Emergency Department EDPMA Practice Management Association

January 4, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3317-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Re: RIN 0938-AS59; CMS-3317-P; Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies

Dear Acting Administrator Slavitt:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, **EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year**. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

EDPMA appreciates the opportunity to provide comment on CMS' proposed revisions to the discharge planning requirements that hospitals must meet in order to participate in the Medicare and Medicaid programs.

Design (Proposed § 482.43(a))
CMS proposes to establish a new standard, "Design", and would require that hospital medical staff, nursing leadership, and other pertinent services provide input in the development of the discharge planning process. CMS also proposes to require that the discharge planning process be specified in writing and be reviewed (initially and periodically) and approved by the hospital's governing body.

Generally, EDPMA supports this proposal. We believe it is in the best interests of patient care and applaud CMS' efforts to insure appropriate and effective transitions of care from the hospital into the community, so that outcomes, safety, and cost considerations are addressed effectively.

However, we are concerned that emergency medicine physicians have not been specifically identified

as required participants in providing input into the development of the discharge planning process. We believe the emergency medicine perspective will be vitally important, particularly given that CMS later proposes (under Proposed § 482.43(b)) to require that the discharge planning process apply to "*…emergency department patients who have been identified by a practitioner as needing a discharge plan…*" Therefore, **we urge CMS to specify that emergency medicine physicians be among the required stakeholders that the hospital must consult when developing its discharge planning processes**. This will be important to ensuring that appropriate protocols are put into place for identifying patients who "need" a discharge plan vs. those who do not, and for ensuring that relevant efforts will make a meaningful impact on both patient care and the economic and practical implications inherent in the discharge planning process.

Applicability (Proposed § 482.43(b))
At proposed § 482.43(b), "Applicability," CMS proposes to require that many types of patients be evaluated for post discharge needs, including *"…emergency department patients who have been identified by a practitioner as needing a discharge plan.…"*

We support this proposal, but again **we urge CMS to adopt our aforementioned recommendation that would ensure emergency medicine physicians are included in the development of the discharge planning process**.

Discharge Planning Process (Proposed § 482.43(c))
Among other things, CMS proposes a new requirement at § 482.43(c)(4) that the practitioner responsible for the care of the patient is involved in the ongoing process of establishing the patient's goals of care and treatment preferences that inform the discharge plan, just as they are with other aspects of patient care during the hospitalization or outpatient visit.

While EDPMA supports this proposal, we encourage CMS to clarify in the final rules that the "*practitioner responsible for the care of the patient*" is not limited to the emergency medicine physician (in the case of "*emergency department patients who have been identified by a practitioner as needing a discharge plan")*, but includes the patient's regular primary care physician (PCP), if there is one, and other medical specialists following the patient for chronic health conditions, if applicable.

As we have explained in previous comments, emergency medicine physicians provide unscheduled acute care that is often limited to a single encounter, or involves an acute exacerbation of a chronic condition. Although, emergency medicine physicians increasingly play a significant role in coordinating care for patients who visit the emergency department, this has largely been unrecognized in Medicare's payment systems, though it is an obvious component of the discharge planning process.

Notwithstanding this important role, there are several realities that face nearly every emergency medicine practice. Not only do emergency medicine physicians coordinate care for patients who have the necessary components available for high-quality care (primary care physician, specialists, means to pay for medication, transportation, etc.), emergency physicians must often play a role as "Safety Net" providers and as such, regularly encounter significant challenges that limit the ability to accomplish meaningful discharge planning. For example, the patient may be unable to communicate their overall goals of care and treatment preferences that would inform a robust discharge plan (including those that

are involved with longitudinal medical care, especially when access to the patient's prior medical records is limited); more importantly, there are additional limitations in establishing appropriate

discharge planning when the patient does not have a primary care physician, appropriate specialists, or adequate means to access community-based medical care.

For these reasons, we maintain that a patient's other regular health care providers should be available to assist in developing the discharge plan. To facilitate this, CMS should develop a quality measure for use in its current and future quality improvement programs (e.g., hospital outpatient quality reporting program (OQR), the Physician Quality Reporting System (PQRS) and the future Merit-Based Incentive Payment System (MIPS)) that would take into consideration whether hospitals and emergency medicine physicians consulted the patient's primary care physician and other specialists managing the patient's chronic health conditions, if applicable, in developing the discharge plan. CMS should develop an additional quality measure that would recognize whether the patients PCP and/or other specialists availed themselves to providing the aforementioned assistance. However, it is important to note that a large number of patients visiting the emergency department do not have a primary care provider. Thus, the quality measures that are developed must reward ED physicians who in good faith attempt to identify the patient's primary care physician even when there is no PCP available.

CMS is also proposing a new requirement at § 482.43(c)(8) to require that hospitals assist patients, their families, or their caregiver's/support persons in selecting a PAC provider by using and sharing data that includes but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. As proposed, the hospital would have to ensure that the PAC data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. CMS would also expect the hospital to document in the medical record that the PAC data on quality measures and resource use measures were shared with the patient and used to assist the patient during the discharge planning process.

