January 4, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted via www.regulations.gov

Re: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Proposed Rule (File Code 317-P)

Dear Acting Administrator Slavitt:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments on the proposed rule, "Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies" (File Code 317-P), as published in the November 3, 2015 Federal Register. We support CMS' efforts to standardize and enhance the quality of hospital discharge planning processes and post-discharge care plans.

NAACOS is the largest organization of Medicare Shared Savings Program (MSSP) ACOs, representing approximately 150 MSSP and Pioneer ACOs. NAACOS is a member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, patient-centric care transition process.

The proposed discharge planning rule is designed to cover hospitals (i.e., critical access hospitals [CAHs], long-term care hospitals [LTCRs], and inpatient rehabilitation facilities [IRFs]) as well as home health agencies (HHAs) in an effort to improve patient health after discharge. As CMS acknowledges in the proposed rule, patients' post-discharge needs are often complicated and multifactorial, requiring a significant level of ongoing planning, coordination, and communication among the health care practitioners and facilities caring for a patient and those who will provide post-acute care for the patient, including the patient and his or her caregivers. The discharge planning process should ensure that patients, their caregivers, and providers involved in post-discharge care are properly prepared to be active partners upon discharge from the hospital or post-acute care (PAC) setting.

In addition to our support for enhanced post-discharge care plans, we urge CMS to expand its focus by requiring more collaborative care in real time during the episode rather than exclusively focusing on

discharge. While improving post-discharge processes would positively affect beneficiary care and outcomes, limiting the focus exclusively to these handoffs or transitions is not enough. CMS must look beyond the point of care transition. It is critical to have a patient's primary care team involved *throughout* the episode of care to allow them to help manage the episode itself, including involvement in the development of the post-discharge care plan. This broader approach would significantly improve outcomes, and successful ACOs have implemented real- time event notification for admissions and discharges to not just hospital but also for skilled nursing facilities and home health, an approach that has directly contributed to better outcomes in cost and quality. We understand this proposed rule focuses specifically on hospital and home health post-discharge processes and that CMS is developing additional regulations to address other aspects of care coordination and transitions between care settings. As part of that broader effort, we urge CMS to involve ACOs and primary care teams throughout episodes of care by requiring that they receive real-time notifications about admissions and developments in their patients' care.

As proposed in this NPRM, we support the use of a common list of core elements in a discharge plan that should be readily shared across providers working in different settings. Requiring a list of core elements would simplify care coordination and basic communication between providers. As part of the effort to enhance post-discharge care planning, NAACOS urges CMS to strengthen requirements to further emphasize the role of primary care providers and ACOs involved in population health management. These providers have a commitment to delivering ongoing care to beneficiaries and must be involved throughout episodes of care including hospitalizations. Additional specific recommendations are detailed below.

Application of discharge planning, §482.43(b) and §485.642(b)
CMS proposes to require that the hospital/CAH discharge planning process apply to all inpatients, as well as certain categories of outpatients, including, but not limited to, patients receiving observation services, 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 category of outpatient as specified in the hospital's discharge planning policies and procedures. We support this expansion and consistency of requiring the discharge planning processes to apply to these categories of patients. Should there be any doubt as to a patient's ability to follow their discharge care plan, hospitals should contact or see a family member or caretaker to discuss the discharge care plan.

Information to practitioners responsible for follow up care, §482.43(d)(3) and §485.642(d)(3)
In addition to the patient receiving discharge instructions and a discharge care plan, CMS proposes that, for patients being discharged to their home, hospitals/CAHs must provide information to practitioners responsible for follow up care. We agree it is important that the providers responsible for follow-up care with a patient receive the necessary medical information to support continuity of care. It is especially important that primary care providers (PCPs) are sent the information for every discharge, as these providers play an essential role managing their patients' ongoing care. CMS proposes to require that the hospital/CAH send detailed information, outlined in §482.43(e)(2) and §485.642(e)(2), to the practitioner(s) responsible for follow up care within 48 hours of the patient's discharge and pending test results within 24 hours of their availability. We urge CMS to require that PCPs are always considered part of the care team responsible for follow up care and should therefore receive this information even if the follow up care directly related to the hospitalization is furnished by another provider. Further, it should be clear to the PCP if the follow up care is to be furnished by someone other than the PCP.

