December 30, 2015

The Honorable Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave, 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

Dear Administrator Slavitt,

The American Case Management Association (ACMA) appreciates the opportunity to submit comments on proposed rule CMS-3317-P. ACMA is comprised of more than 6,000 nurses, social workers, physicians, educators, administrators, and other professionals – representing approximately 985 U.S. hospitals, nearly 40% of all U.S. hospitals – responsible for providing case management and transitions of care services in hospitals or health systems.

As you know, health care delivery system case managers and transitions of care professionals are clinically-competent practitioners who serve as daily advocates on behalf of both patients and the organization for which they work. As such, the changes and processes detailed in this proposed rule are of particular concern to our membership.

The goals of the agency’s proposed rule are consistent with case management’s discharge planning goals, and align with ACMA’s Standards of Practice and Scope of Services for Health Care Delivery System Case Management and Transitions of Care Professionals, which define “assessment” as:

The identification and documentation of the patient’s initial transitional care needs within 24 hours of admission for the following elements:

- Medical necessity for patient status and level of care
- Psychosocial needs
- Clinical needs
- Anticipated discharge needs
- Spiritual needs
- Patient/family/caregiver health care level of understanding

However, we have concerns related to some of the specific requirements and operational expectations outlined in the proposed rule, many of which will place an undue burden on case management professionals; creating inefficiencies and barriers to efficient and effective care.
Outlined below are our organization’s concerns and requests, as well as particular areas we encourage CMS to reevaluate.

**Change in Patient Condition**
As a patient's condition may change during hospitalization – for better or worse – implementing a discharge plan 24 hours after admission may not be possible or practical as multiple factors may change.

**Request**
As reflected in the previously cited Standards of Practice and Scope of Services for Health Care Delivery System Case Management and Transitions of Care Professionals, performing the initial screening within 24 hours is important and can be achieved with the admission assessment. We request that this requirement be satisfied through the admission assessment, and ask that CMS issue guidance clearly stating that the admission assessment is acceptable.

**Requirements for Post-Acute Care Services**
In regards to the proposal to re-designate and revise the requirements of current §482.43(c)(6) through (8) at new §482.43(f), “Requirements for post-acute care services” – while acute care case management professionals accept the responsibility to timely refer the patient upon receipt of a post-acute order, clarification is needed in regards to the acceptance process and responsibility between acute and post-acute facilities.

**Request**
We request that the requirement be revised to clearly state, “once the referral is made by the acute care team, the responsibility to accept patients timely within 12-24 hours of notification lies with the post-acute facility.”

**Home Health Agencies (HHAs)**
In regards to §482.43 Condition of participation: Discharge planning (f) Standard: Requirements for post-acute care services, ACMA members have identified the following challenges:

- **a.** Some HHA offices or service units are located in states that border the facility – information pertaining to which HHAs are able to provide services in more than one state is not accessible. Even if one is able to determine which states offer reciprocity, in the event of a change of ownership, the list becomes inaccurate.
- **b.** It appears as though HHAs are not required to list the geographic area they cover, and as a result, ACMA members report that some HHAs may choose to list areas in which they have not yet penetrated the market and opportunities for business exist, resulting in hospitals providing a list of HHAs with questionable availability in a given geographic area.
- **c.** Ensuring the list of HHAs is current represents a significant burden due to consolidation of HHAs, changes of ownership and closures among other factors. An inaccurate or outdated list of HHAs can often lead to delayed discharges and creates an opportunity for negative patient outcomes. The requirement that providers request to be added to the list
was first included in the Balanced Budget Act of 1997, when Medicare Compare information was not available. At that time, the requirement mandated that skilled nursing facilities (SNFs) request to be added to the list. The SNF requirement was removed with the creation of the Nursing Home Compare website. As there is now an online resource for home care services in Home Health Compare, it is no longer necessary to continue to require that these providers request to be on added to the list.

**Request**

Based on the above issues and challenges, we request the removal of the requirement, which states, “HHAs must request to be listed by the hospital as available.” Additionally, we request that CMS put measures in place and dedicate resources to ensure that medicare.gov remains current, providing patients with an accurate resource in which information can be accessed in real time.

