



**VIA Electronic Submission to <http://www.regulations.gov>**

December 29, 2015

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

**RE: 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 American Association for Homecare (AAHomecare) is pleased to have the opportunity to submit comments on the Centers for Medicare and Medicaid Services' (CMS') proposed rule on revisions to Medicare requirements for discharge planning. The proposed rules would apply to hospitals and providers of post-acute care like home health agencies (HHAs). We support the Agency's efforts to adopt a comprehensive standard for discharge planning that applies across all health care settings. Discharge planning standards like the ones CMS is proposing are important for assuring that Medicare beneficiaries transition seamlessly to post discharge care settings including their homes. Establishing uniform discharge planning standards is a first step to providing modern, comprehensive and quality post discharge care for beneficiaries in their homes.

AAHomecare is the national association representing the interests of suppliers, manufacturers and distributors of durable medical equipment (DME), prosthetics, orthotics and supplies (collectively, DMEPOS). Our members manufacture and furnish technologies that allow Medicare beneficiaries to safely move from institutional care to their homes. We believe that the proposed rules should explicitly address a beneficiary's need for DMEPOS items and services post discharge.

It is impossible to overstate the importance of furnishing beneficiaries who have chronic conditions with the appropriate equipment and services to manage their condition post discharge. Numerous recent studies show that homecare technologies are effective for managing the health needs of the chronically ill while reducing the costs associated with inpatient care.<sup>1</sup> The product innovations brought about by

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<sup>1</sup> 1 See e.g., Landers, S. "Why Health Care Is Going Home," New England Journal of Medicine, October 20, 2010; Oba, Y. "Cost-Effectiveness of Long-Term Oxygen Therapy for Chronic Obstructive Pulmonary Disease," American Journal of Managed Care, February 2009; Lau, J., et al., Long-Term Oxygen Therapy for Severe COPD, June 11, 2004, Tufts-New England Medical Center Evidence Based Practice Center.

DME manufacturers, and the care and oversight furnished by suppliers to beneficiaries in their homes allow Medicare to harness technology that ensures beneficiaries receive effective care quickly and safely without incurring expenses for hospital readmissions.

**A. Discharge standards for hospitals and post-acute providers should include a comprehensive assessment of a beneficiary's discharge needs for DMEPOS items and services.**

**1. For beneficiaries being discharged to their homes, a comprehensive assessment of their needs for DMEPOS items and services facilitates a smooth transition for the beneficiary and his or her caregivers.**

AAHomecare agrees with the need to establish specific, uniform discharge planning standards across all care settings. Beneficiaries who are discharged directly to their homes are the ones most in need of careful discharge planning. These beneficiaries are returning to a home environment that might not be suitable for their post discharge needs. For example, the home may include trip hazards for post-op patients; in these cases DMEPOS suppliers are able to conduct home assessments and other services to address the safety hazards. Consequently we recommend that final standards include a requirement for the discharging provider to assess a beneficiary's need for DMEPOS items and services post discharge.

Roughly 50% of beneficiaries discharged from an inpatient stay receive home health care. The others will have no assistance transitioning to the new home environment unless they use a DMEPOS item and receive services from a supplier. The average length of a home health episode 60 to 90 days, so even beneficiaries who transition home with post-acute home health will likely lose contact with the HHA once they meet the goals established under the plan of care. The DMEPOS supplier and the beneficiary's physician are the post discharge care team that remains in contact with the beneficiary the longest. This means that the DMEPOS supplier can furnish ongoing monitoring of beneficiaries and report changes in the beneficiary's condition to his or her doctor.

Suppliers are well-suited to serve in this role. Many employ health professionals like respiratory therapists (RTs), nurses and nutritionists who have specific expertise in managing the most common chronic conditions that affect the Medicare population. It's a disfavor to beneficiaries when CMS fails to recognize the one source of efficient, inexpensive ongoing care that can manage chronic conditions in the home and recommend interventions when necessary.

It is also keenly important that DMEPOS suppliers who will furnish complex technology to beneficiaries in their homes post discharge to be included in the discharge process. This will ensure that the beneficiary is admitted promptly to the supplier's service with the right DMEPOS technology for that beneficiary. The supplier can confirm the order, meet with the beneficiary and caregivers to provide the necessary training and ensure to meet the beneficiary's expectations.

