

**Government Affairs Office**

1025 Vermont Avenue

Suite 1100

Washington, D.C. 20005

202-639-0550

Fax: 202-639-0559

**Headquarters**

4501 College Blvd, #225  
Leawood, KS 66211-1921

816-756-3140

Fax: 816-756-3144

January 4, 2016

Andy Slavitt

Acting Administrator

Centers for Medicare and Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, SW, Room 445‐G

Washington, DC 20201

**RE:** RIN 0938-AS59 - Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies

Dear Administrator Slavitt,

The National Rural Health Association (NRHA) is pleased to offer comments on the CMS proposed rule for Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies. We appreciate your continued commitment to the needs of the 62 million Americans residing in rural areas, and look forward to our continued collaboration to improve health care access and quality throughout rural America.

The NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America’s health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses and patients. We work to improve rural America’s health needs through government advocacy, communications, education and research.

We appreciate CMS’ continued emphasis on narrowing the gap between rural patients and providers. In collaboration with NRHA policy partners, this letter outlines suggestions and recommendations that we believe will strengthen this proposed rule while ensuring that rural Medicare beneficiaries maintain their access to critical services. We look forward to our continued collaboration.

The discharge planning proposed rule aims to align discharge planning requirements across hospitals, critical access hospitals, and home health agencies in accordance with the IMPACT Act. NRHA applauds these efforts to align discharge planning requirements to improve patient care. We encourage CMS to continue to align the discharge planning requirements with other programmatic requirements designed to reduce readmissions, a cited policy goal of the discharge planning proposed rule to encourage and allow hospitals to continue to use innovative approaches to address readmissions.

**NRHA supports the inclusion of CAHs in discharge planning requirements.** CMS proposes to require that the discharge planning policies and procedures be specified in writing and be reviewed and approved by the governing body and, additionally, that the policies and procedures be developed with input from the CAH's professional healthcare staff, nursing leadership as well as other relevant departments. We support this requirement as it aligns with Joint Commission standards and is current process in many CAHs.

**NRHA encourages allowing rural hospitals to consider the impact of partially available quality reporting data for PAC providers in the local community, especially where geographic considerations are especially important to the patient and caregivers.**

CMS proposes a new requirement for hospitals to assist patients in selecting a post-acute care (PAC) provider by using and sharing data that includes but is not limited to home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), or long-term care hospital (LTCH) data on quality measures and data on resource use measures. Additionally, the hospital would have to ensure that the PAC data on quality measures and data on resource use measures is relevant to the patient's goals of care and treatment preferences and medical record documentation must indicate this information was shared with the patient and used to assist in discharge planning. This requirement is proposed to meet the IMPACT Act requirements that a hospital must take into account PAC provider’s quality and resource use measure data during the discharge planning process.

**NRHA is concerned that this criterion could be utilized to discourage the use of high quality CAH swing beds in rural communities.** The inclusion of considerations of the patient is important and we applaud CMS’s inclusion of statements about the importance of geography. However, we remain concerned that the requirements as written may improperly weigh facilities already reporting quality data over small facilities that are just beginning the difficult process of quality reporting. Rural Americans are more likely to be older, sicker and poorer then their urban counterparts. Specifically, they are more likely to suffer with a chronic disease that requires monitoring and follow up care, making convenient, local access to care necessary to ensuring patient compliance with the services that are necessary to reduce the overall cost of care and improve the patients’ outcomes and quality of life. Yet, many rural Americans live in areas with limited health care resources, restricting their available options for care, including post-acute care options.

Rural health care delivery is challenging. Workforce shortages, older and poorer patient populations, geographic barriers, low patient volumes and high uninsured and under-insured populations are just a few of the barriers. Rural physicians and hospitals work around many of these barriers to provide high quality personalized care to their communities. These care givers and hospitals work with a patient population, and their caregivers, that are more likely to be poor and lacking in many of the resources that often lead to better outcomes. Considerations of geography are more than a matter of convenience, as caregivers may have no means of transportation to allow for care in more distant locations. Such considerations must be heavily weighted in discharge planning options presented to caregivers.

