January 4, 2016

Mr. 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: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies [CMS–3317–P]

Dear Mr. Slavitt:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Many occupational therapy practitioners serve Medicare and Medicaid beneficiaries in acute care hospitals, long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), critical access hospitals (CAHs), and home health agencies (HHAs), therefore they are impacted by changes to requirements in each of these settings. Occupational therapy is a critical component of achieving improved status to maximize health and function and to prepare for discharge from these facilities and should be recognized as a contributing quality factor. We appreciate the opportunity to comment on the proposed revisions to requirements for discharge planning for hospitals (including LTCHs and IRFs), CAHs, and HHAs, published at 80 Federal Register 68126 on November 3, 2015.

The Centers for Medicare and Medicaid Services (CMS) is proposing to revise the requirements for discharge planning that hospitals, CAHs, and HHAs must meet to participate in the Medicare and Medicaid programs. The proposed rule would also take another step in implementing the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). The proposed rule indicates that the revisions will allow patients and their families’ access to information that will help them make informed decisions about their post-acute care, while addressing their goals of care and treatment preferences, and includes a focus on tailoring the discharge plan to the unique goals, preferences, and needs of the patient.
AOTA supports the proposal’s focus on person-centered care. This approach is well-aligned with the foundation of occupational therapy. AOTA also continues to support CMS’ triple aim of achieving better health, better care, and reduced growth rate of health care expenditures, and our members look forward to working with CMS to accomplish these important goals. CMS is pursuing many ways to meet these goals. Some of this work is being done through implementation of the IMPACT Act. CMS proposed and final rules issued in summer 2015 for the post-acute (PAC) settings included provisions to implement the IMPACT Act in LTCHs, IRFs, HHAs, and skilled nursing facilities. In addition, CMS recently finalized a Comprehensive Care for Joint Replacement Payment Model (CJR model) which will test bundled payment and quality measurement for an episode of care associated with hip and knee replacements by seeking to increase coordination of care among hospitals, physicians, other professionals, and PAC providers. The IMPACT Act and the CJR model both seek to facilitate coordinated care and improved outcomes and to achieve cost savings. AOTA has been closely monitoring the IMPACT Act and participating in dialogue with CMS officials regarding implementation of the law across a variety of PAC settings. We also submitted comments to CMS in response to the various proposed rules. The proposed discharge planning requirements would be another change for facilities and their staff to understand and incorporate in everyday operations and practice. Therefore, it is critical that CMS allow appropriate time for providers and staff to adapt to the volume of changes without disrupting patient care.

I. Discharge Planning

A. Proposed Requirements

CMS is proposing to require that hospitals, including LTCHs and IRFs, CAHs, and HHAs must develop a discharge plan based on the goals, preferences, and needs of each applicable patient. They would also be required to send specific medical information to the receiving facility when a patient is transferred. In addition, hospitals and CAHs would be required to do the following for all inpatients and some outpatients, including outpatients receiving observation services:

- Develop a discharge plan within 24 hours of admission or registration and complete a discharge plan before the patient is discharged home or transferred to another facility;

- Provide discharge instructions to patient who are discharged home;

- Have a medication reconciliation process with the goal of improving patient safety by enhancing medication management; and

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• Establish a post-discharge follow-up process.

HHAs would be required to complete an evaluation of the patient’s discharge needs and complete and document a discharge plan before the patient is discharged or transferred to another facility. These proposed discharge planning requirements include involvement by the responsible practitioner and regular re-evaluation of the patient, as well as assisting transfer patients with selecting a PAC provider and taking into account caregiver availability and the patient’s and caregiver’s capabilities.

AOTA supports the above requirements, but requests that an occupational therapist be listed as part of the discharge planning team needed to perform discharge assessment and planning. The patient-centered focus of the care plan and discharge planning processes is part of the foundation of occupational therapy and how occupational therapists assess, treat, and consider discharge and transitions as part of the assessment of a patient’s functional and cognitive status on an ongoing basis. AOTA strongly supports the involvement of the patient in determining their goals of care and discharge planning, as well as taking into account realistic caregiver support after discharge. We believe this would result in appropriate and more informed choices that meet the patient’s needs. In addition, we believe the following issues are important to consider as CMS finalizes its discharge planning rule.

