans, hospices and others. HCA's home care providers are sponsored by hospitals, nursing homes and free-standing nonprofit, public and proprietary agencies.

While we support efforts by the U.S. Centers for Medicare and Medicaid Services (CMS) to revise the Conditions of Participation (CoPs) to "require HHAs to develop and implement an effective discharge planning process that focuses on preparing patients to be active partners in post-discharge care, effective transition of the patient from HHA to post-HHA care, and the reduction of factors leading to preventable readmissions," we have strong concerns about the following changes:

- 1) The proposed new and unfunded costs exceed CMS's estimates, and would be imposed at the very same time that CMS is implementing some of the most dramatic cuts in home health via Medicare rebasing. Meanwhile, New York HHAs have been subject to negative Medicare margins for thirteen straight years, resulting in fiscal pressures that exceed the ability of agencies to undertake new cost mandates;
- 2) CMS's efforts and CMS-approved waivers to New York and other states to enroll Medicaid and dual Medicare-Medicaid patients into managed care have not been taken into consideration as part of the proposal;
- 3) The proposal to require hospitals to assist patients in need of post-acute care by selecting a provider based on "quality" data on those providers is problematic due to the flawed nature of the public reporting measures for quality which do not reflect the differing roles of HHAs, including those HHAs designed to meet the chronic-care maintenance and stability needs of patients with long term illness;
- 4) CMS's proposal does not consider continuity-of-care in specific circumstances, including cases where a patient admitted to the hospital has already been receiving services from a specific HHA

and may want to continue receiving services from a familiar agency already rendering services to the patient;

- 5) Requirements for content and delivery of the discharge and transfer summaries do not reflect the core service and administrative functions of HHAs and should be changed accordingly; and
- 6) The identified content for HHAs to complete when conducting discharge and transfer summaries is beyond the means of many HHA providers that have limited health information technology (HIT) infrastructure, making it unfeasible for HHAs to include some of these elements without unnecessary burdens.

1. Cost Estimates

HHAs currently face major reductions in Medicare reimbursement, pressures to restructure their agencies due to health systems integration, continued unfunded mandates related to physician face-to-face documentation and general compliance requirements, and other burdens. While CMS's goals with regard to the discharge planning changes are well intentioned, we believe that CMS greatly underestimates the amount of time agencies will need to comply with the proposed requirements in preparation for the mandates and in ongoing administrative workflow to comply with the mandates post-implementation. The process whereby agencies will have to modify the current discharge planning process, train their staff in the new procedures, collect all of the relevant information, and transmit the information to the patient and to other providers will all be exceptionally time intensive to a degree beyond what is reflected in the estimates mentioned in the proposal.

Refinement of Discharge Planning Process: As part of the refinement of the planning process, agencies will need to train staff on the new processes once they are developed and work with electronic health record (EHR) vendors to modify standard forms and electronic work flows. Training will require at least one hour per clinical and administrative staff person involved in the discharge/transfer process. Several staff people will spend several hours working on modified forms with the EHR vendor. This exceeds the estimate by CMS.

Collection of Content: CMS estimates that it will take a nurse or other clinician approximately 10 minutes to complete the content requirements for the discharge/transfer summary. Our members' experiences indicate that an hour is more consistent with current documentation practices. For example, gathering most of the data from the EHR would take approximately 15 minutes for a nurse. The nurse would then come to the office to obtain the remaining information that is in paper form in the patient chart. Not considering travel time, this would reasonably take an additional 15 minutes. Travel, communication with the physician, gathering of additional data, verifying data, and creating the summary would take at least an additional 30 minutes. Again, this exceeds the estimate by CMS.

Transmission of Summaries: The back-office time required to send out a summary will take well longer than the 2.5 minutes CMS estimates. Agencies will need approximately an hour to conduct quality control measures required by CMS. The actual printing and sending of the summary alone takes, on average, five minutes.

HCA also notes that CMS did not include the therapist's time in its estimate.

Additionally, these cost estimates do not take into consideration the limited capacity of many HHAs to electronically assemble and submit the discharge summary as proposed by CMS. Considering this lack of existing connectivity and capability, the cost to these HHAs would be even more significant.

HCA believes strongly that cost-imposing revisions to the discharge planning regulations should not be implemented without compensatory adjustments to Medicare and Medicaid rates for home care services, including premium adjustments to Medicaid and Medicare managed care plans for HHA services.

2. Managed Care Implications

The proposed rule does not recognize that many states are requiring their Medicaid-only and dual eligible patients to enroll into managed care plans for acute and/or long term care services. Additionally, many Medicare-only beneficiaries are enrolled in Medicare Advantage managed care plans. Managed care plans often have their own policies and procedures that their contracted HHAs must follow, and some of those may conflict with CMS's proposed rule, or result in duplicative efforts.

Some plans may be very involved in patient discharges, as covered in the proposed rule, and may have policies governing these practices, including policies covering specific elements required as part of the written discharge plan or the role that HHAs should play in assisting its members in selecting a "quality" agency. CMS should revise the proposed rule to incorporate the impact of managed care enrollment on discharge planning.