Additionally, it is still unclear how hospitals will be able to obtain data on PAC providers. CMS states that until IMPACT Act measures are defined, hospitals can use other resources, such as the compare websites, to provide information to patients. This implies that once IMPACT measures are defined they may not be available on the compare websites. Additionally, compare websites do not exist for CAH Swing Bed, IRF and LTCH providers. Hospitals should not be required to collect, purchase, or mine CMS’ publicly available downloadable databases for information on PAC providers. Hospitals should only provide patients information that is available on the compare websites, for a subset of providers based on availability or geography, because that information has been vetted by CMS and PAC providers. Second, this requirement introduces bias into the selection of PAC providers as CMS expects that hospitals would be able to discuss and answer information regarding PAC providers’ quality and resource use information. While we understand CMS’ desire to guide beneficiaries to the highest quality providers, such information must be allowed to be tailored to the needs and abilities of the patient and their caregiver to follow through with such discharge planning. Since the CAH Swing Bed program does not have to report data on its performance, referring facilities will list CAH Swing Bed on their referral list delivered to patients but have no data to include on said list. This vacuum may lead to discharge decisions that could potentially preclude CAH Swing Bed as a possible transfer choice. NRHA recommends that CMS address this by requiring referring facilities to note on their discharge provider list that CAH Swing Beds are not required to report data similar to freestanding SNFs. While not perfect, this will let the patient know that the CAH Swing Bed didn’t report because they simply refused to, but that no reporting is required nor available to this cohort of PAC providers.

While NRHA strongly supports the consideration of non-healthcare services for patients, including home and physical environment modifications including assistive technologies, transportation services, meal services or household services (or both), including housing for homeless patients, we are concerned about this requirement as a condition of participation. Current incentive programs to discourage readmissions already address this crossover of non-health care factors impacting health care outcomes.

**NRHA encourages CMS to allow flexibility in the discharge planning requirements for rural hospitals.** Rural health care delivery is challenging. Rural hospitals contend with workforce shortages, challenging patient populations, geographic barriers, and low patient volumes to provide high quality personalized care to their communities. These small rural facilities provide round the clock care as needed utilizing a minimal workforce. While NRHA supports the notion that discharge planning begins upon admission of the patient to hospital, we are concerned that for some small rural hospitals, this requirement could be problematic for weekend admissions in certain circumstances. Thus we would encourage CMS to allow flexibility to rural hospitals to enable them to manage limited resources while still meeting the policy goals involved in the discharge planning proposed rule.

**NRHA supports the discharge to home requirements, while encouraging alignment with current billing codes.** CMS proposes that the definition of patient discharge to home includes the following: patients returning to their residence (or to the community if they do not have a residence); who require follow-up with their primary care provider (PCP) or a specialist; HHAs; hospice services; or any other type of outpatient health care service. This definition does not include patients who are transferred to another inpatient acute care hospital, inpatient hospice facility or a SNF. While we agree with the intent of this definition (i.e. differentiating between patients who are returning to their residence and patients who are going to another inpatient facility), the definition appears to conflict with the patient discharge status codes used for uniform billing where discharge to home and discharge to home under the care of HHA are separate codes. We recommend that CMS revise this definition to more clearly align with the terms currently in use for billing.

CMS proposes that discharge instructions must be provided at the time of discharge to patients, or the patient's caregiver/support person (s). The instructions (in paper or electronic format) must include written information on the warning signs and symptoms that patients and caregivers should be aware of with respect to the patient's condition, duties the patient or caregiver will need to perform at home, follow-up care (including appointments, pending or planned diagnostic tests) and medications prescribed and over-the-counter for use after the patients discharge. We support these requirements.

Thank you for the chance to offer comments on this proposed rule, and for your consideration on our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality of and access to care. If you would like additional information, please contact Diane Calmus at dcalmus@nrharural.org, or 202-639-0550.

Sincerely,



Alan Morgan

Chief Executive Officer

National Rural Health Association