



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

Dear Administrator Slavitt:

The Steering Committee of the Coalition to Preserve Rehabilitation (CPR) appreciates the opportunity to comment on the proposed rule entitled, *Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies* (the 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. CPR is a coalition of national consumer, clinician, and membership organizations that advocates for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions can regain and/or maintain their maximum level of health and independent function.

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. For instance, a patient being discharged from an acute care hospital may need additional inpatient rehabilitation provided in either a hospital or a skilled nursing setting, or home health care including some type of durable medical equipment to move about their home, oxygen therapy, temporary nursing care, or wound care. Patients with certain conditions may need specialized services such as brain injury treatment programs or prosthetic limb care, depending on the individual needs of patients.

Too often, the current health care system bifurcates 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. Specialty services may be identified but referrals to specialty providers often become the responsibility of the patient and his or her family to pursue and arrange. Prescribed pharmaceuticals and diagnostic tests may be lost in the fog of the post-hospital patient experience, especially when patients lack sufficient support structures from family or friends.

CPR 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 accountability for those designing the discharge plan to follow up through an information loop among providers that extends well beyond the date of discharge. Ensuring proper care in the proper setting will likely lead to decreased hospital readmissions and better patient outcomes over time. Fostering greater communication among appropriate providers will create more seamless transitions in care and better implementation of care plans, allowing patients to avail themselves of rehabilitation and other health care benefits across multiple settings as clinically appropriate.

CPR also supports the fact that the discharge planning requirements in this proposed rule apply to post-acute care (PAC) providers such as Long Term Acute Care Hospitals (LTACHs), Inpatient rehabilitation hospitals and units (IRFs), and Home Health Agencies (HHAs). This will help ensure that patients who pass through these settings will have the same opportunities for appropriate transitions of care and access to necessary follow-up services. However, the glaring deficiency in this proposed rule is the omission of Skilled Nursing Facilities (SNFs). SNFs should be held to the same discharge planning requirements as these other PAC providers so there is no gap in accountability for rehabilitation patients being discharged from any PAC setting.

Proper Care in the Proper Setting

To ensure that patients needing rehabilitative services receive the proper care in the proper setting and actually receive prescribed treatments, CPR believes that the Proposed Rule should address the following:

- The care team for the hospital or PAC 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.
- Discharge planners should be required to discuss in depth with patients and, where appropriate, their families, the services being prescribed post-discharge and a range of 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 with a permanently disabling or chronic condition should be referred and placed in contact with a physician subspecialist with appropriate knowledge and expertise to treat the patient's specific condition post-discharge, and thereby accept new responsibilities to design an ongoing plan of care. For instance, patients with serious neuromuscular conditions or brain injuries should be referred to neurologists and/or physiatrists, patients with kidney failure should be referred to nephrologists, patients with severe arthritis should be referred to rheumatologists, and so on.
- For patients in need of inpatient rehabilitative services, the proposed rule should clarify that discharge planners must:
 - Use best efforts to place each patient in the setting that is most appropriate to meet his or her medical and rehabilitation needs post-discharge. For instance, patients requiring intensive, coordinated, multidisciplinary rehabilitation should be discharged to an inpatient rehabilitation hospital, not a SNF. Similarly, patients requiring skilled rehabilitation and nursing services should be discharged to a SNF, not directly to home. Those who are discharged directly to home should receive the home health services they require under the discharge plan.
 - Disclose the financial relationships between their institution and the providers to which they are referring patients.
- For patients in need of specialty services as a result of their specific condition, the final rule should clarify that discharge planners have a responsibility to identify those providers and connect patients with them through the discharge planning process. A small subset of examples follows for particular types of patients.
 - Patients with neurological or neuromuscular conditions, such as Multiple Sclerosis, should be referred to an MS treatment program, including appropriate neurological or psychiatric specialists to treat the individual patient's needs.
 - To restore or maintain functions essential to daily living, Multiple Sclerosis patients recovering from a severe exacerbation should continue treatment in a setting determined most appropriate by an inter-disciplinary team of therapists familiar with such disorders. The members of the rehab team — including physical therapists, occupational therapists, speech/language pathologists and cognitive remediation specialists — address problems with mobility, dressing and personal care, role performance at home and work, and overall fitness. They also provide evaluation and treatment of speech and swallowing difficulties and problems with thinking and memory that may have appeared or worsened during the exacerbation.
 - Patients who have lost a limb should be referred to a physician with expertise in rehabilitation (commonly known as a physiatrist) and a prosthetist to assess the patient for a prosthetic limb fitting. Recent Medicare data suggests that nearly half of Medicare beneficiaries who lose a limb never file a subsequent claim for a prosthetic limb.
 - Patients with mobility impairments should be referred to a rehabilitation provider or mobility clinic where an assessment can be performed to determine the appropriate mobility device necessary for the patient.
 - Patients with brain injuries should be referred to appropriate physician and/or behavioral health care providers, as well as transitional or residential brain injury programs when these services are necessary for long-term recovery and rehabilitation.

- Patients with spinal cord injuries should be referred to rehabilitation programs appropriate to meet their ongoing rehabilitation, mobility, and medical needs.
- All patients with long term disabling conditions should also be referred to appropriate support groups and peer counseling programs to assist them to 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.

Accountability

CPR 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:

- The provider that receives the patient following discharge should reconnect with the referring discharge planner to ensure a smooth transition and report the patient's status.
- The discharge planner should review the plans of patients that have been discharged, and for every patient where the referred provider has not been in contact, 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 rehabilitation patients.

Concern for Patients in Observation Status (Proposed §482.43(b))

CPR agrees with the proposal to extend applicability of discharge planning services to certain observation-status patients such as persons who are undergoing same-day surgeries and other outpatient same-day procedures where sedation or anesthesia is involved. However, we are concerned about other patients who are hospitalized on observation status for different reasons, who also need appropriate discharge plans for safety and effectiveness. We urge CMS to require discharge planning for all patients who stay overnight in a hospital but are classified as observation status "outpatients." Without such a discharge planning requirement, these patients are in particular jeopardy of being poorly served after hospitalization.

Preserving Patient Choice

There is currently a dichotomy between the patient-centric discharge planning proposed rule and the way new payment models, such as Accountable Care Organizations (ACOs) and other alternative delivery models, strictly 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 and provider setting, one of the hallmarks of the Medicare fee-for-service program. CPR believes that Medicare patients should ultimately be informed of their care options and be active decision-makers in the care process and provider selection process. CPR believes that patients needing rehabilitative services and devices should have a choice of provider and setting to the greatest extent possible.

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

Sincerely,

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