3. Patient Transfers from Hospital to Post-Acute Providers

HCA supports the requirements that hospitals provide comprehensive information to HHAs and other post-acute providers about patients being transferred to their setting, but recommends that it be sent **prior** to, rather than at the time of, the transfer. Such advance notice will enable HHAs to establish a plan for service delivery.

Also, HCA recommends that risk assessments should be part of the information provided by hospitals to HHAs and other providers. Hospitals should be required to assess patients for complications and other risks that may result in a hospitalization or other unplanned care, and share those findings with post-acute providers.

HCA has concerns about hospitals assisting patients in selecting a post-acute care provider by providing data on quality and resource use measures. Many HHAs in New York provide services to patients who require care over a long period of time, with goals of stabilization rather than the expectation of resolution or improvement. Agencies who serve such populations are scored in such a way that does not accurately capture the quality of care they provide or the differing needs of their patients. We believe that such data provided by hospitals will wrongfully create a disincentive for patients to access these and other programs that have a long history of providing exemplary service.

Additionally, the proposed rule does not consider patients who have opted for hospice care. HCA recommends that CMS recognize hospice care and that option for election prior to or during a hospital stay.

Lastly, we believe that CMS needs to be more specific on what this informational assistance entails: is it adequate to refer a patient to *Home Health Compare* or the *Star Rating System* or must the hospital explain the data from that site for a certain number of HHAs?

4. Current HHA patients

The current proposed rule does not address situations when an inpatient stay involves a patient who was receiving HHA services prior to the stay. To address this circumstance, HCA requests that CMS revise the proposal to require that hospitals identify any existing relationships between the patient and an HHA

and, if appropriate, maintain ongoing communication with the HHA and utilize that HHA as the post-discharge HHA if it is the preference of the patient.

5. Content and Delivery of Discharge and Transfer Summaries

CMS provides a comprehensive list of the types of information that must be included in the discharge or transfer summary by the HHA when a patient is being discharged from the HHA. HCA suggests modifying this list to add some additional items and to remove others.

The following content should be **added** to the discharge or transfer summary because these items are important for patient care:

- Name of the provider who will continue to provide care following the patient's discharge;
- Name of any community-based social service agency identified as providing service to the patient;
- Information on upcoming health-related appointments; and
- Instructions for patients and caregivers on what to do if unexpected symptoms or events occur.

HCA also seeks modification to the list of required elements in the summary. The proposed content includes services not available through HHAs (such as laboratory test results, unique identifier for a patient's implantable device, immunization status, consultation results and procedures), but provided by other providers. We believe that HHAs should not be responsible for obtaining this information in completing the discharge or transfer summaries, as the HHAs would not necessarily have access to results and records of procedures and tests performed by other providers, and that HHAs should only be responsible for including content in the summary about services provided by the agency itself.

Instead, the agency receiving the patient at discharge from the HHA should have to obtain such information directly from the provider responsible for ordering or providing such services.

In addition, HCA requests that the language "any other information necessary to ensure a safe and effective transition . . ." be amended to read: "any other information as determined by the HHA to ensure . . ." This clarification will assist HHAs who are being surveyed so that the surveyors apply the proper standard.

HCA also recommends that HHAs not be required to use the PDMP as part of medication reconciliation. This is not a database that HHAs typically use, and it would be an additional burden on the agencies.

In summary, HCA recommends that CMS give HHAs more flexibility to determine what information on the list is relevant for an individual patient and give providers flexibility to use documentation formats that convey the information in a complete yet concise way, such as via checklist.

6. Additional Concerns

Sharing of Information

While HHAs currently conduct discharge planning for all their patients, the proposed requirements would entail greater communication as HHAs will need to share additional data with physicians, hospitals and other providers. To ensure that this process is truly effective and timely, electronic transfer of information

is a necessity. However, many HHAs do not have EHRs and cannot exchange medical information with other providers, or HHAs have EHRs that are not compatible with other providers' systems.

HCA points out that while other institutional and non-institutional providers have been recipients of numerous payments to support investment in HIT, HHAs have been notably excluded from such efforts. We urge CMS to set aside funds for HHAs so they can truly share information on a timely basis.

Provision of Quality Data

Under the proposed rule, HHAs would be required to assist patients and their caregivers who are being transferred in selecting another post-acute care provider by using and sharing data that includes quality measures. As noted in our earlier comments, HCA has concerns about the way "quality" is currently calculated for HHAs and does not support sharing such information with consumers.

If this requirement is not removed, then CMS needs to take into account the time needed to share such data in its estimated time and cost section of the proposed rule. This can be a very time-consuming process (lasting at least one hour) and does not seem to have been considered.

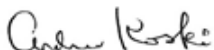
In summary, the implementation of CMS's proposed rule will require much time and effort by HHAs. HCA requests that CMS give agencies one year to achieve compliance so that they can make the necessary internal and external changes and provide adjustments to Medicare and Medicaid rates for home care services to compensate agencies for their new compliance costs.

Thank you for the opportunity to offer our comments on the proposed CoP discharge planning changes. If you have any questions or need additional information, we can be reached at (518) 426-8764.

Sincerely,



Alexandra Blais
Director of Public Policy



Andrew Koski
Vice President for Program Policy & Services