January 4, 2016

VIA ELECTRONIC SUBMISSION

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

RE: Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (RIN 0938–AS59)

Dear Administrator Slavitt:

The undersigned members of the Independence Through Enhancement of Medicare and Medicaid Coalition (ITEM) offer comment on the proposed rule entitled, *Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies* (the Proposed Rule). ITEM is a coalition of national organizations dedicated to raising awareness and building support for policies that will improve access to assistive devices, technologies and related services for individuals of all ages with injuries, illnesses, disabilities and chronic conditions. ITEM appreciates the opportunity to comment on the above-referenced proposed rule. This Proposed Rule would revise the discharge planning requirements with which these settings must conform in order to participate in the Medicare and Medicaid programs.

Overview

The primary purpose of discharge planning is to transition patients to subsequent providers in the continuum of care, and to provide for the patient's immediate needs once discharge from a setting of care takes place. While an improved discharge planning process could have implications on all patients, our comments focus on the implications of improved discharge planning on patients in need of medical rehabilitation, specifically access to durable medical equipment, prosthetic and orthotic care, and other assistive devices and technologies that compensate for functions lost to illness or injury including mobility, hearing, speech, and related functions.

For instance, individuals who are non-ambulatory due to injury or illness may require an assessment and a prescription for a wheelchair or other type of wheeled mobility. A person with hearing loss might need a hearing aid or an assessment for cochlear implantation. An individual

who has had a stroke might require an augmentative communication device (AAC) to assist in the ability to verbally communicate or an ankle-foot orthosis to provide safe ambulation with a stable gait. Patients with recent amputations might need a rehabilitation program to adapt to their new circumstances, such as wound care provided in the home setting, mobility aids and, of course, an evaluation for a prosthetic limb.

Too often, the current health care system separates care between the hospital episode and subsequent follow up. In the intense environment that describes most inpatient acute care hospitals, the discharge planning process often consists of little more than handing off the patient to those providing the next immediate set of services needed by the patient and an opportunity to negotiate payment terms for services rendered. Many patients requiring additional rehabilitation are sent to the setting most likely to accept them, rather than the setting that truly meets their rehabilitation and ongoing medical needs. Too often, patients with continuing rehabilitation needs are simply sent home with little or no follow up.

The need for specialty services such as access to assistive devices and technologies may be identified through the discharge planning process but referrals to specialty providers often become the responsibility of the patient and or his or her family to pursue and arrange. The problem is exacerbated when support structures are not in place, such as family or friends.

For instance, recent Medicare data suggests alarming deficiencies in transitions of care for beneficiaries with limb loss. Approximately 50 percent of Medicare beneficiaries who lose a limb never submit a subsequent claim for a prosthetic limb, and the percentage of those not submitting such claims grows dramatically with each decade of age. While there may be valid reasons why particular amputees do not receive a prosthetic limb, these statistics suggest a major deficiency in the transition of amputees from acute and post-acute hospital providers to outpatient providers of rehabilitation/prosthetic care.

For individuals with long-term mobility impairments who require wheeled mobility, the selection of the proper wheelchair and accessories to enable maximum function is critical. This assessment is often best performed by a seating clinic where experienced providers can take all of an individual's needs into account before recommending the specific components that comprise appropriate wheeled mobility for that individual. Those with hearing loss require referrals to audiologists to assess hearing technology options. Those with vision impairments require referrals to vision professionals to help assess and prescribe appropriate vision aids.

ITEM believes that this Proposed Rule is an opportunity to not only ensure that patients are guided to the best care in the best setting to meet their needs, but also to ensure that a more pro-active, longer-term treatment plan is formally established, with an emphasis on access to assistive devices and technologies. This would include accountability for those designing the discharge plan to follow up through an information loop among providers that extends well beyond the date of discharge. Fostering greater communication among appropriate providers will create more seamless transitions in care and better implementation of care plans, thereby improving health outcomes and the efficiency of the health care system.

Preserving Patient Choice

There is currently a dichotomy between this patient-centric discharge planning proposed rule and the way new payment models, such as Accountable Care Organizations (ACOs) and other alternative delivery models, seek to control their referral patterns, often employing the use of "soft-steering" techniques to help control health care costs and provide efficient care. These arrangements often have the effect of inhibiting patient choice of provider, one of the hallmarks of the Medicare fee-for-service program. ITEM believes that Medicare patients should ultimately be informed of their care options and be active decision-makers in the care process, as well as the provider selection process. ITEM believes that patients needing durable medical equipment, as well as prosthetic and orthotic services should have a choice of the selection of their provider to the greatest extent possible.

Improving Access to Assistive Devices and Technologies

To ensure that patients needing rehabilitative devices or technologies of any kind receive the proper care and actually receive prescribed treatments, ITEM believes that the Proposed Rule should address the following:

- The care team for the hospital or post-acute care provider should be required to take a more active role in discharge planning, including a formal meeting where the patient's care plan post-discharge from each setting is specifically discussed and condensed into writing. The patient and family should have an opportunity to discuss the discharge plan before it is finalized, offer preferences, and arrive at a consensus plan with the discharging provider.

- Discharge planners should be required to discuss in depth with patients and, where appropriate, their families, the rehabilitation devices and assistive technologies being prescribed post-discharge and the range of appropriately credentialed providers available to provide those services. The discharge planner should be obligated to contact selected providers and alert them to the patient's referral to their services and facilitate contact between the patient and the subsequent provider(s). The discharge planner should also be required to follow up after an appropriate time to ensure the referred provider is in contact with the patient, consistent with the discharge plan.

- Choice of provider continues to be a major tenet of the Medicare program and patients and their families should continue to have as much choice as possible, given the incentives inherent in provider networks and other alternative payment arrangements. Patient and family preferences should be fully incorporated into the discharge planning process.

- Any patient in need of wheeled mobility, especially those in need of complex rehabilitation technology (CRT), should be referred to an appropriate physician specialist and/or mobility clinic that can accurately assess the individual's needs and match available technologies to meet those needs.

- Any patient with vision or hearing impairments should be referred to appropriate physician specialists and providers/programs with expertise in improving these functions through vision and hearing devices and technologies.

- Any patient who requires custom orthotic braces or prosthetic limbs should be referred and placed in contact with a physician specialist with appropriate knowledge and expertise of rehabilitation and prosthetics/orthotics as well as an appropriately credentialed prosthetist or orthotist to make an O&P assessment and recommend a treatment plan.

- All patients with long term disabling conditions should also be referred to appropriate support groups and peer counseling programs to assist them in adapting to their new circumstances.

- Finally, all such patients should be referred to appropriate primary care so that basic and ongoing primary health care needs are not overlooked. Discharge planners should ensure that all such primary care providers are fully accessible as required of all health care providers under the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973, as amended.

Accountability

ITEM believes that proper discharge planning should include providers making affirmative obligations to prepare the patient for future care, and mechanisms to hold all parties involved with the patient's care accountable. In the case of patients requiring assistive devices and technologies:

- The physician and/or the provider of the assistive device/technology to which the patient was referred under the discharge plan should reconnect with the referring discharge planner to ensure a smooth transition and report the patient's status.

- The discharge planner should on a timely and periodic basis, review the plans of patients who have been discharged. For every patient where the referred provider has not been in contact, the discharge planner should be expected to follow up to ensure a smooth transition.

- The Proposed Rule should ensure better coordination among acute and post-acute care providers and stress that all of these providers have responsibilities to assist in securing optimal outcomes for individuals in need of rehabilitation devices and assistive technologies.

We greatly appreciate your attention to our comments and recommendations with respect to the proposed rule on discharge planning. Should you have further questions regarding this comment letter, please contact Peter Thomas or Sara Rosta by emailing Peter.Thomas@ppsv.com or Sara.Rosta@ppsv.com, or by calling 202-466-6550.

Sincerely,

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