Public Comment Summary Report

Project Name: Rehospitalization during the First 30 Days of Home Health & Emergency Department without Hospital Readmission during the First 30 Days of Home Health

Date of Report: September 19, 2013

Contractor Name: Acumen, LLC

I. Introduction

- **Public Comment Period:** June 25, 2013 to July 15, 2013
- **Web Site Used:** Centers for Medicare & Medicaid Services website[1]
- **Methods used to Notify Stakeholders and General Public of Comment Period:** E-mail notification to Technical Expert Panel and other relevant stakeholders
- **Volume of Responses Received:** In total, five comment letters were received, from UnityPoint at Home, LovingCare Hospice and Home Health, Visiting Nurse Associations of America, National Association for Home Care & Hospice, and Alliance for Home Health Quality and Innovation.

II. Stakeholder Comments—General

Summary of General Comments and Responses:

All five comment letters expressed support for the *Rehospitalization during the First 30 Days of Home Health* measure (hereafter the "Rehospitalization measure") and *Emergency Department without Hospital Readmission during the First 30 Days of Home Health* measure (hereafter the "ED Use without Hospital Readmission measure"). The comments received fall into nine topic areas, including (1) measure numerator, (2) measure denominator, (3) measure exclusions, (4) risk adjustment, (5) observation period, (6) measure harmonization, (7) reliability of claims data, (8) modification to the OASIS instrument, and (9) increasing measure development transparency. The remainder of this section addresses the comments received under each topic area in turn.

1. Measure Numerator

- One commenter expressed support for the inclusion of observation stays within the *ED Use without Hospital Readmission* measure, but noted it is unclear whether the existing *ED Use without Hospitalization* measure includes observation stays.

  Response: CMS appreciates support for this aspect of the measure. Observation stays that begin in a hospital emergency department will be captured on the claims-based *ED Use without Hospital Readmission* measure. They are also captured in the existing *ED Use without Hospitalization* measure.

2. Measure Denominator

- One commenter said that agencies should not be held responsible for patients who are re-admitted to an acute-care setting within 30 days of entering home health, if these patients have been discharged for appropriate reasons (e.g., patient is no longer homebound) within the 30-day period. Another commenter requested that CMS clarify whether patients discharged from home health within the 30-day period would be included or excluded from the *Rehospitalization* measure.

  Response: Patients who are discharged from home health within the 30-day observation period are counted in the *Rehospitalization* and the *ED Use without Hospital Readmission* measure denominators. To identify the reason for

[1] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html

patient discharge, the measures would have to link to OASIS assessments, as this information is not available in Medicare claims data. However, linking home health claims to OASIS assessments is not currently feasible.

3. Measure Exclusions

- One commenter expressed support for all the proposed exclusions for both measures. Another commenter expressed particular support for the exclusion of planned hospitalizations from the numerator of both measures.

  Response: CMS appreciates the commenters' support.

- One commenter stated that it is unclear as to whether the calculation algorithm for the *Rehospitalization measure* excludes planned hospitalizations and recommended that CMS publicize the list of planned admissions so that home health agencies are aware of exactly which types of admissions the measure will exclude.

  Response: The *Rehospitalization measure* calculation algorithm follows the same algorithm as the *Hospital-Wide All-Cause Unplanned Readmission* (HWR) measure. Planned hospitalizations are defined using the same criteria as the HWR measure. [2]

- One commenter expressed support for the exclusion of Low Utilization Payment Adjustment (LUPAs) from the denominators of both measures, and notes that they may be multiple factors leading to the decision for such early discharges from home care. The commenter recommended that CMS provide more details to explain the decision to exclude LUPAs.

  Response: CMS appreciates support for this aspect of the measure. Currently, home health stays with four or fewer visits to the beneficiary qualify for LUPAs. Due to the low intensity of services provided to the patient in these cases, the home health agency may not have a chance to influence the patient's outcomes during the entire 30-day measure window or the patient may be atypical in other ways. Therefore, CMS excludes LUPAs from the measure denominators.

4. Risk Adjustment

- Two commenters expressed the need for CMS to provide a clear list of the risk adjustment factors used to calculate the measure.

  Response: The public comment materials posted on the CMS Quality Measures Public Comment Page, specifically the Measure Information Forms (MIFs), provide information about the categories of risk factors that will be considered in the risk adjustment model, including the CMS HCCs, DRGs, and ADLs. Once the measures are finalized, CMS will post the final technical specifications on the Home Health Quality Initiative page, which will include the final set of risk adjustment factors.

- Two commenters said it is unclear why *only* the following Activities of Daily Living (ADLs) have been chosen for the purposes of risk adjustment: Dressing Upper or Lower Body (OASIS fields M1810 or M1820), Bathing M1830), Toileting (M1840), Transferring (M1850), and Ambulation (M1860). Both commenters recommended including OASIS data elements (i.e., functional status, medical conditions, cognitive and social support systems) in the risk adjustment model, as these are known to be quality measure risk adjustment factors. One of these commenters also included a comparison document of OASIS-C and OASIS C-1 (see Attachment) that identifies these OASIS data elements. The commenter said it was unclear why the data items marked "PRA" in the Attachment were excluded or not taken into consideration for risk adjustment.

[2] More information about how planned readmissions are defined for the HWR measure can be found in the "Hospital-Wide All-Cause Unplanned Readmission Measure- Final Technical Report" under "Measure Development" section of this webpage: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772504318

Response: CMS appreciates the comment that additional data derived from OASIS may be useful as potential risk adjustment factors for the proposed measures. Currently, CMS has chosen to include all the ADL information that is readily available on Medicare claims as potential risk adjustment factors, including Dressing Upper or Lower Body (OASIS fields M1810 or M1820), Bathing M1830), Toileting (M1840), Transferring (M1850), and Ambulation (M1860). However, incorporating additional OASIS data elements into the risk adjustment model would require the ability to match OASIS assessments to claims accurately. Matching OASIS assessments to claims is currently infeasible.

- One commenter suggested that CMS should consider whether it is possible to assess whether patients have been discharged from the hospital prematurely, and if risk assessment may account for this factor. The commenter observed that it is important to note that in some cases, a patient may be discharged from the hospital prematurely, and in such cases, rehospitalization would be appropriate for that patient.

  Response: CMS agrees with the commenter's point. Using Medicare claims, CMS can only identify cases where the patient is prematurely discharged from the hospital against medical advice, and the measure algorithms exclude these cases. However, claims data do not provide information about premature discharges due other reasons.

- One commenter recommended that CMS appropriately risk adjust both measures for special populations (e.g., disadvantaged and vulnerable patients)

  Response: The Technical Expert Panel recommended conducting further investigation into the risk factors that could impact the performance rates on the proposed measures across special populations. CMS will take the TEP's recommendation into consideration during the measure maintenance process and other future work.

5. Observation Period

- One commenter expressed support for the 30-day observation period for both measures. Additionally, in the event that the *Rehospitalization* measure and *ED Use without Hospital Readmission* measure were adopted for Home Health Quality Reporting, the commenter recommended retiring the existing claims-based *Acute Care Hospitalization* and *Emergency Department Use without Hospitalization* measures, which are based on claims data for the first 60 days of home health. If a patient no longer meets coverage criteria (e.g. homebound, medical necessity) at any time during the first 60 days of home health, Medicare coverage guidelines require the agency to discharge the patient from a home health episode. However, home health public reporting reflects hospitalization and emergency room visits for a full 60 days, some of which occur after the patient is discharged – and are out of the control of the home health agency. The commenter noted that 30 days post start-of-care would be much more reasonable and a more accurate reflection of the impact of home health on the hospitalization and emergency room visits.

  Response: CMS appreciates support for this aspect of the measure. Home health agencies are most often paid in a 60-day payment bundle which covers all home health services for 60 days. As a result, the claims-based *Acute Care Hospitalization* and *Emergency Department Use without Hospitalization* measures use the 60-day window to hold agencies accountable for patient outcomes during this entire payment period. The claims-based *Rehospitalization* measures use a 30-day window to be consistent with other measures of hospital readmission (such as the HWR measure).

  While the rehospitalization measures target specifically the previously hospitalized population, the *Acute Care Hospitalization* and *ED Use without Hospitalization* measures evaluate agencies on their care for all of their beneficiaries who qualify for the measure. While the rehospitalization measures apply only to patients who were hospitalized in the five days prior to starting home health, which includes only about 35 percent of patients, the *Acute Care Hospitalization* and *ED Use without Hospitalization* measures apply to the entire home health population. The two measure sets can be used in conjunction to evaluate home health care quality.

6. Measure Harmonization

- One commenter expressed support for both measures as an effort to harmonize home health quality measures with those of hospitals to align incentives between hospitals and post-acute care providers. This commenter noted that having a standardized *Rehospitalization* measure in the home health setting will enable home health providers to work in concert with hospitals to reduce unnecessary rehospitalizations. Another commenter noted that CMS must be careful to align the incentives across hospitals, home health agencies, and physicians, as these are the key players in reducing hospital and emergency room use. One commenter stated support for aligning the proposed measures with the *HWR* measure, as the consistency achieved through harmonization is important to improve care coordination. Another commenter supported deviations from the HWR measure to accommodate the unique setting of home health.

  Response: CMS appreciates the commenters' support for harmonizing the home health quality measures with those of hospitals and other post-acute care providers

- One commenter indicated support for the continued reporting of the existing claims-based *Acute Care Hospitalization* measure, as it captures hospitalizations that are not preceded by an acute care hospitalization.

  Response: CMS intends to continue reporting the *Acute Care Hospitalization* measure. The rehospitalization measures apply only to patients who were recently discharged from an inpatient hospitalization, which is about 35 percent of home health patients. The *Acute Care Hospitalization* measure applies to the entire home health population. By comparing home health agencies on both sets of claims-based measures, consumers can gain a more complete and accurate picture of how much acute care is used by patients of the agencies.

7. Reliability of Claims Data

- One commenter expressed support for using administrative claims data to calculate the proposed measures. The commenter cited empirical evidence to support the reliability of claims data in establishing whether patients have been admitted to the hospital, used the emergency department, or been placed in observation.

  Response: CMS appreciates support for this aspect of the measure. Medicare claims data are reliable because home health agencies are required to submit claims in order to receive payment for Medicare beneficiaries. Claims data are extremely detailed and include patient identifiers, provider identifiers, services rendered, diagnoses, and payment, as well as additional information.

8. Modification to the OASIS Instrument

- To identify agencies that have followed best practices in preventing a hospitalization (e.g., by contacting the physician in a timely manner about the patient's issues), one commenter recommended that CMS add a question to the OASIS instrument about whether the physician has attempted to order an intervention on any issue(s) brought to her/his attention by other home health staff members (e.g., the home health nurse).

  Response: CMS appreciates this suggestion for modification to the OASIS instrument. However, the proposed quality measures are derived exclusively from claims data, so such an additional OASIS item could not be incorporated into the measure specifications for these measures.

9. Measure Development Transparency

- Two commenters observed that CMS has worked with both the National Quality Forum (NQF) and National Priorities Partnership (NPP) to develop the proposed quality measures. To inform the measure development process for future home health measures, both commenters recommended that CMS seek additional/broader input from the home health community and the public. One commenter suggested organizing an open door forum or town hall meeting for this purpose. Another commenter noted the importance of fostering transparency in the measure development process, including providing specifics about the rationale and methodology used to calculate the measures, to allow clinical experts to comment meaningfully on future proposed measures.

Response: CMS appreciates the above comments. To maintain transparency in future measure development work, CMS will continue to seek input from the public.

III. Measure-Specific Comment Summaries

Please see above for responses to all public comments.

IV. Preliminary Recommendations

The measure developers are not recommending any changes to the measure specifications in response to public comments.

V. Overall Analysis of the Comments and Recommendations to CMS

CMS appreciates the public's comments. At this time, CMS is preparing to submit these measures for NQF endorsement in the fourth quarter of 2013. CMS is not recommending any changes to the measure but will take the comments into consideration during the measure maintenance process and other future work.

Table 1: Verbatim Comments

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization	Recommendations/ Actions Taken
6/27/2013	Rehospitalization during the First 30 Days of Home Health AND Emergency Department Use Without Hospital Readmission during the First 30 Days of Home health	Regarding the proposed recommendation for reporting Rehospitalization During the First 30 Days of Home Health, and Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health. I fully endorse both measures. The new recommendations align strategically with hospital re-hospitalization goals. However if this proposal is adopted, I would ask that the current measure during the first 60 days of home health for both acute care hospitalization and emergent care be retired. The current measure is based on claims data for the first 60 days of Home Health, yet Medicare coverage guidelines (e.g. homebound, medical necessity) require discharge from a home health episode when coverage criteria is no longer met. Home health public reporting reflects hospitalization and ER visits for a full 60 days, some of which occur after home health is discharged – and are out of the control of the home health agency. Thirty days post start of care would be much more reasonable and a more accurate reflection of the impact of home health on these 2 indicators. Thank you.	Valerie J. Edison, RN, BNS, MPA Director of Quality, UnityPoint at Home	Valerie.Edison@unitypoint.org	Hospice and home health care provider	CMS, measure developers, and the TEP have reviewed the comments and provided detailed responses in the Public Comment Summary document above. At the moment, CMS is not recommending any changes to the measure. CMS will also take these comments into consideration during the measure maintenance process and other future work.
7/3/2013	Rehospitalization during the First 30 Days of Home Health AND Emergency Department Use Without Hospital Readmission during the First 30 Days of Home health	I would like to comment in regard to the development of quality measures for **Rehospitalization During the First 30 Days of Home Health, and Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health.** I have been a home care nurse for 12 years, and in my experience, the biggest challenge to preventing rehospitalizations is in dealing with physicians who are uncooperative or unwilling to address issues that the home health nurse identifies and contacts them about. I would like to see as a quality measure (perhaps on the transfer OASIS) a question asking if the physician has been contacted about the issue, and whether any attempts to correct the symptoms were ordered. This way, it would identify if the agency has followed the correct steps to prevent a hospitalization, by timely contacting the physician. If the physician insists, after agency intervention, to send the patient to the ER, it is possible to show that the agency did make an attempt to follow best practices &	Barb Dixon, BSN, RN, LovingCare	barbd@lovingcare.us	Hospice and home health care provider	CMS, measure developers, and the TEP have reviewed the comments and provided detailed responses in the Public Comment Summary document above. At the moment, CMS is not recommending any changes to the measure. CMS will

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		prevent a rehospitalization. Thank you for your consideration.				also take these comments into consideration during the measure maintenance process and other future work.
7/15/2013	Rehospitalization during the First 30 Days of Home Health AND Emergency Department Use Without Hospital Readmission during the First 30 Days of Home health	To Whom It May Concern: The National Association for Home Care & Hospice (NAHC) is the largest trade association in the country representing home health and hospice agencies including Visiting Nurse Associations, government-based agencies, multi-state corporate organizations, health system affiliated providers, and freestanding proprietary agencies. NAHC members serve over 3 million Medicare home health beneficiaries each year. We are writing to request your consideration of our comments on the proposed Home Health Claims-Based Measures: Rehospitalization During the First 30 Days and Emergency Department use Without Hospitalization During the First 30 Days of Home Health. In general, NAHC supports the two proposed claims-based quality measures. Claims based measures are more accurate since they are not subject to the vulnerabilities of self-reporting. In addition, we support CMS' goal to harmonize quality measures across health care settings. Further, we support efforts to continue to collect the acute care hospitalization measure using the current 60 day claims-based measure. However, we do wish to share some of our concerns and recommendations. *Risk Adjustment Methodology* CMS proposes to use a risk adjustment model for health status by using Hierarchical Condition Categories (HCC), Diagnosis Related Groups (DRG) and the Activities of Daily Living (ADL). In particular, the proposed measures include the following ADLs for risk adjustment: Dressing upper or lower body (OASIS fields M1810 or M1820); Bathing (M1830); Toileting (M1840); Transferring (M1850); and Ambulation (M1860). However, it is not clear why only these ADLs have been chosen for the purposes of risk adjustment. **Recommendations:** CMS should consider including additional data derived	Mary K. Carr, Associate Director for Regulatory Affairs, National Association for Home Care & Hospice (NACH)	mkc@nahc.org	Nonprofit organization that represents 33,000 home care and hospice organizations	CMS, measure developers, and the TEP have reviewed the comments and provided detailed responses in the Public Comment Summary document above. At the moment, CMS is not recommending any changes to the measure. CMS will also take these comments into consideration during the measure maintenance process and other future work.

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization	Recommendations/ Actions Taken
		from the Outcome and Assessment Information Set (OASIS) such as functional status, medical conditions, cognitive and social support systems. Many of the OASIS data elements are known to be quality measure risk adjustment factors; as such, there may be other indicators that are strong predictors of risk for hospitalization that should be considered in a risk adjustment model. Further, CMS should provide a clear list of the risk adjustment factors used to calculate the measure to be made public, with an explanation as to why certain OASIS items have been included and others have been excluded. *Increase Measure Development Transparency.* CMS measure development process includes input limited to National Quality Forum (NQF) and the National Priorities Partnership (NPP). **Recommendations:** CMS should consider seeking broader input from the home health care community and public when developing home health measures. This would permit more extensive discussions and help to foster support for new measures than exists under the current measure development process. *Exclusions* **Recommendations:** NAHC supports the proposed exclusions to both the denominator and numerators for both of the quality measures. However, requests that the algorithm for the 30-day rehospitalization measure explicitly exclude planned hospitalizations.				
7/15/2013	Rehospitalization during the First 30 Days of Home Health AND Emergency Department Use Without Hospital Readmission during the First 30 Days of Home health	Response to CMS Request for Public Comments: *The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC, to develop quality measures that can be used to assess the quality of home health care for Medicare beneficiaries. The following measures were developed under this project and are now posted for public comment:* *1. Rehospitalization During the First 30 Days of Home Health* *2. Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health* **VNAA Comments:**	Kathleen M. Sheehan, CAE, Vice President for Public Policy, Visiting Nurse Associations of America (VNAA)	ksheehan@vnaa.org	National trade association that supports, promotes, and advocates for community-based, nonprofit home health and hospice providers	CMS, measure developers, and the TEP have reviewed the comments and provided detailed responses in the Public Comment Summary document above. At the moment, CMS is not recommending any changes to the

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		VNAA agrees in principle with the addition of the two quality measures on re-hospitalization and emergency room use. However, there are several practical concerns that CMS should address to make these measure fair and useful. First, CMS must appropriately risk adjust these measures for special populations. For example, agencies that serve a disproportionate number of disadvantaged, vulnerable patients know that their patients will return to hospitals or emergency rooms at a rate higher than average as a result of conditions beyond the control of their agency. Second, CMS must be careful to align the incentives of hospitals, home health agencies and physicians so that these three key players in hospitalization and emergency room use are equally committed to achieving these reductions in use. Third, agencies who appropriately discharge patients who no longer qualify for home health (e.g. no longer homebound) should not be held responsible in these 30 day statistics for patients who return to hospitals or emergency rooms when they are no longer under the care of the agency. VNAA will submit additional comments as a part of our regulatory submission for the Home Health Proposed Rule for 2014 in August.				measure. CMS will also take these comments into consideration during the measure maintenance process and other future work.
7/15/2013	Rehospitalization during the First 30 Days of Home Health AND Emergency Department Use Without Hospital Readmission during the First 30 Days of Home health	To Whom It May Concern: I am writing on behalf of the Alliance for Home Health Quality and Innovation (the "Alliance") in response to the Centers for Medicare and Medicaid Services' request for Public Comment on the **Proposed Measures for Home Health Claims-Based Rehospitalization and Emergency Department Use Quality Measures.** Thank you for the opportunity to provide comments on this critical initiative to improve the quality of patient care. **About the Alliance for Home Health Quality & Innovation** The Alliance is a non-profit 501(c)(3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America through quality and innovation. We are also a membership based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation's healthcare system. Our comments on the proposed home health quality	Teresa L. Lee, JD, MPH, Executive Director, Alliance for Home Health Quality and Innovation	tlee@ahhqi.org	Organization that supports research and education on home health care	CMS, measure developers, and the TEP have reviewed the comments and provided detailed responses in the Public Comment Summary document above. At the moment, CMS is not recommending any changes to the measure. CMS will also take these comments into consideration during the measure maintenance

		measures reflect consensus from our membership and our Quality and Innovation Working Group, which is comprised of medical and quality officers from our member organizations. Our comments on the proposed measures are as follows: **I. The Alliance supports the use of claims-based measures to track 30-day rehospitalization and ED use as a means to measure home health agency performance.** The proposed measures include two claims-based measures: (1) Rehospitalization during the first 30 days of home health (hereinafter "Rehospitalization Measure"); and (2) Emergency Department Use without Hospital Readmission during the first 30 days of Home Health (hereinafter "ED Use Measure"). The Alliance supports basing these measures on claims data. Additionally, we agree with the conclusions in the Technical Briefing Memo that claims data is often "more reliable."[3] Recently commissioned Alliance data analysis has similarly found that measuring a 30-day acute care rehospitalization rate from home health yields varying results depending on whether the data source is Medicare claims or OASIS.[4] Our analysis compared 30-day home health readmission rates calculated from Medicare claims to those reported in OASIS-C, using a five percent sample of Medicare beneficiaries with an index hospitalization and subsequent home health admission on or before January 1, 2010. Key findings from this data analysis indicated that both data sources independently produced similar 30-day aggregate readmission rates. However, the readmissions data reported in the claims were substantially incongruent with the same measure using OASIS data, as evidenced by the fact that only sixty percent of readmissions identified in Medicare claims had corresponding OASIS assessments capturing the readmission. The primary reason for this disconnect is that home health agencies do not always receive complete information to determine whether a patient has been admitted to the acute care hospital (or whether, for example, the patient was held in observation). Consequently, using Medicare claims is more reliable in determining whether patients have been admitted to the hospital,				process and other future work.

[3] Acumen, *Draft: Home Health Claims-Based Rehospitalization Quality Measures Technical Briefing Memo*, CMS.gov (June 1, 2013) (hereinafter "Technical Briefing Memo"), http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/HH-Claims-Based-Rehospitalization-Measures-for-Public-Comment-.zip (Opens File Packet).
[4] Al Dobson et al., *Validation of an OASIS-Based Home Health 30-Day Readmission Measure with Medicare Claims Data*, Alliance for Home Health Quality and Innovation (June 18, 2013), http://ahhqi.org/images/uploads/1_Dobson_DaVanzo_Readmission_Validation_Findings_-_Final_6.19.13.pdf.

		used the Emergency Department, or been placed in observation. For this reason, the Alliance supports the use of Medicare claims data in the Hospitalization Measure and the ED Use Measure noting that there may be critical uses for OASIS data in the risk adjustment of these measures. (*See infra* Section III.a. of this comment letter.) Moreover, the Alliance supports the Rehospitalization and ED Use Measures as an effort to harmonize home health quality measures with those of hospitals. Measure harmonization is critical to aligning incentives between hospitals and post-acute care providers such as home health. Having a standardized 30-day rehospitalization measure from home health will enable home health providers to work in concert with hospitals to reduce unnecessary rehospitalizations and the Alliance supports CMS's effort to pursue this harmonization. The Alliance further supports continued reporting of acute care hospitalization (ACH). The current ACH measure is over a 60-day episode and captures both hospitalization and rehospitalization within the standard Medicare home health episode. We believe that this measure continues to be valuable because it captures hospitalizations that are not preceded by an acute care hospitalization. **II. Increased transparency regarding the development of measures is critical to ensure that proposed measures accurately capture the nature of home health care clinical practice and post-acute care.** The Alliance is encouraged that CMS has worked with both the National Quality Forum ("NQF") and the National Priorities Partnership ("NPP") to develop the proposed quality measures. As a member of NQF, the Alliance supports NQF's work to endorse measures used to measure the quality of care. We would encourage CMS to consider seeking additional input from the community and public when developing quality measures. Although NQF endorses measures, the organization's focus is not on measure development.[5] NQF's contract with the Department of Health and Human Services focuses on five key areas: (1) make recommendations on a national strategy and priorities; (2) endorse quality measures, which involves a process for determining which ones should be recognized as national standards; (3) maintain—that is, update or retire—endorsed quality				

[5] GAO, *Health Care Quality Measurement: The National Quality Forum Has Begun a 4 Year Contract with HHS* (June 2010), http://www.gao.gov/new.items/d10737.pdf.

		measures; (4) promote electronic health records; and (5) report annually to Congress and the Secretary of HHS.[6] While NQF provides high quality work in endorsing measures, the Alliance would urge CMS to consider an open door forum or town hall meeting on the development of such proposed measures. This would permit a full and open discussion with a broader audience. Increased transparency about the development of measures, including specifics about the rationale and methodology used to calculate measures, would allow clinical experts to provide more detailed and meaningful comments on future proposed measures. **III. Additional Considerations for the Proposed Rehospitalization Measure and the Proposed ED Use Measure** **a. Risk Adjustment Methodology** Both the Proposed Rehospitalization and ED Use Measures incorporate three measures of health status for risk adjustment, including CMS' Hierarchical Condition Categories (HCC), Diagnosis-Related Groupings, and Activities of Daily Living.[7] The Alliance supports the inclusion of condition-related information, but asks that CMS consider including additional functional, medical, cognitive and social support data from the OASIS data set that are already known to be potential quality measure risk adjustment factors. In particular, the proposed measures include the following ADLs for risk adjustment: Dressing upper or lower body (OASIS fields M1810 or M1820); Bathing (M1830); Toileting (M1840); Transferring (M1850); and Ambulation (M1860). It is not clear why only these ADLs have been chosen for the purposes of risk adjustment. There are other data points in OASIS that may be strong predictors of risk for hospitalization and it is similarly unclear why these data points were excluded. The attached comparison document of OASIS-C and OASIS-C1 (see Attachment) identifies these items and are marked in the far right column with the notation "PRA." Current materials accompanying the proposed measures do not indicate whether these items were taken into				

[6] *Id.* at 2.

[7] CMS, *Draft: Rehospitalization During the First 30 Days of Home Health*, CMS.gov (June 1, 2013), at 7 (File Name "HH_HH_Rehospitalization_Draft"); and CMS, *Draft: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health*, CMS.gov (June 1, 2013), at 7 (File Name "HH_HH_ED Use without Hospital Readmisson_Draft"), both available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/HH-Claims-Based-Rehospitalization-Measures-for-Public-Comment-.zip (Opens File Packet).

		consideration. In addition, existing research on home health care suggests that certain risk factors could be particularly significant predictors of the risk of rehospitalization. For example, researchers have found that factors associated with risk of rehospitalization included dyspnea severity at the home health admission in addition to the number of prior hospital stays.[8] Based on this research, the OASIS-C questions related to cardiac status (e.g. M1500, M1510) may be effective data points for risk adjustment. Social environmental factors, like the frequency of caregiver services, can function as predictors of rehospitalization.[9] The OASIS-C Care Management question provides an indication of whether a caregiver is present and able to assist the patient with care (e.g., OASIS C M2100 or OASIS C-1 M2102). These examples indicate that there might be additional data in the OASIS assessment that could potentially provide meaningful information for risk adjustment. The Alliance recommends that CMS consider additional OASIS items, described above, for risk adjustment in the proposed measures. Further, the Alliance recommends that CMS publicly provide a clear list of the risk adjustment factors used to calculate the measure, with an explanation as to why certain OASIS items have been included or excluded. Finally, it is important to note that in some cases, patients may be discharged from the hospital prematurely. In such cases, rehospitalization would be appropriate for that patient. CMS should consider whether there is any means to assess whether patients have been discharged from the hospital prematurely and if risk assessment may account for this factor. **b. Exclusions** The Alliance supports the exclusions of Low Utilization Payment Adjustment (LUPAs) from the denominator calculation in both measures, but notes that there may be multiple factors leading to the decision for such early discharges from home care. The Alliance recommends that CMS provide more detail to explain the decision to exclude LUPAs. In addition, the Alliance supports CMS's decision to exclude planned				

[8] *See e.g.*, E.A. Madigan et al., Rehospitalization in a national population of home health care patients with heart failure, 47 *Health Services Research* 2,316-38 (Dec. 2012); abstract available at: http://www.ncbi.nlm.nih.gov/pubmed/22524242.

[9] Hong Tao et al., The Influence of Social Environmental Factors on Rehospitalization Among Patients Receiving Home Health Care Services, 35 *Advances in Nursing Science* 346-58 (2012); abstract at: http://journals.lww.com/advancesinnursingscience/Abstract/2012/10000/The_Influence_of_Social_Environmental_Factors_on.7.aspx.

		hospitalizations from the numerator of both measures. In the calculation algorithm for the 30-day rehospitalization measure, the Alliance recommends that the Rehospitalization Measure explicitly exclude planned hospitalizations (as they are in the ED Use calculation algorithm). Further, the Alliance recommends that CMS publicize the list of planned admissions so that home health agencies are aware of exactly which types of admissions the measure will exclude. Finally, it is not clear from the materials describing the 30-day Rehospitalization Measure whether patients discharged from home health prior to 30 days would be included or excluded. We recommend including patients discharged from home health within the 30-day measurement period, and ask that CMS clarify this point. **C. Alignment and Harmonization with Other Acute-Care Hospitalization Measures** The Alliance supports the work done to-date to align the proposed measures with the Hospital-Wide All-Cause Unplanned Readmissions Measure ("HWR Measure").[10] It is critical that measures evaluating 30-day rehospitalizations and ED use from home health align with similar measures used by others in the health care system. Consistency through harmonization is important to improve coordination of care in areas like care transitions, which require clear communication between hospitals and post-acute providers like home health. Harmonized measures are also critical for reformed models of care delivery, such as Accountable Care Organizations ("ACOs"), to succeed. ACOs and hospitals, in general, are looking for post-acute care partners with low rates of rehospitalization. Having accurate quality data on rehospitalization will enable hospitals and health systems and home health providers to communicate well. In regard to the ED Use Measure in particular, the Alliance supports the inclusion of observation stays within the measure. There has been a lack of clarity around whether current ED Use Measures include observation stays. In regards to alignment with the HWR measure, the Alliance supports deviations from the HWR to accommodate the unique setting of home health. Additionally, we would encourage CMS to consider additional data				

[10] See https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/downloads/MMSHospital-WideAll-ConditionReadmissionRate.pdf.

Date Posted	Measure Set or Measure	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization	Recommendations/ Actions Taken
		points for risk adjustment purposes, as described above in Section III.a. There is an opportunity to use the OASIS data to better predict the risk of rehospitalization and to more fairly risk-adjust the measure based on functional, medical, cognitive and social support data. As stated above, we would encourage CMS to continue to look at the OASIS data set to determine whether there are additional data points that should be included in the proposed measures. The Alliance greatly appreciates the opportunity to comment.				