



December 29, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

RE: CMS-3317-P: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Proposed Rule; Federal Register Vol. 80, No. 212, p. 68126-68155 (July 14, 2015).

Submitted electronically via www.regulations.gov

Dear Mr. Slavitt:

UnityPoint Health (“UPH”) is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services’ (CMS) Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies proposed Rule. UPH is one of the nation’s most integrated healthcare systems, by providing care throughout Iowa, Illinois and Wisconsin. This is accomplished through more than 30,000 employees and our relationships with more than 290 physician clinics, 17 UPH hospitals, 16 critical access hospitals, 14 UnityPoint at home locations in metropolitan and rural communities throughout our 9 regions. On an annual basis, UPH hospitals, clinics and home health provides a full range of coordinated care to patients and families through more than 4.5 million patient visits. In addition, UPH is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care.

As an integrated healthcare system, we applaud CMS consistent commitment to improving the quality of patient care across the healthcare continuum. We applaud the agency for emphasizing person-centered care by establishing standardized processes that facilitate communication across the spectrum of healthcare to ensure patients are properly prepared for transitions of care. UnityPoint Health appreciates the time and effort spent by CMS in developing the revisions to requirements for discharge planning for hospitals, critical access hospitals and home health agencies. We respectfully offer the following comments to the proposed rule.

Hospital Discharge Planning

Discharge Planning Process and Discharge to Home:

CMS proposes to establish a specific timeframe during which discharge planning must begin. The proposed rule would clarify the requirement by requiring that a hospital would begin to identify anticipated discharge needs for each applicant patient within 24 hours after admission or registration and the discharge planning process is completed prior to discharge home or transfer to another facility. If a patient stays less than 24 hours, discharge needs for each patient must still be identified and discharge planning process completed prior to discharge home or transfer.

Comment: In theory UPH supports these valuable suggestions as we try to improve our discharge process and decrease readmissions, but it is not always possible in practice due to the patient's condition and the process of diagnosing during a highly complex patient's stay. In addition, we would need more resources to be compliant with the proposed rule for the goals of care for all patients. *Section 482.43 should be to require or permit the hospital to initiate discharge planning prior to inpatient admission where the hospital and the patient's provider determine such to be feasible and appropriate.*

Given the potential benefits of PDMPs, CMS propose that providers should be required to consult with their state's PDMP and review a patient's risk of non-medical use of controlled substances and substance use disorders as indicated by the PDMP report. In addition, CMS propose the use of PDMPs in the medication reconciliation process.

Comment: UPH is presently using the States' PDMP to review patient's risk and they are finding value in some cases. While it could be a beneficial practice, it is widely agreed to be labor intensive and challenging to administer on a widespread and consistent basis. CMS can certainly recommend the use of the system in the discharge process but until this PDMP is fully functional and has the ability to be integrated into hospital's EMR systems this should remain a *recommendation* and not a *requirement* as it would put undue burden on providers and hospitals.

Under the proposed rule, CMS would require that the hospital assess its discharge planning process on a regular basis which would include ongoing review of a representative sample of discharge plans, including patients who were readmitted within 30 days of a previous admission, to ensure that they are responsive to patient discharge needs. This evaluation will assist hospitals to improve the discharge planning process. CMS believes the evaluation can be incorporated into the Quality Assessment and Performance Improvement (QAPI) process, although CMS has not explicitly required this coordination and solicit comments on doing so.

Comment: UPH agrees there is value in monitoring the discharge planning process, especially for patients who are at risk for readmission.

Transfer of Patients to another Health Care Facility:

The proposed rule will require using certified health IT when transferring of patients to another health care facility. CMS state that facilities can ensure that they are transmitting interoperable data that can be used by other settings, supporting a more robust care coordination and higher quality of care for patients. CMS is soliciting comments on these proposed medical information requirements

Comment: UPH supports IT interoperability and use of EpicCare Link to enhance care coordination.