**Prescription Drug Monitoring Program (PDMP)**

There are considerable differences in the PDMPs between states in regards to their goals, operations and decision-making processes. Furthermore, restrictions dictate who, why, and when the reports can be utilized. For example, some states do not allow the reports to be part of the medical record, while other states only allow the reports to be in the possession of the person that produced the report. Considerable delays can also exist between the time when a prescription is filled and when the data arrives in the database, which would make the databases less useful for acute needs.

For these reasons, large scale use for medication reconciliation is not feasible. Evidence is currently lacking in support of larger scale benefits with respect to medication reconciliation and PDMPs.

In addition, such a requirement would be particularly challenging for hospitals whose patient population crosses multiple states: would these health care systems be required to check all state databases that may border the hospital? Consideration should be given to the time burden imposed by such a requirement versus the potential benefits.

This requirement also carries the possibility of hardship for hospital case managers, discharge planners and pharmacy staff tasked with conducting cross-checks.

**Requests**

In the absence of standardization or a national repository, a PDMP “requirement” is not a viable option. Until such time that standardization exists and a national repository is introduced, our association does not support the PDMP and requests the removal of this provision.

Furthermore, the manner in which hospitals and health care providers will interpret the current PDMP requirements – and the degree to which health care providers will comprehend the information – will vary widely. The program will not achieve its desired results without a
comprehensive orientation initiative. Once the aforementioned processes to introduce standardization and a national repository have occurred, ACMA requests that CMS establish a national training campaign for health care providers prior to implementing this type of monitoring.

**Patient Choice among Certified Providers**
Currently the Compare website is only updated once per year, allowing significant room for inaccurate or outdated information. In the absence of a current, dynamic resource, no reliable reference exists through which HHAs, SNFs, IRFs, or LTCHs can be identified.

Case management and transitions of care professionals comply with rules requiring informed patient choice in regards to provider. However, assurance that providers’ certification status is accurate and current can only occur through a dynamic, centralized database.

**Request**
ACMA requests that CMS provide a dynamic, publicly available database allowing access to certified providers. Such a database should be regularly updated with certification status by the appropriate agencies.

**Involvement of Patient and Care Giver Support and the provision of Quality Data**
The involvement of the patient and caregiver in the patient’s plan of care is essential for optimal outcomes. In addition, the provision of quality data to patients and families can be very beneficial, however, we are concerned about the manner in which care performance data is made available to patients. While the Hospital Compare website is a valuable resource, in some cases its data can cause confusion, rather than offer clarity. For example, one performance indicator may be positive for a given agency, while another may be less favorable. Patients and families will require the expertise of case management professionals to “sift through” and interpret this data. Further study is needed on data visualization techniques to ensure that data is easily understood and meets CLAS Standards; particularly if hospitals are permitted to use their own performance data to inform patients.

**Request**
We request that CMS establish standard, publically-available data visualization and interpretation standards or guides. Such resources will increase health care consumers’ knowledge and allow them to make informed decisions regarding their care.

**Data Sharing**
While ACMA supports the proposed data sharing requirements for all patients, there is redundancy between the proposed rule and prior rules from CMS, such as the Meaningful Use requirements. Furthermore, the additional criteria of adherence to the national CLAS standards within this proposed rule has potential for confusion.
Request
We request that CMS align this requirement with the agency’s Health IT Certification requirements in order to eliminate redundancies.

Instructional Content
While ACMA supports the instructional content outlined in the proposed rule, we are concerned that these provisions have the potential to cause confusion with similar requirements previously mandated in the Health IT Certification Requirements.

Request
Again, we request that CMS align this requirement with the agency’s Health IT Certification requirements to eliminate redundancies.

Thank you for your time and consideration of our requests and recommendations. We appreciate your willingness to listen to the concerns of health care delivery system case management and transitions of care professionals.

Should you have any questions, please feel free to contact me at 501-907-2262 or lgcunningham@acmaweb.org.

Cordially,

/s/

L. Greg Cunningham, MHA
CEO
ACMA