CMS proposes this information be sent to practitioner(s) responsible for follow up care, *if the practitioner is known and has been clearly identified (emphasis added).* Given the importance of communicating this essential information to providers responsible for follow up care, we urge CMS to specify what the agency would consider an adequate attempt on the part of the hospital to learn about and identify these practitioners. It may be especially challenging to collect this information as many patients are incoherent and may be unable to provide the information in response to a specific request. If a hospital only makes a cursory attempt to identify the PCP by asking a patient one time on a form to indicate their PCP, this should not be sufficient. Hospitals/CAHs should inquire as part of the admission process, and if the information is not provided then, they should also work with patients by inquiring a number of times throughout the hospital stay to properly identify the correct providers.

We support requiring hospitals to provide information to PCPs such as a copy of the discharge instructions, necessary medical information related to the hospitalization and discharge summary in a timely manner. However, we urge CMS to shorten the proposed required timeframe from 48 hours to 24 hours. The first day or two following discharge is critical and ACOs and PCPs need this information as soon as possible, at the time of discharge or at least within 24 hours. Additionally, as part of CMS' focus on care coordination, effective January 1, 2013, the agency finalized Medicare payment for two CPT codes (99495 and 99496) for Transitional Care Management (TCM). These services are designed to help patients following a discharge from an inpatient hospital, skilled nursing facility, community mental health center, or following outpatient hospital observation services or a partial hospitalization. As part of the TCM requirements, providers must make an interactive contact with the beneficiary and/or caregiver, as appropriate, within two business days following the beneficiary's discharge. Given that the contact must be made within two business days, CMS should require hospitals to provide information to ACOs and PCPs within 24 hours to ensure they have time to reach out to, and connect with, beneficiaries within the timeframe required for TCM.

Effective discharge planning is only the start of a successful transition. If information about patients with chronic conditions is only in the hands of a "sending" health care provider, and there are no (or delayed, or poorly organized) communications and preparations made with receiving providers and community-based organizations that can provide timely assistance at home, patient outcomes are likely to be less stable and sustainable than desired. To maximize opportunities for success, we urge CMS to require hospitals provide relevant information to PCPs and those involved in follow up care, such as ACOs, in a timely manner, at the time of discharge or within 24 hours. We also urge CMS to require hospitals to engage these key providers throughout the hospital stay rather than solely upon or after discharge.

Coordination with community-based services for patients discharged to home

CMS discusses the important role played by community-based organizations, such as area Agencies on Aging, Aging Disability Resource Centers, and Centers for Independent Living. The array of social services offered by these organizations, which include home and physical environment modifications, access to assistive technologies, transportation, meals, household services and housing support, are central to keeping individuals living with complex chronic conditions from cycling in and out of high-cost health care settings. We support CMS encouraging hospitals to coordinate with these organizations to help complex and often fragile patients successfully transition to their homes.

Discharge planning for home health agencies, §484.58

Similar to enhancing hospital discharge processes, CMS proposes to standardize and enhance discharge planning for HHAs. CMS proposes to require HHAs to provide detailed summary information, as outlined in §484.58(b), to the receiving facility or health care practitioner. At a minimum, the necessary medical information would include demographics, contact information for the physician responsible for the

home health plan of care, advance directive information, lab tests, diagnoses, procedures, reconciliation of medications, patient goals of care and treatment preferences, and more. We support CMS requiring this robust information be reported and urge the agency to require the information be sent to the physician responsible for the home health plan of care, in addition to the receiving facility or health care practitioner, which would ensure that the physician who established the home health plan of care has information to continue to be involved in the patient's care at a later time, as necessary. Adding this communication would ensure a more effective feedback loop with providers engaged in effective population health management, such as ACOs.

Conclusion

The proposed rule aims to improve the patient discharge process through better and timelier communication that includes patients, health care practitioners, and relevant community organizations. CMS estimates that one third of re-hospitalizations might be avoided with improved comprehensive transitional care from hospital to community, and we support CMS' efforts to improve care transitions. We request the agency consider the feedback from the ACO community outlined in this letter.

Thank you for your consideration of our comments,

Clif Gaus
President and CEO