Home Health Agency Discharge Planning

Discharge or Transfer Summary Content:

In this proposed rule, CMS further address the content and timing requirements for the discharge or transfer summary for HHAs. These proposed changes incorporate the requirements of the IMPACT Act. CMS is soliciting comments on the timeline for HHA implementation of the following proposed discharge planning requirements.

CMS propose to require the HHA discharge/transfer summary include specific information to be sent to the receiving healthcare practitioner or facility.

Comment: These requirements are intended to provide a safe and efficient follow up care planning, however the information required in the proposed rule will involve volumes of documents, many of which are duplicative in an EMR. The required elements for the discharge or transfer summary are aligned with the Office of the National Coordinator for Health Information Technology Common Clinical Data Set specified in the 2015 Edition of the Health Information Technology Certification Criteria. The most direct method to comply with the proposed discharge summary requirements is for agencies to utilize an interoperable EHR that meets the common clinical data set specification that is supported by the Consolidated Clinical Document Architecture (C-CDA) and Health IT Modular Certifications for Transitions of Care and Care Plan.

The intent is excellent; however there must be some allowances for the clinician to be able to give a succinct picture of the patient condition. These requirements will take time to compile, delaying the ability to get pertinent succinct information timely.

The CMS burden estimates for home health agencies to implement the propose requirements are as follows:

- **Discharge planning:** CMS estimates that a physician, registered nurse and social worker will spend 8 hours each for total of 24 hours to implement the discharge plan. CMS also estimates that this will be a one-time expenditure.
- **Discharge/transfer summary contents and submission:** CMS estimates that it will take approximately 10 minutes for the agency to compile the summary and 2.5 minutes to send the information to the receiving entity.

Comment: UPH would like to echo the following comments made by National Association for Home Care and Hospice (NAHC) on this regulation: CMS has grossly underestimated the burden for agencies in implementing the proposed discharge plan and summary requirements. The one time burden estimate for the discharge planning does not take into account the time required for ongoing staff training and complying with several new time consuming components of the discharge place, such as, assisting patients with the selection of a post-acute care provider using relevant quality data. In addition, CMS failed to include the therapist's time in the discharge planning process estimate. The time to compile and send the discharge/transfer summary will take significantly more time than 10 and 2.5 minutes, respectively, estimated per patient. NAHC estimates the time to be approximately one to one and half hours per patient.

With respect to the burden, CMS estimates a one-time cost of \$34 million and a continuing annual coast of \$283 million. This represents a continuing cost increase of 1.57% in relation to the annual costs of home health services.

Comment: In 2016, Home Health Agencies (HHAs) face an aggregate of 2.8% reduction in reimbursement rates related to rate rebasing. The fourth year of rate rebasing will occur in 2017, adding another 2.8% rate reduction. In addition, in 2016 and successive years thereafter, HHAs will face a productivity adjustment that would be approximately a 0.5% reduction in reimbursement rates. Another 0.97% reduction will occur in 2016, 2017, and 2018 through the application of a case mix weight change adjustment. Finally, the 2018 Market Basket Index inflation adjustment is capped at 1%.

With these rate cuts, many HHAs cannot sustain new costs at the level projected from the proposed discharge planning rules. As such, CMS must significantly streamline the requirements and/or adjust payment rates to cover the added costs. These additional costs will not be addressed in the Market Basket Index. A failure to cover the costs will have a far reaching impact on access to care.

UPH agrees with NAHC recommendations:

1. CMS should fully revisit its estimate of financial burdens triggered by the proposed rule, basing its estimate on a realistic assessment of cost changes.
2. CMS should propose streamlined alternatives to the proposed rule, particularly the discharge summary requirements.
3. CMS should include a rate adjustment to cover the added costs of the discharge planning rule.

We appreciate the opportunity to provide comments to the proposed rule for revisions to requirements for discharge planning for hospitals, critical access hospitals and home health agencies. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Public Policy and Government Payors at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,



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VP/Public Policy and Government Payors
UnityPoint Health



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