**2. Discharge standards need to facilitate the beneficiary's admission to home based post discharge services.**

AAHomecare supports the emphasis CMS places on communication under the standards. Improving communication between a hospital or other inpatient facility and a home based post discharge care team, facilitates a smooth transition for the beneficiary. More importantly, adequate communication preserves continuity of care for the beneficiary. From the perspective of a home based post discharge care team, communication includes not only patient demographics and order information like insurance

status, but also an attention to the documentation that HHAs and DMEPOS suppliers must have before they admit the beneficiary to their service.

Both HHAs and DMEPOS suppliers must have medical records that show the beneficiary had a face-to-face encounter with a physician or other qualified practitioner before the home health service or DMEPOS item was ordered for the beneficiary. Suppliers must also have a written order prior to delivery for most items of DME as a condition of Medicare payment. DMEPOS suppliers cannot initiate service for the beneficiary until they have this documentation.

HHAs and DMEPOS suppliers must also document the beneficiary's medical need for the services they provide. The post discharge transmission of information must include:

- The discharge summary,
- Diagnostic tests that support the medical necessity for the home based post discharge services the beneficiary will receive,
- Chart notes that support the beneficiary's medical necessity for home based post discharge services, equipment and supplies.

We recommend that discharging planning standards include a requirement that the discharging provider furnish the receiving provider or supplier with all the documentation necessary to confirm the beneficiary's medical need for any post discharge service that he or she will receive.

It is also important to remove unnecessary barriers to home based care that beneficiary's need post-discharge. Overly zealous contractor audits of services like ventilators and respiratory medications that have been shown to improve outcomes and decrease unplanned hospitalizations restrict access to these items and services for beneficiaries. Using audit strategies to restrict access to these products and services is shortsighted from the perspective both of the beneficiary's health and CMS's obligation to manage program funds effectively. Many deemed improper payment denials are for technical errors, such as a missing date on an order and the ordered item not being clear enough (i.e. hospital bed instead of hospital bed with mattress and rails).

### **3. CMS should support the expansion of coverage for services and technologies that ensure good patient outcomes and facilitate the delivery of home based post discharge care.**

CMS should foster the expansion of home based health care like home health and the use of DMEPOS items and services. And the Agency should support the expansion of coverage for technologies that enhance the services beneficiaries can receive in their homes. For example, in a time of declining reimbursement, telehealth can expand the reach of physicians and members of a beneficiary's post discharge care team to monitor his or her transition to the home after an inpatient stay. Services delivered *via* telehealth are inexpensive and can allow the care team to intervene more quickly than it could if a beneficiary scheduled an in-person encounter with a practitioner.

However, current Medicare coverage for telehealth services is extremely narrow and completely excludes the home as an originating site for care. This prevents the beneficiary from receiving efficient, consistent and low cost follow-up care after discharge from an inpatient stay. Likewise, beneficiaries with chronic conditions such as COPD should be regularly monitored by a RT, but RT services are not covered by Medicare. While we understand that these are legislative issues, we believe that CMS should actively promote the expansion of coverage for these services as a way of reducing the cost of care.

**B. Conclusion**

- 1. The proposed standards should be expanded to include an assessment of a beneficiary's need for DMEPOS items and services for post discharge.**

Again, it is impossible to overstate the importance of giving beneficiaries with chronic conditions DMEPOS technologies and services after they are discharged from inpatient or other post-acute-care settings. DMEPOS items and services allow beneficiaries to receive effective, inexpensive care in their homes. DMEPOS technologies have proven effective in managing chronic conditions and have been shown to improve outcomes for COPD patients and diabetics among others, resulting in fewer unplanned hospital readmissions. The proposed discharge planning standards are incomplete because they do not include an assessment of a beneficiary's need for DMEPOS technologies' as a component of the discharge planning process. We recommend that CMS consider expanding the focus of the proposed standards accordingly.

Thank you for the opportunity to submit these comments. We would be happy to meet with you to discuss these issues in more detail if you believe that would be of assistance to you.

Sincerely,



Kimberley S. Brummett, MBA  
VP for Regulatory Affairs