**B. Importance of Activities of Daily Living**

Appropriate and effective discharge planning should help reduce readmissions and address all of a patient’s needs. Of note with respect to potentially preventable readmissions and a patient’s occupational therapy needs, several recent studies consider whether returning to the community from a recent hospitalization with unmet activities of daily living (ADL) need was associated with probability of readmission. The findings from these studies indicate that this indeed may be a considerable risk factor.

The studies reveal that many older patients are discharged from the hospital with ADL disability. Those who report unmet need for new ADL disabilities after they return home from the hospital are particularly vulnerable to readmission. This area is not typically addressed in a thorough manner through current discharge practices. This needs to change. Patients' functional needs after discharge should be carefully evaluated and addressed. Factors such as enabling self-management and ensuring appropriate medication management and ADLs, such as cooking and eating are addressed, can have a direct effect on readmissions. Self-management is a key element in successful post-acute

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care, and occupational therapists are experts in motivation, task analysis, and psychosocial contexts, which all contribute to enabling positive outcomes.\(^3\)

The profession of occupational therapy is built on delivering patient-centered care, seeking to keep the patient at the highest functional level in the least restrictive setting and to reduce caregiver burden and health care system resource utilization. Occupational therapy directly addresses the enablement of successful performance of ADLs. This focus, experience and research base in occupational therapy must be fully tapped to address this component of readmission prevention.

AOTA requests that CMS specifically add a functional cognition assessment to the items in the discharge plan and the information provided to the next facility when a patient is transferred. This critical area does not appear to be addressed in the language of the proposal. An example of a functional cognitive assessment might consider whether the patient can properly sequence activities such as putting on one’s pants before shoes. Occupational therapists also consider whether patient’s can adapt their ADLs and instrumental activities of daily living (IADLs) if one pattern in the sequence changes, for example, the patient is asked to place their socks on before their pants, and then shoes. This cognitive focused consideration is not typically captured in a straight ADL or falls risk assessment but is critical to post-acute care planning because it is important to figure out what cognitive limitations the patient may have below the surface as they will impact success in the next setting.

C. Medication Management

Occupational therapists play an important role in improving patient safety by enhancing medication management. Medication non-adherence, especially in patients with chronic conditions, results in higher hospitalization rates, poorer outcomes, and dramatically increased health care costs. In fact, studies have shown that between 50-70% of older adults fail to take medications according to physician instructions – resulting in an estimated 3 million older adults being admitted to skilled nursing facilities each year and causing as many as 125,000 deaths annually (Wertheimer & Santella, 2003).

As leading experts in the development of habit and routines, occupational therapy practitioners play a pivotal role in helping patients develop medication management routines. Working with occupational therapy practitioners to establish daily routines aimed at significantly improving medication compliance have proven to increase overall health and functional status, decrease risk of falls, improve cognition, and increase driver safety for older adults (Classen, Mann, Wu, & Tomita, 2004; Lococo & Staplin, 2006).

Studies in this area indicate that medication habits need to be individually developed to promote realistic integration into existing life routines. This finding is consistent with

client-centered practice. Evidence also strongly suggests that patients need and would significantly benefit from skilled intervention, whether it is assisting in developing cues, arranging for equipment, assessing the environment, or arranging for monthly refills. These findings substantiate occupational therapy practitioners’ role in developing specific, individualized, concrete plans for integrating medications into daily routines, thus increasing the patient’s odds of adherence exponentially.

D. Transitions of Care

CMS is proposing to require that certain data elements be included in discharge and transfer documentation, including functional status, as well as psychosocial assessment including cognitive status, in addition to a long list of other data elements. Occupational therapy practitioners play a key role in these areas, as described further in the Functional Cognition section below.

In previous comments related to proposed revisions implementing the IMPACT Act, AOTA has expressed concerns regarding alignment of IMPACT Act data collection in all settings, making sure that the most qualified clinicians are designated to gather the necessary data, and ensuring that CMS invests in training for clinicians to understand the quality measures and assessment item data collected for the measures.

While training and data collection are important, they are only one piece of the puzzle in regard to transitions of care. CMS must also consider permitting and reimbursing for provision of additional services that will ease the transition from one setting to another or to the home, such as allowing an occupational therapy home visit prior to discharge to ensure the patient can safely function, both physically and cognitively, within the new setting.

E. Functional Cognition

AOTA was pleased that Congress recognized the importance of collecting data on cognitive status in the IMPACT Act because cognitive impairments have a significant relationship to Medicare resource use, length of stay, and patients’ long term outcomes. Occupational therapy has a critical role in assessing functional cognition and ensuring that Medicare beneficiaries in acute and PAC settings receive quality care in the most appropriate setting, using only the necessary Medicare resources.

We believe that functional cognition is an area that must be looked at more closely and that, as the Medicare population continues to live to older ages, providers in all PAC settings will need more training in assessing cognitive and functional status for patients with cognitive impairments. Occupational therapists are experts in the measurement of and interventions for functional cognition issues, which encompasses assessment of everyday task performance (e.g., self-care, personal hygiene behaviors and dressing, household management, cooking, medication management and adherence to drug regimens, and patient safety). Occupational therapists specialize in the identification of performance-related or functional cognitive impairments, which range from subtle to
obvious and which affect overall treatment, successful discharge placement, long-term outcomes, and, of course, resource utilization.

Occupational therapy practitioners treat cognitive impairments because they have the potential to compromise the safety and long-term well-being of patients, especially more frail elderly patients. Early identification of performance-related or functional cognitive impairments allows for the timely implementation of an occupational therapy care plan. The plan can include implementing the supports necessary to prevent harmful events which commonly happen during routine everyday activities for patients with cognitive impairments, for example, falls due to problematic sequencing during bathing or dressing activities. The occupational therapy care plan can also promote optimal recovery, stabilization, and success in post-acute care and discharge settings.

This is an important aspect for CMS to consider as it implements the discharge planning requirements of the IMPACT Act because traditional neuropsychological evaluative measures were developed to localize individual cognitive abilities such as selective attention, verbal memory, inhibition, and processing. In contrast, performance-based tasks report how a person interacts with the environment to accomplish an activity, and whether these tasks can be accomplished quickly and efficiently. AOTA has engaged CMS officials in face-to-face meetings to discuss the collection of data on functional cognition, and will continue to provide research studies and related materials to CMS to advocate that assessment of functional cognition be incorporated into the IMPACT Act requirements.

The purpose of occupational therapy is to enable compensatory activities and to improve function where possible. For Medicare beneficiaries, early detection of performance-based cognitive impairments by occupational therapists also facilitates the selection of the most appropriate levels of care, the appropriate resources to support and train caregivers and reduce caregiver burden, and client-centered discharge options, and contributes to reduced hospital readmissions and increased safety at discharge.

Cognition refers to information-processing functions carried out by the brain that include attention, memory, executive functions (i.e., planning, problem solving, self-monitoring, self-awareness), comprehension and formation of speech, calculation ability, visual perception, and praxis skills. Cognitive functions, such as memory, attention, goal-directed behaviors, abstract thinking, and decision making, are critical to occupational performance. An individual who has cognitive impairment may be slow to respond, may lack initiative or perseverate, or may be likely to slide down the continuum from independence to dependence, especially for complex occupations. The AOTA Cognition, Cognitive Rehabilitation, and Occupational Performance Statement describes occupational therapy’s role in addressing cognition as follows:

Occupational therapy practitioners facilitate individuals’ cognitive functioning to enhance occupational performance, self-efficacy, participation, and perceived quality of life through the use of occupations and activities. Cognition is integral to effective performance across the broad range of daily occupations such as work, educational pursuits, home management, and play and leisure…

Occupational therapy practitioners administer assessments and interventions that focus on cognition as it relates to participation and occupational performance. Furthermore, occupational therapy practitioners believe that cognitive functioning can only be understood and facilitated fully within the context of occupational performance. This understanding of the relationship among the client, his or her roles, daily occupations, and context make occupational therapy a profession that is uniquely qualified to address cognitive deficits that negatively affect the daily life experience of the individual.\(^5\)

Moreover, cognitive impairments have a significant relationship to Medicare resource use, length of stay, and patients’ long-term outcomes. Therefore, we believe cognition is a critical area that must be identified and addressed in acute and PAC settings.