EDPMA supports this proposal and looks forward to collaborating with hospital administration, staff and patients to identify, and discharge patients to, the most appropriate PAC provider for the patient's unique needs, especially for transfers from the emergency department to a home health agency. Toward that end, **we urge CMS to make available timely, robust quality and resource use data (as reported by PAC providers) on its various "Compare" web sites to assist hospitals and emergency medicine physicians with making these recommendations. We also urge CMS to develop tools that would help streamline the ability of hospitals and emergency medicine physicians to readily filter quality and resource use data to make a recommendation more easily.** This would help facilitate the CMS expectation that the hospital would be available to discuss and answer patients and their caregiver's questions about their post-discharge options and needs. Finally, **we urge CMS consider developing quality measures for use in its current and future quality improvement programs (as outlined above) that would take into consideration whether hospitals and emergency medicine physicians have consulted available resources to make appropriate PAC referrals.**

Discharge to Home (Proposed § 482.43(d))

CMS proposes to re-designate and revise the current requirement at § 482.43(c)(5) as § 482.43(d), "Discharge to home," to require that the discharge plan include, but not be limited to, discharge

instructions for patients described in proposed § 482.43(b) in order to better prepare them for managing their health post-discharge. CMS also proposes at § 482.43(d)(1) that discharge instructions must be provided at the time of discharge to patients, or the patient's caregiver/support person (s), (or

both) who are discharged home or who are referred to PAC services. CMS is also proposing that practitioners/facilities (such as a HHA or hospice agency and the patient's PCP) receive the patient's discharge instructions at the time of discharge if the patient is referred to follow up PAC services. CMS explains that discharge instructions can be provided to patients and their caregivers/support person(s) in different ways, including in paper and electronic formats, depending on the needs, preferences, and capabilities of the patients and caregivers.

EDPMA notes that a lack of interoperable electronic health records (EHRs) limit the ability of hospitals and emergency medicine physicians in transferring this information in an electronic format to certain PAC providers, particularly if the PAC provider is part of another health system. In addition, PAC providers are not required to adopt and "meaningfully use" EHR systems, as hospitals and eligible professionals are required, which means the PAC providers may not have a certified EHR system for which the hospital or emergency medicine physician could transfer the information in an electronic format. While CMS is not requiring the information to be transmitted electronically, **we urge CMS to work with the Office of the National Coordinator for Health IT to address our longstanding concerns with the lack of interoperable health information technologies which would help facilitate our ability to exchange discharge plans with PAC and other providers.**

CMS also proposes a new requirement at § 482.43(d)(2)(ii) that the discharge instructions include written information on the warning signs and symptoms that patients and caregivers should be aware of with respect to the patient's condition. The warning signs and symptoms might indicate a need to seek medical attention from an appropriate provider, depending on the severity level of the signs or symptoms. The written information would include instructions on what the person should do if these warning signs and symptoms present. Furthermore, the discharge instructions would include information about who to contact if these warning signs and symptoms present. This contact information may include practitioners such as *"…the practitioner who was responsible for the patient's care while in the hospital or hospital emergency care departments…*"

We support CMS' proposal and would encourage patients to return to the emergency department if warning signs and symptoms outlined in the discharge plan were present. However, we note that in many instances, the emergency medicine physician who initially treated the patient in the emergency department may not be the same emergency medicine physician seen for warning signs and symptoms. **We encourage CMS to recognize this anomaly in the final requirements so it is not expected that the same emergency medicine physician is available.**

Transfer of Patients to another Health Care Facility (Proposed § 482.43(e))
CMS proposes to re-designate and revise the standard currently set out at § 482.43(d) as § 482.43(e), "Transfer of patients to another health care facility," by clarifying its expectations of the discharge and transfer of patients. CMS states that it would continue to require that all hospitals communicate necessary information of patients who are discharged with transfer to another facility. While CMS does not propose to mandate a specific transfer form, it does propose to clarify its expectations regarding what constitutes the necessary medical information that must be communicated to a receiving facility to meet the patient's post-hospitalization health care goals, support continuity in the

patient's care, and reduce the likelihood of hospital readmission and align these data elements with the common clinical data set published in the "2015 Edition of Health Information Technology (Health IT) Certification Criteria, Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications" final rule (80 FR 62601, October 16, 2015). By aligning the data

elements proposed in this proposed rule with the common clinical data set specified for the 2015 edition, we are seeking to ensure that hospitals can meet these requirements using certified health IT systems and existing standards.

We thank CMS for not making a requirement that discharge plans are not transferred electronically, but reiterate our concerns with the lack of interoperable EHRs, which would facilitate the exchange of this information with other facilities in a more timely fashion.

Requirements for Post-Acute Care Services (Proposed § 482.43(f))
CMS proposes 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." The current regulation directs hospitals to provide a list of available Medicare-participating HHAs or SNFs to patients for whom home health care or PAC services are indicated, and CMS is proposing that for patients who are enrolled in managed care organizations, the hospital must make the patient aware that they need to verify the participation of HHAs or SNFs in their network. If the hospital has information regarding which providers participate in the managed care organization's network, it must share this information with the patient.

Similar to our aforementioned comments, **we urge CMS to develop tools that would help streamline the ability of hospitals and emergency medicine physicians to readily identify whether a recommended PAC provider is part of the patients "in-network" health plan.**

Thank you for considering our comments on these important revisions to the discharge planning process. Please let us know if you have any questions or if we can provider more detail about our recommendations. Should you have any questions, please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,

Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors