December 10, 2015

To: n4a Members
From: Sandy Markwood, CEO
Re: Notice and Request for Feedback on CMS Proposed Regulations for Hospital Discharge Planning Requirements

n4a is seeking feedback from our members on how pending regulations may affect Area Agencies on Aging ability to support older adults and people with disabilities during the discharge process from Hospitals, Critical Access Hospitals and Home Health Agencies.

This memo includes a brief summary of the proposed rule that would update discharge planning requirements for patients receiving Medicare and Medicaid services. We also request member feedback on several components of the proposed rule that we believe may be of particular significance or importance to AAAs, ADRCs and other community-based organizations participating in transitions of care activities with hospitals and other health care providers. However, we welcome your thoughts on other sections of the proposed rule, as well.


Please submit your feedback to Autumn Campbell (acampbell@n4a.org) by close of business on Thursday, December 17. This will allow us time to share our draft letter with members in advance of the Monday, January 4 final deadline for comments, in the hope that many of your agencies will submit your own letters as well.

About the Proposed Regulations

The Centers for Medicare and Medicaid Services (CMS) is proposing to update regulations covering the discharge planning process that Hospitals, including Long-Term Care Hospitals, and Inpatient Rehabilitation Hospitals, Critical Access Hospitals and Home Health Agencies must follow to participate in Medicare and Medicaid. The stated goal of the proposed rules is improve patient quality of care and outcomes; reduce preventable hospital readmissions and avoidable complications following discharge; and modernize planning requirements to better align them with current practice. The proposed rule also intends to implement legislative requirements included in the Improving Medicare Post-Acute Care Transportation Act of 2014 (IMPACT Act).
Summary of the Regulations

The proposed rule would require that a discharge plan be developed for all Medicare and Medicaid patients within 24 hours of admission and finalized before the patient is discharged home or to another facility. The draft includes requirements that the discharge plan be developed based on the goals, preferences and care needs of each patient and made in collaboration with any available caregiver support, taking into consideration the ability of caregivers to participate in necessary follow-up care. The rule also requires discharge plans outline a medication reconciliation and follow-up process for hospitals.

The proposed rule also acknowledges the critical role that home and community-based supportive services serve in both maintaining the health of patients discharged from Post Acute Care (PAC) settings and preventing often avoidable readmissions to hospitals, and specifies that, “When planning transitions, hospitals should consult with Aging and Disability Resource Centers (ADRCs), or Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs)...”

The draft rule states, “ADRCs, AAAs, and CILs are required by federal statute to help connect individuals to community services and supports, and many of these organizations already help chronically impaired individuals with transitions across care settings, including transitions from hospitals and PAC settings back home.”

Additionally, hospitals and other PAC settings would be required to counsel Medicaid Managed Care (MMC) patients about whether PAC settings, home health agencies and other services providers are available within their service network. Hospitals would be required to use and share data, including data on quality and resource use measures with patients and caregivers during the discharge planning process (notably, these quality measures are still under development and are not available or standardized at this point).

Questions and Issues for Consideration by the Aging Network

While n4a supports the person-centered approach that CMS is endorsing for discharge planning, we would appreciate member feedback on the following questions and concerns we have initially raised, as well as any other questions or concerns you have that are applicable to AAAs, Title VI programs and the entire Aging Network.

- **Recommendations regarding coordination and collaboration with the aging and disability networks and other community-based service providers**
  As written, the rule encourages, but does not mandate, hospital and PAC provider collaboration and coordination with community-based organizations; and
recognizes that community services and supports—including home and physical environment modifications, access to assistive technologies, transportation services, meal services, household services and even housing support services—can be essential to successful patient care post-discharge. However, the rule does not require hospitals to communicate, coordinate or collaborate with local AAAs, ADRCs or other CBO service providers. Furthermore, the rule does not provide any specification about payors for community supportive services other than to say aging and disability network entities are “required by federal statute” to connect patients and caregivers to community-based support options.

n4a is very concerned that the draft regulation does not require hospitals to collaborate with community-based supports and services, nor does it require compensation for the resulting community-based services. Simply recommending that hospitals and PAC providers collaborate with AAAs and other Aging and Disability Network entities could place an undue financial burden on an already fiscally stressed HCBS system.

Please tell us how the regulation as written would affect your agency’s ability to serve your full client population. What recommendations would you have to ensure that community-based service providers receive adequate compensation for their participation in discharge planning activities?

• Implications for Community-Based Care Transitions Program and Other Transitions of Care Activities
The proposed rule expands the discharge planning process and emphasizes the importance of communication, planning, and patient and caregiver input through multiple phases of care and across care settings. However, many AAAs remain engaged in a CMS-supported pilot program to provide many of the exact services outlined in the proposed rule, while others are contracting directly with hospitals for a similar service.

We request your feedback on whether services outlined in the proposed “discharge planning” regulation are aligned with “care transitions” activities and how this nuance and definition might affect or alter current care transitions contracts that AAAs and CBOs have with hospitals and PAC providers. If these services are provided and paid for under the category of discharge planning, could that affect current and future contracts for care transitions services?

• Implications for Medicaid Managed Care Patients and Providers
The proposed regulation applies to both Medicare and Medicaid service providers, and the rule specifies that patients who are part of a Medicaid Managed Care delivery system must be made aware of whether PAC and other health and non-health service providers are part of their MMC network. However, the rule does not address network adequacy concerns emerging within Managed Care systems.
We request feedback on what, if anything, CMS can do to specify and require that hospitals ensure MMC patients and caregivers receive access to needed services and support as part of discharge planning activities if those services are not provided for within their Managed Care network.

We also welcome feedback on any other issues or concerns with the proposed rule and encourage you to share with us any comments you are submitting to CMS. Your feedback will be essential to helping us develop our comments to the rule, which we will share with members later this month.

Again, please submit your feedback to Autumn Campbell (acampbell@n4a.org) by close of business next Thursday, December 17. Thank you for taking time to help n4a develop our response to CMS's proposed rules regarding discharge planning.