II. Telehealth Services

In the proposed rule, CMS encouraged hospitals to consider potential technological tools or methods, such as telehealth, to support the individual’s health upon discharge. AOTA supports CMS’ encouragement for the use of telehealth services, but we want to be sure that occupational therapy is among the mix of services that are allowed for telehealth related to discharge planning. Occupational therapy telehealth services are especially needed in rural areas and some are being delivered through telehealth modes under other programs and payers. Occupational therapy services are similar to professional consultation and professional office visits in regards to telehealth. In many ways, occupational therapy is a perfect match for telehealth technologies that enable completion of one of the key aspects of occupational therapy: defining and enabling function within a specific context and environment, such as a patient’s home. Occupational therapy practitioners have engaged in telehealth services in a variety of areas of therapy service delivery. Specifically, occupational therapy telehealth services would provide highly relevant and specialized services that will assist a patient in terms of functional status, cognitive status, and discharge planning regarding ability to perform ADLs, IADLs, and safely living in the transition setting. The AOTA Telehealth Position Paper describes occupational therapy’s role in providing telehealth services as follows:

Occupational therapy practitioners use telehealth as a service delivery model MODE to help clients develop skills; incorporate assistive technology and adaptive techniques; modify work, home, or school environments; and create health-promoting habits and routines. Benefits of a telehealth service delivery model include increased accessibility of services to clients who live in remote or underserved areas, improved access to providers and specialists otherwise

\(^5\) Id.
unavailable to clients, prevention of unnecessary delays in receiving care, and workforce enhancement through consultation and research among others (Cason, 2012a, 2012b).  

The AOTA Telehealth Position Paper sets forth how occupational therapy practitioners use telehealth technologies as a method for service delivery for evaluation, intervention, consultation, monitoring, and supervision of students and other personnel. Further it references the results of research on the use of telehealth in rehabilitation or habilitation which include occupational therapy. While a variety of occupational therapy services may be provided via telehealth, some examples of services currently reimbursed by other payers include CPT Codes 97535 (self-care/home management training), 97530 (therapeutic activities), and 97110 (therapeutic exercise).

We encourage CMS to monitor patterns of utilization of telehealth services and related effects of its use to help further innovation in this delivery mechanism. AOTA believes that allowing telehealth services would support care coordination and increasing timely access to high quality care for all beneficiaries, regardless of geography.

AOTA has previously requested that CMS add occupational therapy services to the CMS list of approved telehealth services. CMS declined to add therapy services noting a change in statute was necessary for CMS to do this and stating, “physical and occupational therapists are not permitted under current law to furnish and receive payment for Medicare telehealth services.” According to statute, physical therapists, occupational therapists, speech-language pathologists and audiologists are not permitted under current law to provide and receive payment for Medicare telehealth services at the distant site. The statute permits only a physician, as defined by section 1861(r) of the Social Security Act or a practitioner as described in section 1842(b)(18)(C) of the Act (CNS, NP, PA, nurse midwife, clinical psychologist, clinical social worker, registered dietitian or other nutrition professional), to furnish Medicare telehealth services.

AOTA believes this should be changed. Legislation is currently pending in Congress to include occupational therapy as a service appropriate for Medicare coverage when provided through telehealth means. In response to the Medicare Shared Saving Program Proposed Rule, AOTA supported and continues to support that CMS implement a waiver of current CMS telehealth requirements to permit ACO demonstrations and other Alternative Payment methodologies to define occupational therapists as eligible practitioners and occupational therapy as an eligible service to be provided via telehealth. There is a growing base of evidence demonstrating the efficacy of technologically mediated occupational therapy.

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AOTA asserts that the same ethical and professional standards that apply to the traditional delivery of occupational therapy services also apply to the delivery of services received via telehealth. Occupational therapy interventions delivered via telehealth can assist patients regain, develop, and build functional independence in everyday life. Such service availability alternative may also address provider shortages and access problems, making necessary occupational therapy services available to underserved beneficiaries in remote, inaccessible, or rural settings and to beneficiaries with limited mobility outside their home. Further as noted above, occupational therapy is the chief profession with expertise in living and community environments which may be better observed and evaluated through telehealth means. Occupational therapy practitioners can provide telehealth services to Medicare beneficiaries efficiently and effectively.

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Thank you for the opportunity to comment on the proposed revisions to requirements for discharge planning for hospitals, critical access hospitals, and home health agencies. AOTA looks forward to a continuing dialogue with CMS on coverage and payment policies that affect the ability of occupational therapists to provide quality care to Medicare and Medicaid beneficiaries in each of these settings.

Sincerely,

Jennifer Bogenrief
Manager, Regulatory Affairs