August 4, 2022

David Wright
Director, Quality, Safety & Oversight Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

SUBJECT: Forthcoming Guidance on Discharge Planning Requirements

Dear Mr. Wright:

On behalf of our more than 400 hospitals and health systems, including acute and post-acute provides across the patient care continuum, the California Hospital Association (CHA) writes to provide clarifying questions for the Centers for Medicare & Medicaid Services (CMS) to consider as it develops surveyor guidance on the Conditions of Participation for discharge planning for short-term acute care hospitals, critical access hospitals (CAHs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and home health agencies (HHAs).

California hospitals are committed to providing safe and effective discharge planning in partnership with patients and their caregivers and have revised their practices to ensure compliance with the requirements of the 2019 discharge planning final rule. However, as implementation has continued, CHA members have identified several areas that would benefit from clarification or additional information. Notably, the final rule became effective on November 29, 2019 — less than two months before the beginning of the COVID-19 public health emergency (PHE) — and several of the requirements have been waived for the duration of the PHE. As hospitals prepare for the expiration of these waivers at the end of the COVID-19 PHE, we urge CMS to expeditiously issue interpretive guidelines that address providers' questions as detailed below.

Standard: Discharge Planning Process and Selection of Post-Acute Care Provider

The final rule established a new requirement at 42 CFR §482.43(a)(8) that requires hospitals to assist patients and their support persons who are transferred to a post-acute care (PAC) provider — including an IRF, LTCH, skilled-nursing facility (SNF), or HHA — in selecting a provider by using and sharing data that includes IRF, LTCH, SNF, or HHA data on quality measures and resource use.

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 ▪ Office: (202) 488-3740 ▪ FAX: (202) 488-4418

1215 K Street, Suite 700, Sacramento, CA 95814 ▪ Office: (916) 443-7401 ▪ www.calhospital.org

CHA supports informed decision-making and the provision of information to patients to support their care decisions and provider selection. In this context, we appreciate CMS' requirement that the facility must ensure that these data are relevant and applicable to the resident's goals of care and treatment preferences. However, hospitals and discharge planners continue to seek additional clarification on how CMS will view compliance with these requirements, including acceptable types and sources of data, as well as expectations for documenting compliance with these requirements. In addition, hospitals have raised questions about how to support informed patient choice without appearing to steer the patient toward a selection.

Quality and Resource Use Data

In the final rule, CMS states that providers should use setting-specific data from the Care Compare website to assist patients as they choose a PAC provider that aligns with the patient's goals of care and treatment preferences. CMS also states that while providers are not expected to give overly detailed and complex analyses of the quality and resource use data, they should put forth their best effort to answer patient questions regarding the data provided. CHA requests that CMS clarify its view on how a hospital or other providers can demonstrate that this important information has been provided to the patient or their caregivers. CHA suggests that CMS require that 1) health care facilities and services develop policies and procedures that address the need to provide setting-specific data that align with the patient's goals of care and treatment preferences, including, but not limited to, relevant information accessible on Care Compare, and that 2) the patient's medical record includes documentation that information was provided and discussed with the patient and/or their representative.

CMS also notes that providers can use additional information to assist patients in their selection — so long as the information presented aligns with the patient's goals and treatment preferences — and states that the IMPACT Act in no way limits providers' ability to augment the information provided to patients. It is unclear if such additional information is required to be given for all possible providers. For example, if a specific post-acute provider has delivered to the acute care facility additional materials (e.g., brochure, quality report) about their facility, is it acceptable to provide that to the patient if similar information is not available for other facilities providing that level of care, or would CMS view this as the hospital steering a patient toward a specific facility? We urge CMS to clarify its view on the provision of additional information beyond publicly reported quality and resource use data.

Standard: Requirements Related to PAC Services

The final rule requires hospitals to include within the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, are participating in the Medicare program, and serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. The regulation also requires that hospitals must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services, and that hospitals must not specify or otherwise limit the qualified providers or suppliers that are available to the patient. **CHA is concerned that this requirement could inadvertently lead to patient confusion and dissatisfaction when a hospital provides a full list of PAC providers in a geographic region, despite knowledge that certain facilities are unwilling or unable to admit them.**

Hospitals and discharge planners understand that many patients who require PAC services have conditions or characteristics that will significantly limit the number of facilities that are willing or able to

admit them. For example, many post-acute facilities will not accept patients with complex medical needs, such as those who require dialysis or costly medications, bariatric patients, and individuals who exhibit aggressive or disruptive behavior. Hospitals also report significant delays in placing patients in post-acute settings that are able to meet behavioral health needs of patients with serious mental illness and substance use disorders. In these scenarios, patient choice is limited by post-acute facility admission policies. Providing a patient or their caregiver with a full list of facilities in the geographic region can result in several frustrating rounds of selecting and being denied admission to a post-acute facility, ultimately delaying the discharge process. CHA requests that CMS clarify that hospitals may reasonably include in the facility list any available information about actual bed availability, as well likelihood of timely access and acceptance. We also suggest that hospitals may include information on implications of delayed discharge, including patient responsibility for payment if applicable.

Preferred Provider Designation

Hospitals have increasingly developed relationships with PAC providers to better manage patient care. These partnerships have been key to successes under alternative payment models, such as the Comprehensive Care for Joint Replacement model, as these close partnerships help to improve quality and function and reduce readmissions to the hospital. Our members believe it would be beneficial to patients and their families to be provided information when these partnerships exist. However, in the preamble of the final rule CMS states that "hospitals must not develop preferred lists of providers."

CHA is also aware of communication from CMS to the Health Dimensions Group in December 2019 which stated that while hospitals cannot share an exclusive list of preferred providers with patients under the discharge planning regulations, "it is acceptable for the hospital to note which of the PAC providers on the list are identified as 'preferred providers' of the hospital so long as the hospital is not presenting the patient with an exclusive list of only preferred providers or suppliers." **CHA believes that this clarification allows the hospital to provide additional relevant information to the patient's goals and treatment preferences, without restricting or limiting the patient's freedom to choose among the full range of post-acute providers or suppliers available to the patient at discharge. We urge CMS to codify this clarification in its interpretive guidelines.**

Documentation

We appreciate that in the preamble of the final rule, CMS stated that "it is important to allow hospitals the flexibility to determine the manner in which they document in the patient's medical record that the list of PAC providers was presented to the patient or to the patient's representative." CHA agrees that hospitals should be permitted to develop documentation policies that work best for their organization. For example, some hospitals and health systems have worked with their electronic health record vendors to develop discharge planning modules that allow staff to indicate that the information was provided to the patient, which post-acute provider the patient selected, if the patient declined PAC services, and other relevant information. **However, we are concerned that absent further guidance on documentation, surveyors will inconsistently apply these standards. We urge CMS to include several examples of permissible documentation practices to ensure hospitals have a clear understanding of expectations prior to surveys.**

CHA appreciates the opportunity to provide input on the ongoing implementation of discharge planning requirements. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-

3742, or my colleague Patricia Blaisdell, vice president, policy, at pblaisdell@calhospital.org or (916) 552-7553.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy