

Public Comment Summary Report Including Verbatim Comments

Skilled Nursing Facility Readmission Measure

August 28, 2013

RTI International

Introduction

- ◆ Dates of public comment period: July 15, 2013 through July 26, 2013
- ◆ Web site used: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html>
- ◆ Methods used to notify stakeholders and general public of comment period:
 - Email notification to relevant stakeholders and stakeholder organizations, including:
 - Advancing Excellence in America's Nursing Homes
 - American Health Care Association
 - American Medical Directors Association
 - LeadingAge
 - National Consumer Voice for LTC
 - Pharmacy Quality Alliance
 - State QIOs
 - The American Hospital Association
 - The American Medical Association
 - Various field experts
 - Email notification to Technical Expert Panel members
 - Posting on CMS Public Comment website
- ◆ Volume of responses received: CMS received 14 comments in total (the vast majority containing more than one point). These comments represent a mix of perspectives, including providers and individual clinicians in the long term care industry with a clinical background, provider and professional organizations, individuals in academic/research organizations with technical expertise in quality measurement, and advocacy groups representing consumers.

Stakeholder Comments—General

- ◆ Summary of general comments.
 - Importance

Overall, nine comments addressed the importance of quality measures measuring hospital readmission from skilled nursing facilities (SNFs). Among these, three comments suggested that such a measure would create incentives for facilities to reduce the incidence of hospitalization. Three mentioned its importance in reducing preventable costs, six suggested it would help improve quality of care, and three stated the measure would encourage needed improvement in care coordination, particularly between nursing facilities and hospitals. Two commented that the increasing trend of beneficiaries enrolling in Medicare Advantage/Medicare Managed Care Plans would diminish this particular measure's relevance due to its reliance on Medicare Fee For Service claims.

Several comments suggested that transferring residents between hospitals and nursing facilities presented risks to residents' health and that many of these events could be prevented through better care by the nursing facilities for residents previously hospitalized. Many comments held that it was important to provide an additional incentive for facilities to pay attention to residents being admitted

from prior hospitalizations and to coordinate care for such residents with the hospitals that treat them. Several commenters believed that reducing such re-hospitalizations and avoidable complications in previously hospitalized residents would reduce costs, which one comment put would be “critical to the protection of the public [Medicare] trust.”

Response: *We appreciate the important evidence, insight and experiences that the commenters shared with us. CMS takes all commenters’ expertise and input into careful consideration and will use this information to carefully guide the development of the SNF readmission measure (SNFRM).*

o Numerator Definition – General

There were four general comments addressing aspects of the outcome definition, i.e. comments regarding the definition of a readmission that would trigger the numerator. There were also comments related to observation stays and to the role of physicians in making the decision to hospitalize a SNF patient included in the following sections.

▪ **Identifying planned readmissions appropriate for the SNF population**

Comments from rehabilitation providers (Patricia Stimac (Spartanburg Hospital for Restorative Care), American Medical Rehabilitation Providers Association (AMPRA), and Kindred Healthcare (Kindred)) included input on planned readmissions, of which two (Patricia Stimac, AMRPA) suggested additional procedures common in the SNF patient population, including planned surgery to close a flap due to a severe pressure ulcer, spinal stenosis implants, PEG or IVC filter placement, endarterectomy, close of a craniotomy site, total joint revision, removal of internal fixation device, and others. The comment from Kindred included concerns regarding the ability to internally validate hospitalizations as planned versus unplanned and encouraged measure developers to assess accuracy moving forward.

▪ **Clinical evaluation of patients prior to readmission**

On a similar note, Dr. Steven Levenson and Kindred Healthcare, Inc. noted that patients’ hospital readmissions should be clinically evaluated as necessary, noting high rates of misdiagnosis/over-diagnosis of particular conditions that result in readmission.

▪ **Role of Physicians in Decision to Hospitalize**

CMS received two (of 14 respondents) comments related to the role of physicians in the decision to hospitalize. Comments were received from a post-acute medical director/CMS consultant (Levenson) and a post-acute corporation (Kindred Healthcare, Inc.). Both reviewers pointed out the importance of physician and staff role in the decision to hospitalize. Kindred Healthcare requests that the physicians’ input regarding the necessity of the hospitalization should be measured. They state that the SNF does not transfer a patient to the hospital on its own direction, but through the direction of the attending physician. Dr. Levenson pointed to the limitations of using an administrative data set to capture the decision to hospitalize. He states, “a number of re-hospitalizations occur when patients who have been sent for postacute care are sent during their postacute care stay to a clinic or a consultant related to the hospital that sent the patient initially. These clinics and consultants often rehospitalize the patient on the spot-sometimes without even asking or telling the postacute facility-because they decide that they need to resume managing the patient. Often, such patients are stable enough to have remained in the postacute facility but wind up back in the hospital. This is not an unusual occurrence. This unfortunate reality of clinical practice would not be identifiable by any administrative data set and does not appear to have been identified (or even considered) by any researchers.” Dr. Levenson adds, “Facilities differ widely in the quality and quantity of the discharge summary that comes with the patient upon hospital discharge. They also differ widely in the capacity and consistency of staff reading the discharge summary, communicating with the attending physician in the postacute facility, identifying all pertinent issues and risk factors, and going beyond the often limited or organ system or diagnosis specific information that they receive from the hospital at the time of transfer.”

Response to: Identifying planned readmissions appropriate for the SNF population

CMS has included additional procedures relevant to the rehabilitation population along with those identified in CMS' Hospital Wide Readmission (HWR) measure based on communication with technical expert panels for the IRF and LTCH readmission measures. These procedures are documented in Appendix Table A3 and include several of the diagnoses suggested. CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.

Response to: Clinical evaluation of patients prior to readmission

Please see response to Role of Physicians in Decision to Hospitalize

Response to: Role of Physicians in Decision to Hospitalize:

CMS acknowledges the reviewers' important comments and notes significant challenges associated with accurately specifying 'decision roles' in a hospital readmission measure. The SNFRM, as well as all of the readmission measures, have been developed to foster coordination between providers in each setting. Thus, the measure should not adjust for physicians' decision to readmit because this limits the measure's ability to detect disease states or other factors where additional coordination may be required. CMS notes that a similar request to risk-adjust for the physician decisionmaking was raised by the ESRD TEP, and in addition to the conceptual flaws with including such an adjustment, there are serious technical concerns, such as the difficulty in determining which physician is responsible for the patient's care and the decision to readmit. Ultimately, this measure does not focus on the decision to readmit, rather it focuses on the coordination and maintenance of care necessary to ensure the patient does not reach a disease state that necessitates readmission, or at least to minimize the frequency with which this occurs. This measure may help shape the behavior of physicians, and the communication and coordination among physicians and SNF staff. CMS will continue to refine the model specification to include these and other important influences on hospital readmissions, as data are available during annual measure maintenance.

o Numerator Definition – Observation Stays

▪ **Comment summary**

Toby Edelman, Senior Policy Attorney for the Center for Medicare Advocacy, Robyn Grant Director of Public Policy & Advocacy for the National Consumer Voice for Quality Long-Term Care, and the California Advocates for Nursing Home Reform argue strongly for counting hospital observation stays (which are technically classified as outpatient instead of inpatient) in the numerator of the SNF 30-day all-cause readmission measure (SNFRM). They cited evidence from recent studies documenting the substantial increase in the use of hospital outpatient services among Medicare beneficiaries and the potential negative impact on beneficiaries such as access barriers to SNF care and undue financial burdens.

Response: *CMS agrees that the increased use of hospital observation stays as outpatient care is an important issue which may have significant adverse impact on some Medicare beneficiaries in terms of both care access and out-of-pocket spending. CMS acknowledges the TEP support of including observation stays in the measure, however, both the absolute number and percentage share of observation stays involving Medicare beneficiaries in the SNF setting are small relative to other settings (the vast majority are to and from the community) and relative to the total number of SNF stays. Details from the analyses substantiating these statements, conducted by Feng, Wright and Mor in 2012 are included in the Measure Justification Form. The SNFRM is harmonized with CMS' Hospital-Wide Readmission measure and other readmission measures being developed for other settings (inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)). However, CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.*

- Denominator Definition
 - **Denominator: SNFRM focuses only on the Fee for Service (FFS) population yet there is a growing number of beneficiaries with Medicare Advantage (MA) and Medicare Managed Care Plans (MMC)**

Two academic researchers (Greg Arling, PhD, Vince Mor, PhD) were concerned that the measure focused solely on patients enrolled in Medicare FFS, excluding patients enrolled in MA and/or MMC plans. They cited the growing number of patients enrolling in MA plans and as a corollary, the increasing number of SNF admissions involving MA members. In addition, they stated that there is significant geographic variability in MA/MMC participation by state so in the future, and recommended a more comprehensive SNF readmission measure will need to include members with MA/MMC plans. However, Dr. Mor acknowledged that Medicare FFS was “an important place to begin.”

- **Denominator: Broadest population at odds with a homogeneous population**

The Center for Medicare Advocacy (CMA) indicated that the denominator should be as inclusive as possible, and voiced concerns that the SNFRM’s current exclusion of beneficiaries who have a gap of more than 24 hours between their prior proximal hospital discharge and SNF admission would narrow the covered population. However, CMA also noted that these residents are likely different from those who are admitted to the SNF directly upon hospital discharge—which is the primary reason they were excluded from the SNFRM—their readmission risk was different than those who were admitted to a SNF within 24 hours of discharge from the prior proximal hospitalization.

- **Denominator: Psychiatric hospitalizations as a prior proximal hospitalization**

Dr. Mor questioned the inclusion of SNF stays in which the prior proximal hospitalization was from a psychiatric stay because these patients are likely very different from those who are discharged from acute care hospitals (e.g. psychotropic medications) and that by allowing these discharges, the SNF measure will not harmonize with the other readmission measures. Dr. Mor was concerned that this inclusion is not fully harmonized with the HWR measure. The commenter pointed out that “many Medicare beneficiaries admitted to Psychiatric hospitals are transferred to them from an acute hospital.” Thus, individuals discharged from psychiatric facilities may represent a patient population that is substantially different than the SNF population.

Response to: SNFRM focuses only on the Fee for Service (FFS) population yet there is a growing number of beneficiaries with Medicare Advantage (MA) and Medicare Managed Care Plans (MMC)

CMS acknowledges the importance of the growing population of Medicare beneficiaries enrolled in MA and MMC plans. The current measure, based on FFS claims, is harmonized with CMS’ current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (i.e., inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)). CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.

Response to: Broadest population at odds with a homogeneous population

CMS agrees that a measure that covers the broadest population possible is a goal. However, another component of the goal is to create a measure that is robust, relatively easy to compute, and valid. For this reason, the denominator is restricted to patients who went directly from their prior proximal hospitalization to the SNF.

Response to: Psychiatric hospitalizations as a prior proximal hospitalization

Including patients discharged from psychiatric facilities in the denominator of this measure harmonizes with CMS’ hospital-wide readmission (HWR) measure. Further, the inpatient rehabilitation facility (IRF) and the long-term care hospital (LTCH) measures also include discharges from psychiatric facilities. Patients from the

Acute Care Inpatient Prospective Payment System Hospitals (IPPS) and Critical Access Hospitals (CAH) with psychiatric diagnoses are included in the measure. As a result, including patients with an inpatient psychiatric facility stay for psychiatric diagnoses preceding the SNF stay is also appropriate. There were about 0.3 percent of such stays in the measure using 2009 claims data.

o Measure Exclusions

CMS received eight comments regarding the measure exclusions for the SNF Readmission Measure. The comments were submitted by academic researchers (2), trade groups (2), facility administrators (2), an advocacy group, and a healthcare provider company. All eight of the exclusions for this measure (listed below) were in some way addressed by the comments. In addition, a provider (Kindred Healthcare, Inc.) suggested additional exclusion criteria.

- **Exclusion 1: SNF stays where the patient had one or more intervening PAC admissions (IRF or LTCH), which occurred either between the prior proximal hospital discharge and SNF admission or after the SNF discharge, within the 30-day risk window or where the patient had multiple SNF admissions after the prior proximal hospitalization were identified using the MedPAR.**

An academic researcher (Vincent Mor, PhD) supported the denominator exclusion of patients with one or more intervening PAC admissions. However, also pointed out that a substantial and increasing proportion of hip fracture, stroke, and congestive heart failure patients who were discharged directly to SNF ended up receiving HHA services, warning that discharging patients to HHA “is an obvious way in which SNFs could ‘game’ the system.” Steven Levenson, MD, a nursing home medical director, questioned the rationale of the criterion: “intervening postacute care stays are relevant to quality even if they cannot be attributable to any one facility.” However, the Coalition of Geriatric Nursing Organizations (CGNO), a trade group specializing in elder care, supported this measure exclusion, noting that this group was clinically different and that responsibility in these cases is difficult to assign.

Response: We appreciate these comments. CMS is moving forward with this measure exclusion based on the TEP recommendation, and will continue to monitor the measure performance and consider future refinements.

- **Exclusion 2: SNF stays with a gap of greater than 1 day between discharge from the prior proximal hospitalization and the SNF admission were identified using the MedPAR.**

The Center for Medicare Advocacy disagreed with this criterion, noting that “[a] resident with a 48-hour gap also has all of his or her post-acute care provided by the SNF.” and pointing out that this group is clinically different than those who received care in multiple PAC settings. CMA also noted that the TEP did not support an exclusion criterion for residents with a minor 24-48 hour gap in SNF services.

Response: We appreciate these comments. CMS is moving forward with this measure exclusion, and will continue to monitor the measure performance and consider future refinements. Note, the TEP direction was that readmissions occurring within the first 24-48 hours should be included in the numerator, and the measure is specified to include these readmissions, in agreement with the TEP direction.

- **Exclusion 3: SNF stays where the patient died during the 30-day risk window post proximal hospital discharge and where a readmission did not occur were identified using the MedPAR and the Medicare Denominator file.**

Dr. Mor noted that this criterion was “potentially problematic,” because facilities would be effectively punished for effectively managing end-of-life care. He also noted that, although deaths in this population are rare (around 5%), they are likely to be concentrated in certain regions, leading to bias. CMA supported this criterion with no stated reservations.

Response: We appreciate these comments. CMS is removing this measure exclusion, which will harmonize with the hospital-wide readmission (HWR), inpatient rehabilitation facility and long-term care hospital

readmissions measures. CMS will continue to monitor the measure performance and consider future refinements.

- **Exclusion 4: Lack of 12 months of FFS Medicare enrollment prior to the proximal hospital discharge was identified by patient enrollment status in Part A FFS using the Medicare Denominator file. Enrollment must be indicated during the month of prior proximal hospital discharge and the 11 months preceding the prior proximal hospital discharge.**

CMA emphasized that the measure should include the greatest possible number of patients, and expressed concern that this exclusion was not adequately justified.

Response: We appreciate these comments. CMS is moving forward with this measure exclusion, harmonizing with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements. This exclusion was applied to ensure adequate and equivalent diagnosis information to identify comorbidities across all patients included in the measure. Multiple studies have shown that using lookback scans of a year or more of claims data provides superior predictive power for outcomes including rehospitalization compared to using data from a single hospitalization (e.g., Klabunde et al, 2000; Preen et al, 2006; Zhang et al, 1999).

- **Exclusion 5: Lack of FFS Medicare enrollment during the 30 days after discharge from the prior proximal hospitalization was identified by patient enrollment status in Part A FFS using the Medicare Denominator file. Enrollment must be indicated for the month(s) falling within 30 days of discharge from the prior proximal hospitalization.**

CMA objected to this exclusion criterion for the same reason as the center objected to Exclusion 5: inadequate justification for the exclusion of patients.

Response: We appreciate these comments. CMS is moving forward with this measure exclusion, harmonizing with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements. This exclusion was applied to ensure adequate and equivalent information to identify readmissions across all patients included in the measure. Patients with fewer than 30 days enrollment after discharge could have readmissions occurring within the risk period that would not be identifiable in Medicare claims, introducing error and potential bias into the measure.

- **Exclusion 6: Table 1 indicates all cancer discharge condition categories excluded from the measure. Cases are identified using MedPAR claims for prior proximal hospitalization.**

CGNO supported this measure exclusion and suggested adding other terminal conditions to this measure exclusion. Dr. Levenson, however, noted that the term “cancer treatment” subsumes a wide array of illnesses, levels of severity, and types of treatments, and thus questioned the rationale for excluding due to cancer but not for other classes of illness.

Response: We appreciate these comments. CMS is moving forward with this measure exclusion, harmonizing with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements.

- **Exclusion 7: Discharges from the SNF against medical advice were identified using the discharge disposition indicator on the corresponding SNF claim from the MedPAR.**

Two comments, one from CGNO, the other from the healthcare provider company Kindred, Inc., both supported this criterion but cautioned that it may be due to high rates of error since this type of information is not present on the MDS and thus subject to miscoding by non-clinical staff.

Response: *We appreciate these comments. CMS is moving forward with this measure exclusion.*

- **Exclusion 8: “Rehabilitation care; fitting of prostheses and for the adjustment of devices” are identified by principal diagnosis codes (ICD-9 codes) included in CCS 254, using MedPAR claims for prior proximal hospitalization.**

The American Medical Rehabilitation Providers Association (AMRPA), a trade group, and Dr. Levenson both objected to this criterion, with Dr. Levenson stating that prosthesis fitting and adjustment is “primarily a marketing label and not a valid clinical entity.” Researcher Barbara Gage, PhD, distinguishing between prosthesis adjustments and prosthetic-related infections that could have been avoided with proper care. Dr. Gage indicated that adjustments, but not avoidable infections, should be excluded.

Response: *We appreciate these comments. A patient would have to have had a primary diagnosis included within the Agency for Healthcare Research and Quality’s (AHRQ’s) Clinical Classification Software (CCS) 254 code to be excluded for rehabilitation. CCS 254 only includes diagnosis codes related to prostheses fitting, adjustment, physical and occupational therapy. Note that only 1,979 patients were excluded for having CCS 254 as a primary diagnosis. Infections associated with prostheses as a primary diagnosis are not excluded. CMS is moving forward with this measure exclusion, harmonizing with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements.*

- **Suggested exclusions.**

Kindred Healthcare, Inc., suggested two additional exclusions. The first suggestion was for the exclusion for SNF stays of under 24 or 48 hours that ended with a return to acute care. The reasoning here was two-fold: such patients were likely to be less stable and thus still requiring of acute care, and short stays are also a likely byproduct of inadequate transitional care (which is a function of multiple settings working in concert). The second suggestion was for low-admission and -volume SNFs to be excluded from reporting, as proportions based on smaller numbers can be misleading.

Response: *We appreciate these comments. CMS is moving forward with this measure exclusion based on TEP recommendations to hold SNFs accountable for readmissions occurring within the first 48 hours of a SNF admission. One of the primary purposes of the measure is to encourage improved transitions at discharge and choice of discharge destination.*

- Small Facilities

Two public comment responses expressed concern about how the SNFRM handles small SNFs and another indicated that the hierarchical regression modeling and 95% confidence limits around facility rates will help with the interpretation of small facility rates.

- **Exclude facilities with few SNF admissions**

Kindred Healthcare suggested that SNFs with very low admissions should be excluded from the measure, in particular SNFs admitting 25 or fewer residents should be excluded.

- **Measure developers carefully consider how methods will affect rates for small facilities**

Cheryl Phillips, MD, Senior Vice President of Public Policy and Advocacy for LeadingAge suggested the potential for small facilities to be disadvantaged by the SNFRM but hoped that the measure development methods took this into account.

- **Ability of hierarchical regression and 95% confidence limits to aid in the interpretation of rates for small facilities**

Dr. Arling noted that the numerators and denominators of the facility rates will range from just a few admissions to over thousands of admissions per year but that the use of hierarchical regression modeling will provide reliable estimates for the rates and that confidence intervals will aid in interpretation of the facility rates.

Response to: Exclude facilities with few SNF admissions

CMS has not excluded facilities with small numbers from the measure, but has made an effort in the past to only report readmission rates for facilities with which we have a certain degree of confidence and to ensure patient confidentiality; we seek to remain consistent on these points.

Response to: Measure developers carefully consider how methods will affect rates for small facilities

CMS has been very cognizant of how the SNFRM methodology will affect facility rates for small facilities. Modeling methods include shrinkage estimators which shift estimates for small facilities towards the mean, reducing small facility's vulnerability to having their estimates heavily weighted by just a few numerator triggering events. CMS will continue to monitor the measure performance and consider future refinements.

Response to: Ability of hierarchical regression and 95% confidence limits to aid in the interpretation of rates for small facilities

CMS appreciates this comment regarding the usefulness of 95% confidence limits for the facility rates for understanding the variability in readmission rates for small facilities and may consider publically reporting such information in the future.

- Risk Adjustment

Of the seven comments discussing some aspect of risk adjustment, the vast majority (six out of the seven) supported the risk adjustment approach but some comments also suggested additional covariates for adjustment

- **Risk adjusting the SNFRM is “very welcome”**

Dr. Mor stated that that the modeling and risk adjustment approach used in this measure was “very welcome in light of the much more limited efforts at risk adjustment in the case of other SNF quality measures”, and then commended both the use of the diagnostic information from prior proximal hospital stay (note: the SNFRM used diagnostic information from all hospitalizations in the 12 months prior to the prior proximal hospitalization), as well as the use of ICU days.

The representative from AMRPA also expressed appreciation that RTI recognized the importance of age, post acute length of stay, ICU stay, and prior diagnoses and comorbidities. Kindred was “pleased to see the thoughtful approach to risk adjustment”, highlighting the importance of risk adjustment given the diversity of facility types and patient characteristics reflected in the SNF population.

- **Dual eligibility as a risk adjuster**

Dr. Mor suggested that dual eligibility is an important risk adjuster based on his own research.

- **Dialysis status in addition to end-stage renal disease (ESRD)**

Dr. Steven Levenson suggested that dialysis status in addition to end-stage renal disease as a comorbidity, be considered for risk adjustment.

- **Include factors from the Minimum Data Set (MDS)**

Multiple comments recommended the addition of risk factors to the risk adjustment model, which could be obtained from the MDS. The Coordinator for the Coalition of Geriatric Nursing Organizations (CGNO), and the representatives from AMPRA and Kindred Healthcare strongly advocate that factors available from the MDS such as functional status, mobility, cognitive function, hospice care, and life expectancy be considered for risk adjustment. It was also recommended that the presence of social supports be included in the model.

- **Type of SNF should be considered as a risk adjuster**

AMPRA and LeadingAge suggested that the type of SNF should be included as a risk adjuster, such as whether the SNF is hospital-based or a rural provider or focuses on specific types of rehabilitation care (e.g., orthopedic post-surgical care).

- **Inclusion of ACS conditions in the risk adjustment set may be inappropriate**

Dr. Arling discussed whether the measure should have taken ambulatory care sensitive conditions into account in risk adjustment, given that these are conditions that by definition should be possible to manage in ambulatory settings.

- **Concerns regarding use of comorbidities and system-specific surgical indicators**

Dr. Levenson voiced multiple concerns regarding the use of comorbidities and system-specific surgical indicators. The commenter cautioned that comorbidities and surgical indicators could fail to give the full clinical picture. Conditions may be misdiagnosed or not properly documented and readmission events could occur for causes unrelated to the reason for the original hospitalization. Dr. Levenson suggested that use of surgical indicators in risk adjustment may be inadequate because the SNF patient's other medical conditions may put the patient at greater risk of readmission. Further, that patient frailty "depends as much or more on the number of complications or impairments that result from those comorbidities, not just on the number of conditions or illnesses."

- **Controlling for prior hospitalizations to the same hospital from the same SNF erroneously controls for poor quality being provided by SNF**

Dr. Arling pointed out that having multiple prior hospitalizations to the same hospital from the same SNF may be an indicator of poor care being provided in the facility and inappropriately control away poor quality care being provided in the SNF.

- **The risk adjustment models should be stratified.**

AMPRA advocated for a risk adjustment model that was stratified by patient characteristics to provide a finer description of the types of readmissions cases and to allow identification of patterns or trends. They acknowledged that the model sought to address issues regarding stratification on its risk adjustment utilizing a surgical/medical split and examining individual and multiple comorbidities.

Response to: Dual eligibility as a risk adjuster

CMS did not use dual eligibility as a risk adjuster because it is often correlated with socioeconomic status, a risk factor for health disparities, and the current thinking is that markers of vulnerability to health disparities should not be included in risk adjustment models. Including these markers in a risk adjustment model would suggest a lower standard of quality for vulnerable populations. This measure is not specifically adjusted for factors such as race, SES, or English language proficiency. We believe such additional adjustments are not

appropriate because the association between such patient factors and health outcomes can be due, in part, to differences in the quality of health care received by groups of patients with varying race/language/SES. Differences in the quality of health care received by certain vulnerable groups may be obscured if the measures risk-adjust for socio-economic status or ethnicity. In addition, risk-adjusting for patient SES, for instance, may suggest that SNFs with a high proportion of low SES patients are held to different standards of quality than SNFs treating fewer low SES patients. Our analysis indicates that better quality of care is achievable regardless of the demographics of the SNF's patients.

Response to: Dialysis status in addition to end-stage renal disease (ESRD)

The proposed readmission measure is a risk-standardized readmission measure that adjusts for case-mix differences based on the clinical status of the patient at the time of admission to the SNF. That is, the measure is risk-adjusted for certain key variables that are clinically relevant or have been found to have strong relationships with the outcome, including age group, sex, comorbid diseases, history of repeat admissions. CMS will investigate in the future if including additional data elements such as dialysis status would produce substantive improvement of the model.

Response to: Include factors from the Minimum Data Set (MDS)

CMS acknowledges that the MDS is a potentially rich source of additional patient risk adjustment variables, however, the timing of assessments upon admission to facilities, which for the Prospective Payment System (PPS) assessment may be completed up to five days after admission could introduce bias by inappropriately controlling for clinical conditions and characteristics that develop during the first five days of the SNF stay. The use of Medicare FFS claims harmonizes with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital readmissions measures. However, CMS will continue to monitor the measure performance and consider future refinements.

Response to: Type of SNF should be considered as a risk adjuster

CMS typically does not adjust for provider characteristics such as suggested by the commenter. Adjusting for these characteristics would suggest that there were acceptable differences in levels of quality of care by provider characteristic.

Response to: Inclusion of ACS conditions in the risk adjustment set may be inappropriate

We appreciate Dr. Arling's consideration of the appropriateness of including ambulatory sensitive conditions as risk adjustment variables in the measure. The SNFRM focus on all-cause readmissions is harmonized with CMS' current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (i.e., inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)).

Response to: Concerns regarding use of comorbidities and system-specific surgical indicators

The proposed readmission measure is a risk-standardized readmission measure that adjusts for case-mix differences based on the clinical status of the patient at the time of admission to the SNF. That is, the measure is risk-adjusted for certain key variables that are clinically relevant or have been found to have strong relationships with the outcome, including age group, sex, comorbid diseases, history of repeat admissions. The model does not control for system-specific surgeries in isolation, but additionally controls for primary medical conditions and comorbidities for individuals with these surgical procedures in their prior proximal hospitalization. CMS acknowledges that quantifying individual risk for readmission is complicated and dependent on interactions of many factors measureable and unmeasurable. CMS will continue to monitor the measure performance and consider future refinements.

Response to: Controlling for prior hospitalizations to the same hospital from the same SNF erroneously controls for poor quality being provided by SNF

We appreciate Dr. Arling's consideration of the appropriateness of controlling for repeat hospitalizations to the same hospital from the same SNF. CMS will continue to monitor the measure performance and consider future refinements.

Response to: The risk adjustment should be stratified.

Thank you for your comment. While developing this measure, CMS tested models stratified by major groupings, in part to take into account risk factors might have different effects on risk for readmission for patients with different conditions, but also to harmonize with the HWR measure. This topic was discussed with TEPs to ensure that the appropriate strata were considered. However, analyses indicated that using stratification did not improve model fit or calibration. Therefore the current model, without stratification, was moved forward, which has the additional advantage of being easier to interpret. CMS will continue to evaluate the data and may revisit this topic in the future.

o Claims

CMS received four (of 14 respondents) comments related to using Medicare Part A claims to specify a SNF hospital admission measure. Comments were received from academic researchers (Mor and Arling), a national trade association (AMPRA) and a post-acute corporation (Kindred Healthcare, Inc.). In general commenters stated that the measure was well designed but pointed out limitations of a SNF hospital readmission measure specified solely on Medicare Part A claims.

- **Claims are limited in terms of 'real time' event reporting making it difficult for facilities to take actionable steps to improve quality.**

Dr. Mor (Brown University) stated that using claims data to define the SNFRM presents real time reporting challenges given the lag in claims data. He also pointed out that the timeliness of measures based upon Medicare Part A claims limited the utility of these measures for facilities' own quality improvement efforts. Dr. Mor stated that unless the modeling and risk adjustment approach "is incorporated into event level data to which providers have more "real time" access, such as the MDS, facilities' ability to take action designed to improve care will be more limited." Kindred Healthcare stated that since data outside the SNF are used to specify the measure, facilities "have no ability to monitor progress/improvement in real time which is the hallmark of quality improvement efforts in the SNF." Dr. Arling (Indiana University) stated that the 6-month lag (or longer) in the MEDPAR data will result in facility rates based on admissions occurring from 6-18 months prior. "The lag could make it difficult for facilities to conduct effective quality improvement."

- **The use of hospital-based diagnosis to track post-acute placement (readmissions).**

Kindred Healthcare raised concerns regarding using ICD-9 coding captured from the index acute care hospitalization in administrative claims data to specify the SNFRM. They stated that since the hospital admission diagnosis is listed to track post-acute placement and may not capture, for example, a re-admission for dementia with behavioral disturbance, chronic anemia, or iatrogenic complications of the index hospitalization. They state that "there is no input from the SNF on the actual conditions/problems/diagnoses that specified admission to the SNF, there is no way to directly link re-admission to those codes.

- **Fee for service claims may not adequately capture managed care populations.**

Dr. Arling stated that using Medicare claims for the fee-for-service population "may exclude sizable proportions of residents in some states or in certain facilities within states that have large managed care populations." Dr. Mor echoed this concern in his comment.

- **Use of alternative data source (MDS 3.0) to specify the SNF hospital readmission measure.**

Kindred Healthcare stated that “the risk adjustments specific to claims data could be more robust with the inclusion of clinical information from the MDS specific to ADL function and dementia which are high predictors of re-hospitalization.” Dr. Arling suggested an alternative data source is the Minimum Data Set (MDS), which captures all hospitalizations from the nursing facility (not just FFS admissions). He adds that the MDS data are received in ‘real time’ reducing the lag between data collection and reporting (as in the claims) and contain risk adjusters (e.g., cognitive impairment, ADL functioning) not found in Medicare claims. AMRPA recommended that, in addition to claims data, patient-specific data also be utilized.

- **Multiple years of claims data should be used to define readmissions to capture regulatory changes and atypical years.**

The American Medical Rehabilitation Providers Association voiced concerns regarding the basis of the measure on only one year of claims data and recommended using multiple years of claims data to provide a sufficiently robust database (avoiding one ‘atypical’ year) to define readmission. AMRPA cited example of regulatory changes from 2004 through 2012.

Response to: Claims are limited in terms of ‘real time’ event reporting.

CMS acknowledges reviewers’ concerns. The validity of using the presence of hospital claims to identify readmissions is more well established than the validity of using of patient assessment data. As with other quality reporting measures, the SNFRM will be updated annually using most recent data and will include analyses regarding potential impacts of the lag in claims on facility rankings.

Response to: The use of hospital-based diagnosis to track post-acute placement (readmissions).

The SNFRM was analyzed with respect to both data item (variable) and measure level validity. The data elements focused on variables that are likely to be coded most consistently across hospitals and SNFs. The relationship between the SNFRM and current NH quality measures was examined as well. The SNFRM specification is based on studies which have examined the validity of using Medicare hospital claims for multiple NQF-endorsed quality measures used in public reporting and other studies which have validated claims for detection of several conditions and procedures. (see MJF Section 2b2.1 Validity Testing).

Response to: Fee for service claims do not capture managed care populations.

CMS acknowledges the reviewer’s concern and will examine possible refinements to the model in the future, including capturing the Medicare managed care population.

Response to: Use of alternative data source (MDS 3.0) to specify the SNF hospital readmission measure.

CMS acknowledges the reviewer’s comments and points out that the foundation and intent of the SNFRM specification was harmonization across provider settings (e.g., hospital, LTCH, IRF). This included measure specification based on Medicare claims data, examining a risk adjustment model which accounted for variation across SNFs in case-mix and patient characteristics (demographic and clinical). CMS will examine possible refinements in the future which potentially include non-claims based patient level clinical elements such as cognition and ADL function.

Response to: Multiple years of claims data should be used to define readmissions to capture regulatory changes and atypical years.

Multiple years of data were used to examine reliability of the SNFRM. MedPAR claims and Medicare Denominator files for 2009, 2010 and 2011. See MJF Reliability & Validity, Section 2a2.1. After exclusions, the final analytic files included the following counts of patients and SNFs:

*2009: 2,148,638 index SNF stays in 16,712 SNFs
2010: 2,159,070 index SNF stays in 16,668 SNFs
2011: 2,174,299 index SNF stays in 16,656 SNFs*

Consistent with the reliability testing done for CMS' Hospital Wide Readmission (HWR) QM, data from 2009 and 2010 were pooled, splitting the file randomly within facility at the patient level into two data sets. The two data sets derived from the two years of pooled data were used for reliability testing and the third year (2011) was used to assess stability over time. The final analytic files included 16,889 SNFs reporting over 2009 and 2010, and had the following counts of patients:

Sample 1: 2,153,826 index SNF stays in 16,817 facilities

Sample 2: 2,153,882 index SNF stays in 16,889 facilities

Patient specific data was included in the model. See MIF Stratification/Risk Adjustment section that defines hospital readmission as a function of patient-level demographic and clinical characteristics and a random SNF-level intercept. Provider level information was also accounted for in the model.

CMS recognizes the importance of evaluating whether significant policy changes may potentially impact hospital readmissions. Toward this end, CMS will continue to monitor the performance of the SNF hospital readmission measure and examine possible refinements that might improve the model and the measure, including externalities and confounding factors that may disproportionately impact providers.

o 30-Day Risk Window

For concerns pertaining to the 30-day risk window component of the SNF Readmission Measure, CMS received a total of (7) comments from (2) advocacy groups, (1) trade group, (1) university researcher, (2) facilities, and (1) independent researcher. Most commenters indicated support for use of the 30-day risk window in the measure, though others raised concerns about the ways in which this window could result in possible exclusions from the measure.

▪ **Support.**

Some commenters, including Vincent Mor, PhD, American Medical Rehabilitation Providers Association (AMRPA), and Coalition of Geriatric Nursing Organizations (CGNO), said they agreed with the 30-day observation window used in the numerator for the SNF Readmission Measure.

▪ **Concern 1: Consider including patients with intervening admissions within 30-days.**

University researcher, Vincent Mor, PhD, raised concern over exclusion of SNF residents who were admitted to other post-acute care (PAC) settings during the 30-day risk window.

For more information on this concern, see Exclusion 1 under "Exclusion Criteria."

▪ **Concern 2: Readmissions occurring after discharge to community but during the 30-day risk window should be excluded.**

A nursing home administrator, Patricia Stimac, indicated that individuals discharged from the SNF prior to 30-days should be excluded, particularly if they were released to a home environment. She suggested that it was not appropriate to hold SNFs accountable for readmissions from the community occurring during the 30-day risk window because patients were no longer under SNF care. In a contrasting opinion, an individual researcher, Barbara Gage, PhD, suggested that SNFs should be held accountable for readmissions occurring in the 30-days post-discharge period and recommended creation of a secondary measure to track readmissions within 30 days for residents discharged from SNFs.

For more information on these concerns, see Exclusion 2 under "Exclusion Criteria."

Response: CMS acknowledges these comments and suggestions and consider these aspects beyond the scope of this specific measure (e.g., such as creation of secondary or companion measures) during future refinement. The use of the 30-day risk window harmonizes with the hospital-wide readmission (HWR), end-stage renal disease (ESRD), and home health agency (HHA) readmissions measures. One of the primary purposes of the measure is to encourage improved transitions at discharge and choice of discharge destination, which should be aided overlapping risk windows for the HWR and SNFRM.

Additionally, this measure holds SNFs accountable for the quality of discharges to the community occurring within the 30-day risk period. Readmissions occurring among discharged patients may indicate that the decision to discharge was premature, or preparation for discharge including patient and family education was inadequate. CMS will continue to monitor the measure performance and consider future refinements.

- Unintended Consequences
 - **CMS received a total of five (5) comments related to unintended consequences of the SNF Readmission Measure. Comments were categorized as follows: (3) advocacy groups, and (2) trade groups. The primary consequence that emerged from these comments pertained to potential concern over access to hospitalization when advanced care is medically necessary. Reduction in necessary hospitalization.**

The Center for Medicare Advocacy (CMA), California Advocates for Nursing Home Reform (CANHR), American Medical Rehabilitation Providers Association (AMRPA), National Consumer Voice for Quality Long-Term Care (Consumer Voice), and Coalition of Geriatric Nursing Organizations (CGNO) expressed concern that this measure will provide a disincentive for skilled nursing facilities to send residents to a hospital for additional care, even when that care may be medically necessary. CANHR and the Consumer Voice provide anecdotal examples of SNF residents who expired after being denied hospital admission. All three organizations and CGNO advocate further guidance to facility surveyors so that failure to admit residents who need hospitalization would be cited as a survey deficiency.

Response: *All comments and feedback are greatly appreciated, as ongoing discussion will ensure thorough evaluation of this measure. Some of the suggestions provided, such as revised survey guidelines, are beyond the scope of the measure itself, however, CMS will take these recommendations under consideration for future measure refinement and development. Other suggestions, such as providing greater detail to the measure response section regarding disincentives to hospitalize residents, will be addressed. Finally, inclusion of managed care residents in the measure is under further review. CMS recognizes that in some cases, hospital readmission will occur. Hospital readmission is not a “never event” that hospitals are expected to reduce to zero. The measure of hospital readmission is risk-adjusted to account for the factors that increase this risk, so that hospitals seeing a disproportionately larger share of these patients do not perform worse on the quality measure due to factors out of their control. As with all quality measures that are implemented, CMS will examine SNF data to monitor for potential unintended consequences.*

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2. Preen, D. B., Holman, C. D., Spilsbury, K., Semmens, J. B., & Brameld, K. J. (2006). Length of comorbidity lookback period affected regression model performance of administrative health data. *Journal of Clinical Epidemiology*, 59(9), 940–946.
3. Zhang, J. X., Iwashyna, T. J., & Christakis, N. A. (1999). The performance of different lookback periods and sources of information for Charlson comorbidity adjustment in Medicare claims. *Medical Care*, 37(11), 1128–1139.
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Verbatim Comments

* The comments included here are verbatim and the content was not changed or edited

ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization	Recommendations/Actions Taken
1	7/22/2013	<p>This is an important measure that provides definitive tracking of re-hospitalization rates from SNF over the course of the first 30 days following discharge from hospital. This measure is based upon Medicare FFS claims so is only applicable to admissions from hospital that have evidence of a Part A inpatient hospital claim followed by a Part A SNF claim. While this is an important place to begin, this measure will become increasingly limited as the number of Medicare beneficiaries choosing Medicare Advantage plans increases. The figure below presents a SNF level analysis of the proportion of all admissions entering SNF between 2000 and 2010 who were MA members upon admission. From a nadir of a median of only about 3%, by 2010 the median SNF had over 10% of its admissions who were MA members based upon the Medicare enrollment record and 25% of all SNFs had over 20% of admissions who were MA members. Since these are facilities with the highest number of admissions from hospital and there is considerable geographic concentration among MA plans across the country and the rate of increase of MA membership continues to rise, plans for creating a more comprehensive measure are necessary.</p> <p>Another issue of considerable importance is the timeliness of measures based upon Medicare Part A claims and the utility of these measures for facilities' own quality improvement efforts. While the modeling and risk adjustment approaches proposed are very welcome in light of the much more limited efforts at risk adjustment in the case of other SNF quality measures, unless this type of information is incorporated into event level data to which</p>	Vincent Mor, PhD, Brown University	vincent_mor@brown.edu	Researcher (university)	<p><i>Response to: SNFRM focuses only on the Fee for Service (FFS) population yet there is a growing number of beneficiaries with Medicare Advantage (MA) and Medicare Managed Care Plans (MMC)</i></p> <p>CMS acknowledges the importance of the growing population of Medicare beneficiaries enrolled in MA and MMC plans. The current measure, based on FFS claims, is harmonized with the current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)). CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.</p> <p><i>Response to: Claims are limited in terms of 'real time' event reporting.</i></p> <p>CMS acknowledges reviewers' concerns. The validity of using the</p>

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		<p>providers have more “real time” access, such as the MDS, facilities’ ability to take action designed to improve care will be more limited.</p> <p>Specific Comments on the Measure.</p> <p>Inclusion Criteria: While there may be nothing wrong with including admissions directly from Psychiatric Hospitals, there is no data to substantiate this decision. Indeed, it is my understanding that many Medicare beneficiaries admitted to Psychiatric hospitals are transferred to them from an acute hospital. This would suggest that this inclusion is not consistent with harmonization with the all cause rehospitalization measure for selected diagnoses. In the absence of specific data to the contrary, one could argue that patients discharged from psychiatric hospitals are absolutely different than those discharged from an acute hospital, are more likely to be taking significant psychotropic medications that, in and of themselves, place the patient at increased risk of rehospitalization. As importantly, psychiatric hospitals disproportionately discharge their patients to a select number of nursing homes that are moderately geographically proximate to the hospital and these facilities have a disproportionate share of such patients residing in them.(1)</p> <p>Exclusion Criteria: Patients are excluded from the calibration of the rehospitalization rate if they are admitted to HHA, IRF, LTAC or have no PAC service for a few days in between hospitalization and SNF admission. This is more than appropriate. However, there is also an exclusion if patients are admitted to SNF within one day of hospital discharge but then transferred to another PAC</p>				<p>presence of hospital claims to identify readmissions is more well established than the validity of using of patient assessment data. As with other quality reporting measures, the SNFRM will be updated annually using most recent data and will include analyses regarding potential impacts of the lag in claims on facility rankings.</p> <p><i>Response to: Psychiatric hospitalizations as a prior proximal hospitalization</i></p> <p>Including patients discharged from psychiatric facilities in the denominator of this measure harmonizes with the hospital-wide readmission (HWR) measure, the inpatient rehabilitation facility (IRF), and the long-term care hospital (LTCH) measures also include discharges from psychiatric facilities, which contributes to measure harmonization. Patients from the IPPS and CAH settings with psychiatric diagnoses are included in the measure. As a result, including patients with an inpatient psychiatric facility stay for psychiatric diagnoses preceding the SNF stay is also</p>

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		<p>setting within the first 30 days. Even prior to the bundling demonstrations and to the emergence of PAC conveners who take risk for ACOs and hospital systems for all PAC services, between 2000 and 2009, the proportion of FFS Medicare beneficiaries hospitalized for Hip Fx, stroke and CHF who were transferred directly to SNF who then went on to received HHA services increased from around 25% to over 30%. While there may not be a definitive answer as to what the allocation of accountability should be under this circumstances, it is an obvious way in which SNFs could “game” the system.</p> <p>Another exclusion criteria that is potentially problematic is the decision to eliminate from the denominator those cases that are admitted to the SNF who die without having been hospitalized. This exclusion is decidedly introducing a bias for several reasons. First, as noted in the description of these cases, these are extremely vulnerable cases at high risk of dying and therefore at high risk of being re-hospitalized. To exclude cases from the denominator where the SNF was “successful” in preventing a re-hospitalization, either by addressing advanced care planning or by carefully managing patients’ complex clinical needs until their death, is very unfortunate. Although there are only 5% of all SNF admissions that die during the first 30 days without having been hospitalized, these rates are probably unevenly distributed across the country and even within areas. A recent paper focused on hospitals in the UK and finds that excluding deaths from the rehospitalization rates introduces bias into the calculation of the re-hospitalization rates. [Laudicella, M., Donni, P.L., Smith, P.C., Hospital readmission rates: signal of failure or success?, Journal of Health Economics (2013), http://dx.doi.org/10.1016/j.jhealeco.2013.06.004]</p> <p>Risk Adjustment. Reliance on the hospitalization data from the</p>				<p>appropriate. There were about 0.3 percent of such stays included in the measure based on analysis of 2009 data.</p> <p><i>Response to concerns regarding Exclusion 1: SNF stays where the patient had one or more intervening PAC admissions (IRF or LTCH), which occurred either between the prior proximal hospital discharge and SNF admission or after the SNF discharge, within the 30-day risk window or where the patient had multiple SNF admissions after the prior proximal hospitalization were identified using the MedPAR.</i></p> <p>Response: We appreciate these comments. CMS is moving forward with this measure exclusion based on the TEP recommendation, but will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to concerns regarding Exclusion 2: SNF stays with a gap of greater than 1 day between discharge from the prior proximal hospitalization and the SNF admission were identified using the</i></p>

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		<p>“qualifying” hospitalization is great as is the indicator of use of the ICU. Our own work has used a count variable to estimate the number of ICU days preceding discharge to a SNF since among those with any ICU stays, days in the ICU appears to matter.(2) In addition to the measure of the patient being disabled from the Medicare Enrollment record, I would strongly recommend the indicator variable noting that the patient is dual eligible. This variable works extremely well and our data strongly suggest that dual eligible patients are discharged to poorer functioning facilities and they are less likely to be discharged back into the community.</p> <p>1. Rahman M, Grabowski DC, Intrator O, Cai S, Mor V. Serious Mental Illness and Nursing Home Quality of Care. Health Serv Res. 2012.</p> <p>2. Rahman M, Zinn JS, Mor V. The Impact of Hospital-Based Skilled Nursing Facility Closures on Rehospitalizations. Health Serv Res. 2012.</p>				<p><i>MedPAR.</i> We appreciate these comments. CMS is moving forward with this measure exclusion, but will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to concerns regarding Exclusion 3: SNF stays where the patient died during the 30-day risk window post proximal hospital discharge and where a readmission did not occur were identified using the MedPAR and the Medicare Denominator file.</i> We appreciate these comments. CMS is removing this measure exclusion, which will harmonize with the hospital-wide readmission (HWR), inpatient rehabilitation facility and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to: Include dual eligibility as a risk adjuster</i> CMS did not use dual eligibility as a risk adjuster because it is often</p>

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						<p>correlated with socioeconomic status, a risk factor for health disparities. Markers of vulnerability to health disparities should not be included in risk adjustment models according to NQF recommendation. Including these markers in a risk adjustment model would suggest a lower standard of quality for vulnerable populations.</p>
2	7/22/2013	<p>How about increasing the Skilled nursing facilities staff skill level in surveillance or be educated on signs and symptoms of delirium which is frequent in nursing facilities?</p> <p>The CAM - confusion assessment method - is the most widely used tool</p> <p>If the resident is exhibiting mental status changes, the staff should immediately:</p> <ul style="list-style-type: none"> Check for urinary retention Check for fecal impaction Pulse ox to look for hypoxia Blood sugar - to rule out hypo or hyperglycemia Urine dipstick - to rule out UTI Chest x-ray to rule out pneumonia VS with temp Check medication record for any new medications added Check to see if the patient is receiving any anticholinergic drugs and or on medications that should be avoided in the older adult 	<p>Michelle Moccia, MSN, ANP-BC, CCRN Program Director, Senior ER St. Mary Mercy Hospital Livonia, Michigan</p>	<p>ph 734-655-3643, pg 734-797-6506</p>	Hospital	<p>Response: We appreciate the important evidence, insight and experiences that the commenters shared with us. CMS takes all commenters' expertise and input into careful consideration and will use this information to help guide the development of the SNF readmission measure (SNFRM).</p>

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		<p>(BEERS 2012) Look to see if they are using their visual or hearing aids Check to ensure they are hydrated - what is their intake and output? If able too, draw stat labs for basic metabolic profile and add on PT INR if patient receiving anticoagulation</p> <p>Maybe by doing the above, they can intervene and stop the readmission and or admission.</p> <p>Michelle Moccia</p>				
3	7/24/2013	<p>We at LeadingAge, a national organization that represents over 6000 nonprofit provider organizations of aging services, appreciate the importance of an all-cause valid measure for 30-day hospital readmissions from the nursing home. We believe there is opportunity to reduce or prevent many of these costly events that represent potential risk and trauma to the patients transferred. We are pleased to see the thoughtful approach to risk adjustment, given the diversity of both facility types, patient characteristics and geographic differences. Not only must risk adjustment account for the complexity of the beneficiaries' medical and functional characteristics, but nursing homes themselves vary significantly in the types of patients they serve. For example, a nursing home that focuses on orthopedic post-surgical rehab would most certainly expect to have a lower readmission rate than a nursing home that focuses on ESRD, HIV, or other complex care patients that are not fully captured by the diagnostic categories listed in the summary of the risk adjusted diagnoses codes. Furthermore, when using rates to compare nursing homes within regions, small bed facilities will have significant disadvantages with even small number of readmissions</p>	<p>Cheryl Phillips, M.D. Senior VP Public Policy and Advocacy LeadingAge 2519 Connecticut Ave N.W. Washington, DC 20008 (202) 508 9740</p>	<p>cphillips@LeadingAge.org</p>	Trade Group	<p><i>Response to: Risk adjustment should take into account the nursing home level variation in types of patients served.</i></p> <p>We appreciate your comments regarding risk adjustment. The proposed readmission measure is a risk-standardized readmission measure that adjusts for case-mix differences based on the clinical status of the patient at the time of admission to the SNF. CMS will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to: Exclude facilities with few SNF admissions.</i> CMS has not excluded facilities with</p>

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		<p>compared with larger facilities with high turnover. We hope that the proposed methodology adequately takes these factors into account.</p> <p>We hope that this risk-adjustment methodology will be beta tested across a variety of nursing homes that would reflect variations in size and patient-mix prior to linking it to payment or public reporting.</p>				<p>small numbers from the measure, but has made an effort in the past to only report readmission rates for facilities with which we have a certain degree of confidence and to ensure patient confidentiality; we seek to remain consistent on these points.</p> <p><i>Response to: Measure developers carefully consider how methods will affect rates for small facilities:</i></p> <p>CMS has been cognizant of how the SNFRM methodology will affect facility rates for small facilities. Modeling methods include shrinkage estimators which shift estimates for small facilities towards the mean, reducing small facility's vulnerability to having their estimates heavily weighted by just a few numerator triggering events. CMS will continue to monitor the measure performance and consider future refinements.</p>
4	7/24/2013	<p>We are writing in response to your request for comments on the Skilled Nursing Facility (SNF) Readmission measure. California Advocates for Nursing Home Reform is a statewide, nonprofit advocacy organization dedicated to improving the choices, care and quality of life for California's long term care consumers.</p> <p>CANHR strongly endorses the comments of the Center for</p>	California Advocates for Nursing Home Reform	canhrmail@canhr.org	Advocacy Group	<p><i>Response to: The measure will result in reduction in access to necessary hospitalization.</i></p> <p>All comments and feedback are greatly appreciated, as ongoing discussion will ensure thorough evaluation of this measure. Some of</p>

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		<p>Medicare Advocacy on this measure, including its well-justified recommendation to include observation stays.</p> <p>Our comments here address the concern that the proposed measure will jeopardize the ability of some nursing home residents to get hospital care when their life depends on it. Throughout its 30-year history, CANHR has frequently received complaints from families that nursing home residents have died or suffered because nursing homes refused to arrange needed hospitalization.</p> <p>To give a very recent example, this week we received a complaint involving a nursing home resident who died due to an untreated infection after her daughter expressed grave concerns about her health and her doctor twice ordered her to be taken to the hospital. The nursing home did not allow the transfer, which led to the resident's death.</p> <p>This complaint is typical of many we have received from desperate families who are trying to protect loved ones who are critically ill by arranging hospital care over the objections, and sometimes active interference, of misguided nursing homes. It is very likely that the proposed measure will make it even more difficult for residents of some nursing homes to be hospitalized when they really need it.</p> <p>It is commendable that CMS is seeking a measure to deter neglect and improve care coordination when a person is admitted to a nursing home by looking at unplanned re-hospitalization as a sign of poor care. However, the proposed measure takes a very one-sided look at quality care by only considering hospital readmission</p>				<p>the suggestions provided, such as revised survey guidelines, are beyond the scope of the measure itself, however, CMS will take these recommendations under consideration for future measure refinement and development. Other suggestions, such as providing greater detail to the measure response section regarding disincentives to hospitalize residents, will be addressed. CMS recognizes that in some cases, hospital readmission will occur hospital readmission is not expected as a "never event" that hospitals are expected to reduce to zero. The measure of hospital readmission is risk-adjusted to account for the factors that increase this risk, so that hospitals seeing a disproportionately larger share of these patients do not perform worse on the quality measure due to factors out of their control. As with all quality measures that are implemented, CMS will examine SNF data to monitor for potential unintended consequences.</p> <p><i>Response to: Suggestions for Future Measures</i></p>

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		<p>rather than other factors that are equally critical.</p> <p>We recommend that a companion measure be developed concerning residents who suffer serious decline or unexpected death, but were not re-hospitalized during the 30-day period following admission. Such a measure would share the same goal as the measure currently under consideration: to improve care coordination and improve assessment of quality of care for newly admitted residents. The measure would need to identify residents who died unexpectedly during the 30-day period following admission or who suffered an adverse significant change in condition during this period.</p> <p>Adopting such a measure would send a strong message to nursing home operators that it is the resident’s well-being that matters most, not merely whether or not she was readmitted to the hospital.</p> <p>Absent such a measure, it is simply a matter of time before a resident will die when a nursing home decides to delay her hospital re-admission beyond the 30-day period examined in the proposed measure.</p> <p>Thank you for considering our comments.</p>				<p>CMS appreciates all of these suggestions. As for a measure of unexpected death and severe decline without hospitalization, patient safety is CMS’ top priority, and CMS plans on monitoring data very closely to ensure that adverse events are minimized. CMS has included as part of its provider education strategy the notion that hospital readmissions are not a “never event,” but rather that hospitalization should not be the first response to changes in SNF patient condition. CMS seeks to reduce hospitalization rates as a way to encourage post-acute providers to improve the quality of care provided within their institution, not as a way to reduce access to care</p> <p><i>Response to: Numerator definition should include observation stays-</i> CMS agrees that the increased use of hospital observation stays as outpatient care is an important issue which may have significant adverse impact on some Medicare beneficiaries in terms of both care access and out-of-pocketing spending. CMS acknowledges the</p>

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						<p>TEP support of including observation stays in the measure, however, both the absolute number and percentage share of observation stays involving Medicare beneficiaries in the SNF setting are small relative to other settings (the vast majority are to and from the community) and relative to the total number of SNF stays. Details from the analyses substantiating these statements, conducted by Feng, Wright and Mor in 2012 are included in the Measure Justification Form. The SNFRM is harmonized with the current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)). However, CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.</p>
5	7/25/2013	<p>All-Cause 30-day Hospitalizations from Nursing Facilities – Quality Measure</p> <p>The proposed measure is well developed with a strong research base. The numerator and denominator definitions, including</p>	<p>Greg Arling, PhD Associate Professor of Medicine & Scientist, Indiana</p>	<p>GARling@IUPUI.edu</p>	<p>Researcher (university)</p>	<p><i>Response to: Controlling for prior hospitalizations to the same hospital from the same SNF erroneously controls for poor quality being provided by SNF</i></p>

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		<p>exclusions, are described clearly. The risk adjustment and estimation methods are appropriate for this application. The measure harmonizes well with the NQF Hospital-wide Readmission measure.</p> <p>Nonetheless, I have a few concerns with the measure.</p> <p>1. It does not appear that a patient’s history of hospitalizations from the same facility is being tracked or factored into the risk adjustment model. If prior hospital admissions serves as a risk adjuster without regard to the origin of those admissions (i.e., from the same NH versus another facility, home, etc.), the risk adjustment model may have the unintended consequence of adjusting away the effects of poor quality care. For example, a facility’s residents may be repeatedly readmitted to the hospital for conditions resulting from poor care, e.g., pressure sores or fall-related injuries. History of hospitalizations and conditions acquired in the facility, if not removed from the risk adjustment model, would lead to a downward adjustment of the facility’s hospitalization rate. The simplest way to address this problem would be to exclude from risk adjustment any prior hospitalizations, including associated conditions, if they originated in the same facility.</p> <p>2. The risk adjustment model includes diagnostic conditions such as CHF, pneumonia, UTI and other ambulatory sensitive conditions (ACS) that have been used as indicators of avoidable hospitalization in prior studies (Spector, Limcangco, Williams, Rhodes, & Hurd, 2013). These conditions increase the risk of re-hospitalization. Yet, re-hospitalizations presumably can be avoided in many cases if these conditions are managed properly</p>	<p>University Center for Aging Research Regenstrief Institute</p>			<p>We appreciate Dr. Arlring’s consideration of the appropriateness of controlling for repeat hospitalizations to the same hospital from the same SNF. CMS will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to: Using Ambulatory Care Sensitive Conditions (ACS) in the risk adjustment</i></p> <p>We appreciate the commenters’ consideration of the appropriateness of including ambulatory sensitive conditions as risk adjustment variables in the measure. The SNFRM focus on all-cause readmissions is harmonized with CMS’ current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (i.e., inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)).</p> <p><i>Response to: Ability of hierarchical regression and 95% confidence limits to aid in the interpretation of rates for small facilities</i></p>

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		<p>in the nursing facility. Entering ACS or similar conditions as risk adjusters in an all-cause hospitalization measure raises interesting questions.</p> <p>a. If a facility admits and properly cares for a resident with a condition such as CHF, does that resident still have an increased risk of hospitalization compared to the average NH admission without CHF?</p> <p>i. If so, then that increased risk should be entered into the adjustment model. Technically, one would adjust for the incremental increase in risk for a CHF patient who was properly cared for and not just an average CHF resident.</p> <p>ii. On the other hand, if a resident with CHF who is properly cared for does not present any greater risk of hospitalization compared to an average resident without CHF, then it would be inappropriate to use CHF as a risk adjuster.</p> <p>b. Using ACS or related diagnoses as proxies for avoidable or preventable hospitalizations is a complex issue. I am not sure we have solid research evidence to indicate how much risk of hospitalization remains, if any, when an ACS condition is effectively managed in a nursing facility.</p> <p>c. Risk adjustment of ACS conditions probably needs to be addressed on a condition-by-condition basis because some conditions may be more effectively managed than others.</p> <p>3. Mention is made of constructing confidence intervals around the adjusted facility hospitalization rates. I strongly support the use of confidence intervals in the reporting of facility hospitalization rates. The number of residents in the numerators and denominators of facility rates will vary greatly, with potentially large numbers of admissions in post-acute oriented facilities and potentially very few admissions in small facilities with mainly long-stay residents. The use of hierarchical</p>				<p>CMS appreciates this comment regarding the usefulness of 95% confidence limits for the facility rates for understanding the variability in readmission rates for small facilities.</p> <p><i>Response to: SNFRM focuses only on the Fee for Service (FFS) population yet there is a growing number of beneficiaries with Medicare Advantage (MA) and Medicare Managed Care Plans (MMC)</i></p> <p>CMS acknowledges the importance of the growing population of Medicare beneficiaries enrolled in MA and MMC plans. The current measure, based on FFS claims, is harmonized with the current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)). CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.</p> <p><i>Response to: Claims are limited in</i></p>

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		<p>regression modeling for the risk adjustment will increase the reliability of the estimates. Confidence intervals should further inform interpretation of the rates. The wider the confidence interval, the less reliable the estimate. The upper and lower bounds, when compared to a standard, such as the mean for facilities in the community, state, or nationally, is an indication of where the facility stands from a statistical perspective.</p> <p>4. Basing the quality measure on Medicare claims from the fee-for-service population may exclude sizable proportions of residents in some states or in certain facilities within states that have large managed care populations. For example, some states have high Medicare advantage participation and/or they have many Medicaid dual eligible recipients enrolled in managed care plans. Also, managed care enrollment can vary considerably within a state – with some facilities having a much higher percentage of managed care enrollees than other facilities. It would be very informative to see the distribution of facilities by number of residents in the numerators and denominators. This analysis will give an indication of how many facilities will have too few Medicare FFS admissions from which to obtain reliable hospitalization rate estimates. It would also be helpful to know where they are located.</p> <p>5. The 6-month lag in the MEDPAR data can present a problem. Facility rates will be based on admissions occurring from 6-18 months prior. The lag could be even longer due to processing delays. This lag could make it difficult for facilities to conduct effective quality improvement.</p> <p>6. An alternative source of data for a measure of hospitalizations from the nursing home is the nursing home Minimum Data Set (MDS). The MDS data system captures all hospitalizations from the nursing facility and not just FFS</p>				<p><i>terms of 'real time' event reporting.</i> CMS acknowledges reviewers' concerns. The validity of using the presence of hospital claims to identify readmissions is more well established than the validity of using of patient assessment data. As with other quality reporting measures, the SNFRM will be updated annually using most recent data and will include analyses regarding potential impacts of the lag in claims on facility rankings.</p> <p><i>Response to: Use of alternative data source (MDS 3.0) to specify the SNF hospital readmission measure.</i> CMS acknowledges the reviewer's comments and points out that the foundation and intent of the SNFRM specification was harmonization across provider settings (e.g., hospital, LTCH, IRF). This included measure specification based on Medicare claims data, examining a risk adjustment model which accounted for variation across SNFs in case-mix and patient characteristics (demographic and clinical). CMS will examine possible refinements in the future which potentially include non-claims based</p>

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		<p>admissions; and MDS data are flowing continuously into this system, reducing the lag between data collection and reporting. Also, the MDS system contains many risk adjusters, including cognitive impairment and ADL functioning, which are not found in Medicare claims. Although an MDS-based hospitalization measure would not harmonize as well with other hospital-based measures, it would harmonize with the quality measures in Medicare’s Nursing Home Compare.</p> <p>Spector, W. D., Limcangco, R., Williams, C., Rhodes, W., & Hurd, D. (2013). Potentially Avoidable Hospitalizations for Elderly Long-stay Residents in Nursing Homes. <i>Med Care</i>, 51(8), 673-681. doi: 10.1097/MLR.0b013e3182984bff</p>				<p>patient level clinical elements such as cognition and ADL function.</p>
6	7/25/2013	<p>The Center for Medicare Advocacy (Center) submits the following comment on the Skilled Nursing Facility (SNF) Readmission measure. The Center, established in 1986, is a national nonprofit, nonpartisan organization that provides education, advocacy, and legal assistance to help older people and people with disabilities obtain fair access to Medicare and necessary health care. The Center is headquartered in Connecticut and Washington, DC.</p> <p>Toby S. Edelman, a Senior Policy Attorney with the Center, was a member of the Technical Expert Panel (TEP) that worked on development of the measure. She wrote these comments.</p> <p>The Center has two main points – observation time should be counted as rehospitalization and additional efforts must take to reduce incentives for SNFs not to hospitalize residents who need to be hospitalized. Additional concerns about the proposed measure are addressed below.</p>	<p>Center for Medicare Advocacy, Inc. (sent by Toby S. Edelman Senior Policy Attorney)</p>	<p>tedelman@medicareadvocacy.org</p>	<p>Advocacy Group</p>	<p><i>Response to: Numerator definition should include observation stays - CMS agrees that the increased use of hospital observation stays as outpatient care is an important issue which may have significant adverse impact on some Medicare beneficiaries in terms of both care access and out-of-pocketing spending. CMS acknowledges the TEP support of including observation stays in the measure, however, both the absolute number and percentage share of observation stays involving Medicare beneficiaries in the SNF setting are small relative to other settings (the vast majority are to and</i></p>

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		<p>Observation time must be counted.</p> <p>The proposed measure does not count observation status time as a readmission, although the TEP members strongly supported counting observation time. RTI wrote in an August 23, 2012 paper entitled “Key Issues for TEP Consideration,” “The TEP was definitive that the SNF HRRM should include observation stays. RTI agrees that observation stays should be included in the measure.” RTI does not explain why it rejects the TEP’s position and reverses its own view.</p> <p>Observation status should be counted because the issue, for purposes of readmission, is whether a SNF sent the resident to the hospital for care and treatment. Whether the resident is called an inpatient or an outpatient (in observation status) is not within the control of the SNF; the decision about how to classify a patient who is in the hospital is made solely by the hospital. However, what is within the control of the SNF is the decision to send the resident to the hospital in the first place. If the SNF sends a resident to the hospital, its decision to hospitalize the patient is a readmission decision. Whether the hospital calls the patient an inpatient or an outpatient (observation status) is irrelevant and has no significance for purposes of the readmission quality measure.</p> <p>Over the past few years, hospitals have increasingly categorized patients as outpatients in observation status, largely because of their concern about the Recovery Audit Contractor (RAC) program. Under current procedures, if a RAC reviews a hospital’s decision to classify a patient as an inpatient and decides that the</p>				<p>from the community) and relative to the total number of SNF stays. Details from the analyses substantiating these statements, conducted by Feng, Wright and Mor in 2012 are included in the Measure Justification Form. The SNFRM is harmonized with the current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)). However, CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.</p> <p><i>Response to: The measure will result in reduction in access to necessary hospitalization.</i></p> <p>All comments and feedback are greatly appreciated, as ongoing discussion will ensure thorough evaluation of this measure. Some of the suggestions provided, such as revised survey guidelines, are beyond the scope of the measure itself, however, CMS will take these</p>

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		<p>patient should have been classified as an outpatient, the hospital receives virtually no reimbursement from the Medicare program for whatever medically necessary services it provided. Avoiding RAC review, and the significant financial consequences of a RAC's reversal of an inpatient decision, leads hospitals to call increasing numbers of patients "outpatients" in observation status.</p> <p>Researchers have documented that hospitals' use of outpatient observation status parallels the decline in inpatient stays. Reviewing 100% of Medicare claims data for 2007-2009, researchers found that the number of outpatient observation stays for Medicare beneficiaries increased over the three-year period, while inpatient admissions decreased, suggesting "a substitution of outpatient observation services for inpatient admissions."</p> <p>The Brown University researchers also reported that the average length of stay in observation increased during the 36 months by more than 7%. Significantly, they found that more than 10% of beneficiaries were placed on observation status for more than 48 hours (despite the fact that the Medicare Manual suggests that observation should generally not exceed 24 hours, may sometimes be up to 48 hours, and, in "only rare and exceptional cases," more than 48 hours.) With nearly one million beneficiaries held in observation status each year, the 10% figure meant that approximately 100,000 people were in observation for more than 48 hours. Finally, the researchers identified a sharp increase in beneficiaries held in observation status for 72 or more hours – 23,841 beneficiaries in 2007; 44,843 beneficiaries in 2009 – an 88% increase. The researchers confirmed that their counts of observation stays were conservative and might be too</p>				<p>recommendations under consideration for future measure refinement and development. Other suggestions, such as providing greater detail to the measure response section regarding disincentives to hospitalize residents, will be addressed. Finally, inclusion of managed care residents in the measure is under further review. CMS recognizes that in some cases, hospital readmission will occur hospital readmission is not expected as a "never event" that hospitals are expected to reduce to zero. The measure of hospital readmission is risk-adjusted to account for the factors that increase this risk, so that hospitals seeing a disproportionately larger share of these patients do not perform worse on the quality measure due to factors out of their control. As with all quality measures that are implemented, CMS will examine SNF data to monitor for potential unintended consequences.</p> <p><i>Response to concerns about Exclusion 1: SNF stays where the patient had one or more intervening PAC admissions (IRF or LTCH), which</i></p>

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		<p>low.</p> <p>The Brown University researchers recognized both hospitals' motivation to avoid RAC auditors and the significant harmful impact on Medicare beneficiaries of hospitals' increasing use of observation status:</p> <p>[I]t is reasonable to be concerned that observation services may create barriers for access to postacute skilled nursing facility care, especially for those having been held for observation for an extended period of time. The dual trends of increasing hospital observation services and declining inpatient admissions suggest that hospitals and physicians may be substituting observation services for inpatient admissions – perhaps to avoid unfavorable Medicare audits targeting hospital admissions.</p> <p>The researchers predicted, correctly, that incentives in the Affordable Care Act (ACA) to reduce inpatient hospitalizations "may drive even greater use of observation services" in the future. Hospitals' use of observation status has in fact increased dramatically in recent years. Readmission penalties imposed by the ACA increase hospitals' motivation to use outpatient observation status.</p> <p>In proposed rules published on May 10, 2013, the Centers for Medicare & Medicaid Services (CMS) reported that the percentage of patients in observation for more than 48 hours increased from 3% to 8% between 2006 and 2011. Moreover, not only has the percentage of patients in observation nearly tripled, but the total number of observation stays of any duration also increased by nearly 50% over the same five-year period. In</p>				<p><i>occurred either between the prior proximal hospital discharge and SNF admission or after the SNF discharge, within the 30-day risk window or where the patient had multiple SNF admissions after the prior proximal hospitalization were identified using the MedPAR.</i></p> <p>We appreciate these comments. CMS is moving forward with this measure exclusion based on the TEP recommendation, but will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to concerns about Exclusion 2: SNF stays with a gap of greater than 1 day between discharge from the prior proximal hospitalization and the SNF admission were identified using the MedPAR.</i></p> <p>We appreciate these comments. CMS is moving forward with this measure exclusion, but will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to concerns about</i></p>

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		<p>2006, approximately 920,000 Medicare beneficiary hospitalizations were in observation status. In 2011, approximately 1.4 million Medicare beneficiary hospitalizations were in observation status. Between 2006 and 2011, there was a more than 400% increase in the number of patients in observation status for more than 48 hours (27,600 people in 2006; 112,000 people in 2011).</p> <p>Use of observation status is more pervasive than RTI reports. RTI describes a million observation stays in 2009 (only 1.74% of which were immediately preceded by a SNF stay). But more recent data discussed above show 1.4 million observation stays in 2011 and the numbers of observation stays are increasing rapidly as hospitals respond to negative incentives resulting from RAC review and readmission penalties.</p> <p>Observation status time must be recognized as readmission.</p> <p>The measure must be drafted to reduce incentives for SNFs not to hospitalize residents who need to be hospitalized.</p> <p>The readmission quality measure will encourage SNFs not to hospitalize residents, even those who need hospital care. RTI recognizes this potential “unintended consequence,” but offers a limited response to mitigate the problem – “training, and making it clear that there is no expectation of perfect scores where no patients are ever readmitted.” Measure Development, page 31.</p> <p>This concern is far more serious than RTI acknowledges. The nursing home industry is lobbying Congress not make cuts in Medicare reimbursement by promising to save \$2 billion over 10</p>				<p><i>Exclusion 4: Lack of 12 months of FFS Medicare enrollment prior to the proximal hospital discharge was identified by patient enrollment status in Part A FFS using the Medicare Denominator file. Enrollment must be indicated during the month of prior proximal hospital discharge and the 11 months preceding the prior proximal hospital discharge.</i></p> <p>We appreciate these comments. CMS is moving forward with this measure exclusion, harmonizing with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements. This exclusion was applied to ensure adequate and equivalent diagnosis information to identify comorbidities across all patients included in the measure.</p> <p><i>Response to concerns about Exclusion 5: Lack of FFS Medicare enrollment during the 30 days after</i></p>

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		<p>years by reducing rehospitalizations. Where is the qualification for necessary and appropriate rehospitalizations?</p> <p>SNFs' failure to hospitalize residents, or even to call residents' physicians when residents experience a "significant change" (as required by federal Requirements of Participation), has been the subject of federal deficiencies and enforcement actions against nursing facilities. (The Center has never seen a federal deficiency imposed against a SNF for hospitalizing a resident who did not need hospital care.) Failure to hospitalize residents who need to be hospitalized has been the cause of unnecessary and avoidable resident suffering and death. The Center strongly endorses the statement on the rehospitalization quality measure that California Advocates for Nursing Home Reform (CANHR) has submitted. CANHR describes the frequent complaints it has received over its 30-year history from families whose relatives have suffered and died because their nursing facility refused to arrange for necessary hospitalization.</p> <p>In addition to the recommendations suggested by RTI, the Center has two further recommendations. First, as CANHR proposes, the Centers for Medicare & Medicaid Services (CMS) needs to develop a companion measure on death and decline of residents who were not hospitalized. A well-designed measure would determine whether SNFs improperly avoided hospitalizing residents who should have been hospitalized. Second, CMS must provide specific guidance to surveyors in the State Operations Manual about SNFs' new incentives not to hospitalize residents. CMS must direct surveyors in how to identify the issue of failure to hospitalize a resident who needs hospital care and how to cite and classify the deficiency.</p>				<p><i>discharge from the prior proximal hospitalization was identified by patient enrollment status in Part A FFS using the Medicare Denominator file. Enrollment must be indicated for the month(s) falling within 30 days of discharge from the prior proximal hospitalization.</i></p> <p>We appreciate these comments. CMS is moving forward with this measure exclusion, harmonizing with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements. This exclusion was applied to ensure adequate and equivalent information to identify readmissions across all patients included in the measure. Patients with fewer than 30 days enrollment after discharge could have readmissions occurring within the risk period that would not be identifiable in Medicare claims, introducing error and potential bias into the measure.</p>

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		<p>Other Issues</p> <p>Exclusions should not include residents who had a minor gap between their discharge from the hospital and their admission to the SNF.</p> <p>The proposed measure excludes residents with a more than 24-hour gap. Id.14. The TEP did not support excluding residents with a minor 24-48 hour gap. The RTI exclusion accounts for 147,388 people, 5.4% of rehospitalized patients. Id. 14, Table 3.</p> <p>RTI says that these residents and residents who have an intervening post-acute care stay “are clinically different and their risk for readmission is different than the rest of the SNF admissions.” Id. 15. However, RTI does not distinguish between two categories – residents with gaps and residents with post-acute care stays.</p> <p>Residents who spent time in another post-acute setting, by definition, received some of their post-acute care elsewhere and not just in the SNF that later sent them to a hospital. For residents who received care elsewhere, it could be unreasonable to attribute their rehospitalization automatically and solely to the SNF. Such residents could be quite different from residents who spent 48 hours at home and then went to the SNF.</p> <p>However, RTI simply concludes, perhaps tautologically, that the two types of exclusions (gap and intervening post-acute care) make “the resulting SNF population . . . more homogeneous with respect to readmission risk.” Id. RTI adds, “and more</p>				<p><i>Response to: Facility characteristics should be considered as a risk adjuster</i></p> <p>CMS typically does not adjust for provider characteristics such as suggested by the commenter. Adjusting for these characteristics would suggest that there were acceptable differences in levels of quality of care by provider characteristic.</p> <p><i>Response to: Broadest population at odds with a homogeneous population</i></p> <p>CMS agrees that a measure that covers the broadest population possible is the goal. However, part of the goal also is to create a measure that is robust, relatively easy to compute, and valid. For this reason, RTI sought CMS’ approval to restrict the denominator to those who went directly from their prior proximal hospitalization to the SNF.</p>

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		<p>importantly, the SNFs will only be held responsible for the care they provide.” Id.</p> <p>These arguments are not compelling. A resident with a 48-hour gap also has all of his or her post-acute care provided by the SNF. Medicare pays for post-acute care in a SNF for a resident who goes to the SNF within 30 days of discharge from the hospital. Residents with a short gap should be included in the measure. They are different from residents who received care in multiple post-acute settings and then were hospitalized from the SNF.</p> <p>The readmission quality measure should include as many residents as possible.</p> <p>RTI’s various exclusions result in the exclusion of 21.3% of residents from the denominator. Id. 14, Table 3. While some exclusions seem entirely appropriate – residents who die during the 30-day period with no hospital readmission – other exclusions are not.</p> <p>In addition to the gap of greater than one day, discussed above, the Center is concerned about the exclusions of two categories of residents – residents who were not continuously enrolled in Medicare fee-for-service (FFS) for the full year before prior proximal hospital discharge and residents not enrolled in Medicare FFS for the month of the prior proximal hospitalization and the one month after the hospitalization – 4.5% and 5.5%, respectively. Id. RTI does not explain the reason for these exclusions, only their impact. Id. 16.</p> <p>RTI reports research and other findings that</p>				

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		<ul style="list-style-type: none"> • higher hours of nurse staffing per resident per day are correlated with lower rates of hospital readmissions (MedPAC 2011), id. 3; • “structural factors” affect readmissions, including “nurse staffing ratios; staff turnover rate; staff education; presence of an on-call clinician such as a nurse practitioner, physician assistant, or physician; and clinical sophistication such as provision of intravenous fluids” (Intrator, Zinn & Mor, 2004; Kane, Keckhafer, Robst, 2002; Ouslander, Lamb, Perloe, 2010), id. 5; and • facility characteristics associated with higher readmission rates (for-profit ownership; free-standing facility; large proportion of Medicaid stays (Li, 2011), id. 21. <p>These factors are not related to the exclusions that RTI proposes for the measure. The FFS-related exclusions should not be adopted in the final measure.</p> <p>The denominator should include “the broadest population based on the evidence for which the target process, condition, event, and outcome is applicable.” Id. 3 (2a1.4). The proposed measure is not as broad as it could and should be.</p> <ul style="list-style-type: none"> i Zhanlian Feng, David B. Wright, and Vincent Mor, "Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences," Health Affairs 31, No. 6 (2012). ii CMS, Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf (scroll 				

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		<p>down to §20.6 at p. 18); same language in Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 4, §290.1.</p> <p>iii These provisions include, for example, Hospital Readmissions Reduction Program, §3025, 42 U.S.C. §1395ww(q); National Pilot Program on Payment Bundling, §3023, 42 U.S.C. §1866C; and Independence at Home Demonstration Program, §3024, 42 U.S.C. §1866D, all of which have reducing rehospitalizations as an explicit goal.</p> <p>iv 78 Fed. Reg. 27486, 27644 (May 10, 2013).</p> <p>v Elise Viebeck, "Nursing home industry ready for battle over Medicare funding," The Hill (July 25, 2013), http://thehill.com/blogs/healthwatch/medicare/313363-nursing-home-lobby-ready-for-battle-over-medicare.</p>				
7	7/25/2013	<p>July 25, 2013</p> <p>Marilyn Tavenner Administrator, Center for Medicare and Medicaid Services Department of Health and Human Services 7500 Security Boulevard Baltimore, MD 21244</p> <p>Re: Skilled Nursing Facility Readmission Measure Call for Public Comment</p> <p>Dear Administrator Tavenner:</p> <p>On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to submit comments regarding the development of a readmissions measure for skilled nursing facilities (SNFs). AMRPA is a national trade association representing over 500 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers. Most, if not all, of our members are Medicare participating providers. Inpatient rehabilitation hospitals and units (IRH/Us) serve approximately 400,000</p>	<p>American Medical Rehabilitation Providers Association (AMRPA), (Marsha Lommel, MA, MBS, FACHE Chair, AMRPA Board of Directors President and CEO, Madonna Rehabilitation Hospital)</p>		Trade Group	<p><i>Response to: Multiple years of claims data should be used to define readmissions to capture regulatory changes and atypical years.</i></p> <p>Multiple years of data were used to examine reliability of the SNFRM. MedPAR claims and Medicare Denominator files for 2009, 2010 and 2011. See MJF Reliability & Validity, Section 2a2.1. After exclusions, the final analytic files included the following counts of patients and SNFs:</p> <p>2009: 2,148,638 index SNF stays in 16,712 SNFs</p> <p>2010: 2,159,070 index SNF stays in 16,668 SNFs</p> <p>2011: 2,174,299 index SNF stays in</p>

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		<p>Medicare beneficiaries per year. Medicare Part A payments represent, on average, over 60 percent of IRH/Us revenues. AMRPA members work with patients to maximize health, functional skills, independence, and participation in society so they may return to home, work, and/or an active retirement. To demonstrate AMRPA's commitment to quality improvement and development of proper quality measures, we created a Quality Committee in 2009, which has since worked in pursuit of these goals in the rehabilitation industry. The purpose of the committee is to explore the current status of definitions, development and use of quality measures and indicators, define principles pertaining to quality care in IRH/Us, adopt a framework for analyzing measures, and define such measures. The committee also analyzed the strategic considerations for promoting such measures in various forums, as well as the role of other types of entities such as Patient Safety Organizations (PSOs), and data networks, to name a few. The mission of the committee is to identify structures and processes that lead to achievement of high quality outcomes and demonstrate achievement of those high quality outcomes. Our vision is that outcomes are measured accurately and consistently without excessive burden to the provider or patient. Outcomes must be relevant, meaningful, and understandable for the patient and the provider. Selected outcomes would ideally show that care is delivered in the absence of preventable negative occurrences with meaningful patient progress and in a cost effective, efficient manner.</p> <p>Development of Readmissions Measures is Critically Important and Should be Done Carefully</p>				<p>16,656 SNFs Consistent with the reliability testing done for CMS' Hospital Wide Readmission (HWR) QM, data from 2009 and 2010 were pooled, splitting the file randomly within facility at the patient level into two data sets. The two data sets derived from the two years of pooled data were used for reliability testing and the third year (2011) was used to assess stability over time. The final analytic files included 16,889 SNFs reporting over 2009 and 2010, and had the following counts of patients: Sample 1: 2,153,826 index SNF stays in 16,817 facilities Sample 2: 2,153,882 index SNF stays in 16,889 facilities Patient specific data was included in the model. See MIF Stratification/Risk Adjustment section that defines hospital readmission as a function of patient-level demographic and clinical characteristics and a rand SNF-lever intercept. Provider level information was also accounted for in the model.</p> <p>CMS recognizes the importance of accounting for significant policy</p>

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		<p>One measure area on which the AMRPA Quality Committee has spent considerable time is readmissions. At this time, such a measure has been proposed in the fiscal year (FY) 2014 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) as part of the IRF Quality Reporting Program (QRP). As we stated in our comment letter and interactions with CMS staff responsible for the IRF QRP, a key general concern is that any readmission measure(s) continue to preserve, if not enhance, access to needed medical rehabilitation services and does not unintentionally contain a disincentive to admitting complex patients in need of such services.</p> <p>In this instance with respect to the proposed SNF readmission measure, in the measure justification document in support of the development of this measure, RTI states that the measure has been harmonized to the greatest extent possible with CMS' 30-day All-Cause Hospital-Wide Unplanned Readmission Measure (HWR), developed by Yale University. AMRPA analyzed the proposed measure in great detail and would like to offer the following general considerations and suggestions for the development of a readmissions measure for SNF.</p> <p>I. Current Literature and Effort</p> <p>We are aware that there is a large body of literature looking at the issue of readmissions to acute care hospitals from various settings, including home. The Post Acute Care Payment Reform Demonstration (PAC-PRD) includes references to most of the current articles of interest. In addition, the AHRQ Healthcare Cost and Utilization Project (HCUP) has published two briefs – one on 30 Day Readmissions following Hospitalizations for All Cause Readmission by Payer and Age and one on Chronic vs. Acute Conditions for 2008. The report entitled "Hospital-Wide</p>				<p>changes that may potentially impact hospital readmissions. Toward this end, CMS will continue to monitor the performance of the SNF hospital readmission measure and examine possible refinements that might improve the model and the measure, including externalities and confounding factors that may disproportionately impact providers.</p> <p><i>Response to: Type of SNF should be considered as a risk adjuster. CMS typically does not adjust for provider characteristics such as suggested by the commenter. Adjusting for these characteristics would suggest that there were acceptable differences in levels of quality of care by provider characteristic.</i></p> <p><i>Response to concerns about Exclusion 8: "Rehabilitation care; fitting of prostheses and for the adjustment of devices" are identified by principal diagnosis codes (ICD-9 codes) included in CCS 254, using MedPAR claims for prior proximal hospitalization.</i></p> <p>We appreciate these comments. A patient would have to have had a</p>

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		<p>All Cause Unplanned Readmission Measure,” as developed by the Yale-New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (Yale), was reviewed by our committee and also forms the basis for some of our comments. In addition, the National Quality Forum (NQF) created a consensus standards endorsement project which recently issued a report titled “Patient Outcomes: All Cause Readmissions Expedited Reviews 2011: A Consensus Report,” which discussed three potential readmissions measures and sought public comment thereon. AMRPA submitted comments on the NQF report.</p> <p>II. Factors to be Addressed</p> <p>As we address both measurement and prevention of readmissions, we believe there are several factors to be considered.</p> <p>A. Data to be Used for the Analysis</p> <p>The number of readmissions, however defined, should be based on data from multiple years in order to provide a sufficiently robust database. We are concerned that analyzing only one year of data, for example, may risk inclusion of an atypical year. For example in the IRH/U space, there have been numerous regulatory changes. Starting in July 2004 the 75% Rule was rewritten, which increased the compliance threshold annually from July 2004 to December 2007. This change, authorized by the Medicare, Medicaid, and SCHIP Extension Act of 2007, was followed by a statutory change mandating the threshold at 60%. In addition, CMS issued another comprehensive regulatory change to the Medicare IRH/U coverage criteria effective January 1, 2010, and to the classification criteria in the FY 2012 IRF-PPS Final Rule. SNFs have gone under some legislative and regulatory</p>				<p>primary diagnosis included within the Agency for Healthcare Research and Quality’s (AHRQ’s) Clinical Classification Software (CCS) 254 code to be excluded for rehabilitation. CCS 254 only includes diagnosis codes related to prostheses fitting, adjustment, physical and occupational therapy. Note that only 1,979 patients were excluded for having CCS 254 as a primary diagnosis. Infections associated with prostheses as a primary diagnosis are not excluded. CMS is moving forward with this measure exclusion, harmonizing with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to: Identifying planned readmissions appropriate for the SNF population</i></p> <p>RTI included additional procedures relevant to the rehabilitation</p>

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		<p>changes as well over the last several years which, if not accounted for, could skew the readmissions data inappropriately. For example, CMS made changes to the use of group and concurrent therapy services as well as modified the Minimum Data Set (MDS), the assessment tool SNFs utilize. There is a bit of a delayed effect with such massive changes. Hence, the data analysis should include multiple years. Second, we recommend that in addition to claims data, patient-specific data also be utilized. Third, we suggest that the data be split by type of provider and that additional provider-specific data be considered, including characteristics such as being hospital-based or a rural provider.</p> <p>B. Inclusion and Exclusion Criteria The measure justification document developed by RTI lists a series of exclusions from the denominator including patients for which the primary diagnosis for the preceding hospital stay was for rehabilitation and the fitting or adjustment of a prosthesis. We believe that such admissions should be included in the denominator.</p> <p>Exclusion 8 – SNF Stays where the patient’s principle diagnosis during their proximal hospitalization was for “rehabilitation care; fitting of prostheses and for the adjustment of devices. Very few patients’ prior proximal hospitalization involved rehabilitation care (n=1,979 [0.07%]), of which 17% were readmitted within 30 days, compared to 21.3% of patients without a principle diagnosis of rehabilitation care. These patients were so few in number that a facility analysis was not informative.</p> <p>C. Definition of Readmissions Yale conducted an analysis to define planned readmissions that</p>				<p>population along with those identified for the HWR based on communication with technical expert panels for the IRF and LTCH readmission measures. These procedures are documented in Appendix Table A3 and include several of the diagnoses suggested. However, CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.</p> <p><i>Response to: The risk adjustment should be stratified.</i> Thank you for your comment. While developing this measure, CMS tested models stratified by major condition groupings, in part to take into account risk factors might have different effects on risk for readmission for patients with different conditions, but also to harmonize with the HWR measure. This topic was discussed with TEPs to ensure that the appropriate strata were considered. However, analyses indicated that using stratification did not improve model fit or calibration. Therefore the current model, without stratification, was moved</p>

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		<p>would be excluded from the measure. It defined them as a readmission in which one of 35 specified procedures occurred and those for maintenance chemotherapy or rehabilitation. Admissions for acute illness or for complications of care are not considered planned. The study then identified readmissions as acute or non-acute by observing the principal discharge condition. Many of the identified diagnoses are seen in rehabilitation; although, some not as frequently, such as treatment for a hysterectomy or lumpectomy. We recommend other conditions should be added to this list, such as planned surgery to close a flap due to a severe pressure ulcer, spinal stenosis implants, PEG or IVC filter placement, endarterectomy, close of a craniotomy site, total joint revision, and others.</p> <p>D. Observation Window The observation window is usually the period of time that will be included in the definition of a readmission. The most commonly discussed window is readmission within 30 days of discharge from the acute care hospital. We have no objection to the observation window as established.</p> <p>E. Stratification of Cases All readmissions should not be viewed as one large group on the assumption that they are homogeneous. Instead, we recommend stratifying readmissions patients by several factors. Doing so would provide a finer description of the types of readmissions cases and their circumstances and may facilitate the identification of any patterns or trends. In addition, different groups have different risk factors associated with their readmissions. It appears RTI sought to</p>				<p>forward, which has the additional advantage of being easier to interpret. CMS will continue to evaluate the data and may revisit this topic in the future.</p> <p><i>Response to: Using social support factors as risk adjustors</i> CMS thanks you for your comment and we appreciate your support of the risk adjustment model. CMS recognizes the role that additional factors may play in a facility's readmission rate, including the patient population and their access to social supports, and that this information is not readily available on claims data. The use of Medicare FFS claims harmonizes with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements.</p>

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		<p>address several issues regarding stratification on its risk adjustment utilizing a surgical/medical split and examining individual and multiple comorbidities.</p> <p>F. Risk Adjustment AMRPA strongly believes that proper risk adjustment is mandatory with respect to these measures. We commented on this point in our December 2, 2010, letter to CMS (attached for reference). Such adjustment is necessary to assure that any quality measure reflects the true picture of the provider reporting data on the measures. In addition, it is particularly critical to rehabilitation patients given their variability and complexity. For example, no two strokes are the same. Multiple factors can be included for risk adjusting and include demographics such as age, gender, and living status; medical status including comorbidity, medical condition or diagnosis; functional ability including self-care, mobility, and cognitive; other severity factors; and case mix adjustment. We note that RTI used several of these factors in its approach to case mix adjustment. AMRPA believes that risk adjusting outcomes is more challenging than risk adjusting other clinical results. At the outset, characterizing rehabilitation interventions is frequently difficult. Furthermore, outcomes are diverse and depend on a myriad of factors, including patients' physical and cognitive abilities, underlying medical diseases, sensory and emotional factors, willingness to participate in care and supportive environments.</p> <p>We appreciate that RTI has recognized the importance that age, post acute length of stay, ICU stay, and prior diagnosis and comorbidities in its model. We note, however, that family and support status play a direct role in whether a patient is</p>				

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		<p>readmitted to the acute hospital after SNF discharge. For example, studies show that a male patient is more likely to be discharged home if he is part of an intact couple. The presence of an involved family, caregiver, or other supports or support system plays a large role in discharge site decisions, almost from the point of the admission. They can also affect a readmission in that if they are present they may help the patient make the necessary follow-up appointment; help the patient physically get to the appointment, and make the next follow-up appointment; follow-up with therapy at home, help manage medications; assure community transportation is available, among other mechanisms of support.</p> <p>Development of a Readmissions Measure for SNFs is Long Overdue</p> <p>SNFs have significantly higher readmission rates when compared to many of their post-acute care colleagues. As noted in the support materials for the development of this measure and many stakeholders, including the Medicare Payment Advisory Commission (MedPAC), readmission rates for SNFs should be addressed. In a report issued by MedPAC in March 2013, the Commission noted the readmission rate for all SNFs was 19.2%. Freestanding SNFs' readmission rate was even higher at 19.8%. In contrast, the readmission rate for IRH/Us is much lower at 12%. In a 2012 report, MedPAC Commissioners recommended reducing payments to SNFs with high-risk adjusted rates of rehospitalizations. In the support materials for the development of this measure, RTI notes that studies have shown that approximately 78% of SNF readmissions to acute care hospitals were deemed potentially avoidable. Given these factors,</p>				

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		<p>we encourage CMS to develop a readmission measure for SNFs as soon as possible to ensure Medicare beneficiaries receive high quality care and avoid unnecessary readmission to the hospital which increases costs and the likelihood of additional medical complications. We applaud SNFs for working to identify readmissions reduction strategies. A readmission measure for SNFs complements this effort.</p> <p>Conclusion In closing, we appreciate CMS' recognition of this critical quality improvement need. We remain committed to working with CMS to ensure the development of a readmission measure balances the need for improved quality of care for Medicare beneficiaries while minimizing provider burden. If you have any questions, please do not hesitate to contact Sarah Warren (swarren@amrpa.org) or Carolyn Zollar (czollar@amrpa.org) at 202-223-1920. Thank you for your consideration of our comments. Sincerely, Marsha Lommel, MA, MBS, FACHE Chair, AMRPA Board of Directors President and CEO, Madonna Rehabilitation Hospital</p>				
8	7/25/2013	<p>Comments on Skilled Nursing Facility Readmission Measure Submitted by the National Consumer Voice for Quality Long-Term Care</p> <p>July 25, 2013 Sent to: RMPublicComments@cms.hhs.gov The National Consumer Voice for Quality Long-Term Care (Consumer Voice) appreciates the opportunity to comment on</p>	<p>National Consumer Voice for Quality Long-Term Care (Consumer Voice) (signed Robyn Grant Director of Public</p>		Advocacy Group	<p><i>Response to: The measure will result in reduction in access to necessary hospitalization.</i></p> <p>All comments and feedback are greatly appreciated, as ongoing discussion will ensure thorough evaluation of this measure. Some of</p>

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		<p>the proposed skilled nursing facility readmission measure. The Consumer Voice is a national non-profit organization that advocates for quality care on behalf of long-term care consumers across all care settings. Our membership consists primarily of consumers of long-term services and supports, their families, long-term care ombudsmen, individual advocates, and citizen advocacy groups. The Consumer Voice has over 38 years' experience advocating for quality care.</p> <p>The Consumer Voice strongly endorses the comments of the Center for Medicare Advocacy and California Advocates for Nursing Home Reform (CANHR). Our specific comments are presented below.</p> <p>The Measure</p> <p>The Consumer Voice supports a measure that creates an incentive to nursing homes to avoid preventable and unnecessary hospitalizations of nursing home residents. As noted in the rationale for the measure, hospital readmissions are "common, expensive, and may cause additional morbidity or mortality." The potential harm to residents of such readmissions cannot be underestimated. As the rationale states: "readmission to the hospital interrupts the SNF patient's therapy and care plan, causes anxiety and discomfort, and exposes the patient to hospital-acquired adverse events such as infection or venous thromboembolism (Covinsky, Palmer, Fortinsky 2003) (Boockvar, Fishman, Kyriacou 2004)." In addition, hospitalizations can also result in reduced functioning on return to the nursing home (Ouslander et al., 2010), with hospital episodes being even more difficult for residents with dementia, who become disoriented in new, confusing settings (Hospitalizations of Nursing Home Residents: Background and Options, US Department of Health and Human Services, June 2011). This measure is an important</p>	Policy & Advocacy)			<p>the suggestions provided, such as revised survey guidelines, are beyond the scope of the measure itself, however, CMS will take these recommendations under consideration for future measure refinement and development. Other suggestions, such as providing greater detail to the measure response section regarding disincentives to hospitalize residents, will be addressed. Finally, inclusion of managed care residents in the measure is under further review. CMS recognizes that in some cases, hospital readmission will occur hospital readmission is not expected as a "never event" that hospitals are expected to reduce to zero. The measure of hospital readmission is risk-adjusted to account for the factors that increase this risk, so that hospitals seeing a disproportionately larger share of these patients do not perform worse on the quality measure due to factors out of their control. As with all quality measures that are implemented, CMS will examine SNF data to monitor for potential unintended consequences.</p>

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		<p>step toward improved quality of care by reducing avoidable hospitalizations that may stem from such reasons as poor care, inadequate staffing, and lack of training. However, we have two major concerns about the proposed measure.</p> <p>1. The measure incentivizes nursing homes to not send residents to the hospital when hospitalization is needed. We frequently hear of instances when family members note that something is seriously wrong with a resident, yet facility staff refuse to send the resident to the hospital, despite the urgent pleas of families. In desperation, family members then call 911 or take the resident to the hospital themselves. These families frequently report that hospital staff tell them that the resident would have died had he or she not come to the hospital. Tragically, we also hear of cases in which residents have died. Failure to hospitalize a resident who needs such care is just as serious an issue as unnecessary hospitalization. While RTI notes that this could be an “unintended consequence,” it does not go far enough in addressing this problem. The Consumer Voice supports the recommendations made by the Center for Medicare Advocacy in its comments: The Centers for Medicare & Medicaid Services (CMS) must provide specific guidance to surveyors about SNFs’ incentives not to hospitalize residents. CMS must direct surveyors in how to identify the issue of failure to hospitalize a resident who needs hospital care and how to cite and classify the deficiency.</p> <p>We also urge CMS to adopt the recommendation of California Advocates for Nursing Home Reform to develop a companion measure to identify residents who suffer serious decline or unexpected death but were not re-hospitalized during the 30-day period following admission. As CANHR notes, “Such a measure</p>				<p><i>Response to: Develop measures capturing rates of residents experiencing a serious decline or unexpected death who were not hospitalized</i></p> <p>CMS appreciates all of these suggestions. Patient safety is CMS’ top priority, and CMS plans on monitoring data very closely to ensure that adverse events are minimized. CMS has included as part of its provider education strategy the notion that hospital readmissions are not a “never event,” but rather that hospitalization should not be the first response to changes in SNF patient condition.</p> <p><i>Response to: Numerator definition should include observation stays</i></p> <p>CMS agrees that the increased use of hospital observation stays as outpatient care is an important issue which may have significant adverse impact on some Medicare beneficiaries in terms of both care access and out-of-pocketing spending. CMS acknowledges the TEP support of including observation stays in the measure, however, both</p>

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		<p>would share the same goal as the measure currently under consideration: to improve care coordination and improve assessment of quality of care for newly admitted residents.”</p> <p>2. The measure excludes observation stays, which are sharply on the rise.</p> <p>When a SNF sends a nursing home resident to the hospital, its intent is to have the resident admitted for care or treatment. As the Center for Medicare Advocacy notes, “Whether the hospital calls the patient an inpatient or an outpatient (observation status) is irrelevant and has no significance.”</p> <p>The Consumer Voice urges CMS to count observation stays as a readmission. This is the recommendation from members of the TEP, and RTI agreed with this recommendation. RTI provides no reason for this change in position.</p> <p>Finally, while outside the scope of this measure, the concerns about rehospitalization raise the issue of staffing. As RTI acknowledges:</p> <ul style="list-style-type: none"> • Higher hours of nurse staffing per resident per day are correlated with lower rates of hospital readmissions (MedPAC 2011). • “Structural factors” affecting readmissions include nurse staffing ratios and staff turnover. <p>The Consumer Voice requests that CMS develop the staffing measure that it is statutorily required to create under the Affordable Care Act. This measure is long overdue and urgently needed. Study after study, including CMS’s own study, has shown the relationship between staffing levels and quality of nursing home care. A staffing measure would create an incentive for nursing homes to provide adequate numbers of nursing staff,</p>				<p>the absolute number and percentage share of observation stays involving Medicare beneficiaries in the SNF setting are small relative to other settings (the vast majority are to and from the community) and relative to the total number of SNF stays. Details from the analyses substantiating these statements, conducted by Feng, Wright and Mor in 2012 are included in the Measure Justification Form. The SNFRM is harmonized with the current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)). However, CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.</p> <p><i>Response to Additional Measures Suggested for Staffing:</i> CMS understands that there are a variety of structural factors, including staffing, that contribute to a facility’s readmission rate and</p>

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		<p>which in turn, would help prevent the poor care that often leads to hospitalizations. Such a measure should also include, or a separate measure should be created, to indicate whether a facility has a registered nurse 24 hours a day, 7 days a week. There is strong evidence that RNs have a positive effect in decreasing unnecessary hospitalizations of nursing home residents (Decker 2008), (O'Malley, Caudry & Brabowski 2011), (Dorr, Horn and Smout 2005), (Horn, Buerhaus, Bergstrom and Smout 2005).</p> <p>Furthermore, once the measure is implemented, more nursing staff, and more skilled, trained nursing staff will most certainly be needed to care for residents who remain in the SNF instead of being transferred to the hospital.</p> <p>Since one of the main purposes of quality measures is to incentivize high quality care, the most important step CMS can take is to develop this staffing measure.</p> <p>Thank you for your consideration of these comments.</p> <p>Sincerely,</p> <p>Robyn Grant Director of Public Policy & Advocacy</p>				<p>overall quality. While there are various staffing measures publically reported on CMS' Nursing Home Compare website CMS will continue to consider designing complementary measures associated with the SNFRM for future measure refinement.</p>
9	7/25/2013	<p>Dear Ms. Tavenner:</p> <p>The Coalition of Geriatric Nursing Organizations (CGNO), appreciates the opportunity to comment on the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM). The CGNO includes eight geriatric nursing organizations whose</p>	<p>Coalition of Geriatric Nursing Organizations (sent by Coalition Coordinator: Sarah Burger, RN,</p>	<p>sgburger@rcn.com</p>	<p>Trade Group</p>	<p><i>Response to: The measure will result in reduction in access to necessary hospitalization.</i></p> <p>All comments and feedback are greatly appreciated, as ongoing discussion will ensure thorough</p>

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		<p>membership has more than 28,000 nurses primarily working in long term care and is coordinated at the Hartford Institute for Geriatric Nursing (HIGN), New York University, College of Nursing by Sarah Burger. The CGNO mission is to leverage our collective strengths to create a health care environment for older adults that is accessible and reflects person centered care, quality outcomes and evidence based practice across all settings. Nursing home quality is a priority concern of our member organizations, including the American Academy of Nursing, Expert Panel on Aging (AAN, EPoA), The American Association of Long Term Care Nursing (AALTCN), The American Association of Nurse Assessment Coordination (AANAC), The Gerontological Advance Practice Nurses Association (GAPNA),The Hartford Institute (HIGN), National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC) and the National Gerontological Nurses Association (NGNA). The diverse memberships include geriatric nurses who are PhD teachers, researchers and clinicians, Masters prepared Advance Practice Nurses, RNs, LPNs, and some nursing assistants. Please contact Sarah Burger with any questions at sgburger@rcn.com.</p> <p>The Measure: The CGNO supports the SNFRM because it will incentivize providers to focus on avoiding unnecessary hospitalization resulting in decreasing transfer trauma to the frail elderly. The resulting reduction in Medicare costs is critical to protection of the public trust. When this measure is finalized and in use, the CGNO would caution CMS to assure that those who need hospitalization are not denied it.</p> <p>As patients continue to be cared for in the SNF rather than being transferred to the hospital, increasing acuity will result and SNF's</p>	MPH, FAAN)			<p>evaluation of this measure. Some of the suggestions provided, such as revised survey guidelines, are beyond the scope of the measure itself, however, CMS will take these recommendations under consideration for future measure refinement and development. Other suggestions, such as providing greater detail to the measure response section regarding disincentives to hospitalize residents, will be addressed. Finally, inclusion of managed care residents in the measure is under further review. CMS recognizes that in some cases, hospital readmission will occur hospital readmission is not expected as a “never event” that hospitals are expected to reduce to zero. The measure of hospital readmission is risk-adjusted to account for the factors that increase this risk, so that hospitals seeing a disproportionately larger share of these patients do not perform worse on the quality measure due to factors out of their control. As with all quality measures that are implemented, CMS will examine SNF data to monitor for potential unintended consequences.</p>

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		<p>will be required to have more skilled, trained staff to meet the care needs of these patients. A critical component of the supporting research identified in this proposal is the correlation between lower licensed nurse staffing and the negative effect of avoiding re-hospitalizations. While this measure does not include staffing information, it will provide insight toward continued research in determining appropriate staffing and the importance of licensed nursing in quality care. The CGNO includes some staffing recommendations at the end of these comments that speak to current staffing and use of Advance Practice Nurses.</p> <p>Consideration by providers for their legal liability in not providing aggressive treatment is likely contributing to pressure for treatment in hospital settings rather than in SNF's. As this measure puts the opposite pressure on SNF's to treat in the facility, adjustments will be made in care delivery systems. A positive result will be more integration of primary providers (MD, NPs) with facility staff for cohesive care.</p> <p>Denominator:</p> <p>Exclusion 1: The CGNO supports the measure's exclusion of residents with one or more intervening post-acute care admissions because they are clinically different and assigning responsibility for a readmission to a particular provider is difficult.</p> <p>Exclusion 6: The CGNO supports the measure's exclusion of those residents whose prior proximal hospitalization was for the medical treatment of cancer. Consideration could also be made for other terminal conditions being excluded or at least included as a Risk Adjustment (such as MDS coding items for Hospice,</p>				<p><i>Response to concerns about Exclusion 7: Discharges from the SNF against medical advice were identified using the discharge disposition indicator on the corresponding SNF claim from the MedPAR.</i></p> <p>We appreciate these comments. CMS will monitor the performance of this measure.</p> <p><i>Response to: Numerator definition should include observation stays</i></p> <p>CMS agrees that the increased use of hospital observation stays as outpatient care is an important issue which may have significant adverse impact on some Medicare beneficiaries in terms of both care access and out-of-pocketing spending. CMS acknowledges the TEP support of including observation stays in the measure, however, both the absolute number and percentage share of observation stays involving Medicare beneficiaries in the SNF setting are small relative to other settings (the vast majority are to and from the community) and relative to the total number of SNF stays.</p>

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		<p>O0100K and Prognosis, life expectancy of less than 6 months, J1400)</p> <p>Exclusion 7: The CGNO supports the measure excluding those that discharge the SNF against medical advice (AMA). However, since the MDS does not indicate discharge against medical advice and this exclusion is based on the claim, there could be a high error rate for this exclusion. Although from your data research, AMA status is not statistically significant, medical professionals might not contribute to the claim data designation of the AMA status and therefore it could be miscoded (or under coded) on the claim by non-clinical staff. Is this exclusion assuming that the resident chooses to readmit to the hospital against medical advice? A potential resolution could be the addition of this item to the MDS.</p> <p>Numerator: The CGNO support the numerator as defined to be “an all-cause,” unplanned readmission to an acute care or critical access hospital within 30 days of discharge from an eligible prior proximal hospitalization. In addition, the patient will be required to have been admitted to a SNF within 1 day after discharge from an eligible hospitalization; however, the numerator exclusion of hospital observation status is of concern. In the changing health environment, provider organizations appear to be looking at their own financial security rather than each patient’s well-being as their primary responsibility; therefore, the CGNO recommends evaluation of patient well-being, and the growth and financial consequences of “observation status,” on a quarterly basis. Remove the exclusion if warranted by poor patient or financial outcomes.</p>				<p>Details from the analyses substantiating these statements, conducted by Feng, Wright and Mor in 2012 are included in the Measure Justification Form. The SNFRM is harmonized with the current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)). However, CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.</p> <p><i>Response to: Measure or surveyor guidance to encourage timely clinical assessment by a primary care provider of the need for a resident to be sent to an ER/acute hospital and staffing recommendations</i> CMS understands that there are a variety of structural factors, including staffing, that contribute to a facility’s readmission rate and overall quality. While there are various staffing measures publically reported on CMS’ Nursing Home</p>

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		<p>Risk Adjustment: the CGNO supports the SNFRM risk adjustments that include the following items because they represent variability to the outcome.</p> <ul style="list-style-type: none"> • Age • Sex • Length of stay during prior proximal hospitalization • Any time spent in the intensive care unit (ICU) during the prior proximal hospitalization • Disabled as a reason for Medicare coverage • End-stage renal disease (ESRD) • Number of acute care hospitalizations in the 365 days prior to the prior proximal hospitalization • Principal diagnosis as categorized using AHRQ’s single-level CCS • System-specific surgical indicators <p>Individual comorbidities as grouped by CMS’ hierarchical condition categories (HCCs) or other comorbidity indices</p> <ul style="list-style-type: none"> • Multiple comorbidities, modeled using the sum of HCCs if sum is >2 and the square of this sum <p>Staffing Recommendations: CMS’ evidence in the structure, process and outcome section of the measure citation document indicates that certain facility characteristics such as for profit status, chain status (Harrington 2012) and geography increase the risk of rehospitalizations. A second issue and related to the facility characteristics is the numbers of RNs, LPNs and CNAs to provide care (MedPac 2011). The CGNO agrees with that determination and recommends a complementary measure or, at a minimum, posting information on the Nursing Home Compare Website about the availability of a provider to assess residents whose condition changes.</p>				<p>Compare website CMS will continue to consider designing complementary measures associated with the SNFRM for future measure refinement.</p>

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		<ul style="list-style-type: none"> The CGNO recommends that CMS develop a measure, requirement or at the least surveyor guidance for timely assessment by a primary care provider prior to the resident being sent to an ER/acute hospital. Determine if the resident was physically assessed by a primary care provider (APRN included) within 24 hours of re-admission. <p>Rationale: CMS provides evidence in the “measure development citation paper” for this recommendation (Intrator, Zinn & Mor, 2004; Kane,Keckhager,Robst, 2002; and ouslander, Lamb, Perloe et al 2010)</p> <ul style="list-style-type: none"> The CGNO recommends 24 hour on site RN staffing, rather than using LPNs/LVNs on the evening and night shifts as the Nursing Home Reform Law allows. They are excellent unit mangers but lack more advanced knowledge and skills. RNs are the only professional in the facility whose license and knowledge permit the in-depth assessment required to recognize a change in condition early and develop and implement a plan of care that may avoid an unplanned hospitalization. Such staff stability is imperative for inner city nursing homes where rehospitization rates for African Americans are higher, which would begin to address an important disparity in care. <p>Rationale: Of particular relevance to today’s health care improvement initiatives is the positive effect of RNs in decreasing unnecessary hospitalizations of nursing home residents. (Decker 2008), (O’Malley, Caudry & Brabowski 2011), (Dorr, Horn and Smout 2005), (Horn, Buerhaus, Bergstrom and Smout 2005) Most importantly, Dorr et al showed that the savings in hospitalizations</p>				

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		<p>paid for the increased RN time. References:</p> <p>Decker, F.H. 2008. "The Relationship of Nursing Staff to the Hospitalization of Nursing Home Residents," Research, Nursing and Health. 31 (3):238-51.</p> <p>Dorr, D.A., S.D. Horn, and R.J. Smout. 2005. Cost Analysis of Nursing Home Registered Nurse Staffing Times. J. American Geriatric Society. 53 (5):840-5.</p> <p>Harrington, C., Olney, B., Corillo, H., Kang, T..(2012) Nurse staffing and deficiencies in the largest for profit nursing home chains and chains owned by private equity companies. Health Sciences Research. 47 (2): 106-128.</p> <p>Horn, S.D., P. Buerhaus, N. Bergstrom, and R.J. Smout. 2005. "RN Staffing Time and Outcomes of Long-stay Nursing Home Residents: Pressure Ulcers and Other Adverse Outcomes Are Less Likely as RNs Spend More Time on Direct Patient Care". American J. of Nursing. 105 (11):58-70.</p> <p>Intrator O., Zinn,J., Mor.,V. (2004)Nursing home characteristics and potentially preventable hospitalizations of long-stay residents. Journal of the American Geriatrics Society. 52(10): 1730-1736.</p> <p>Kane,R., Keckhafer, G., Robst, J. Evaluation of the Evercare</p>				

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		<p>demonstration Project: Final Report: May, 2002 (as prepared for the Centers for Medicare and Medicaid. Baltimore, MD.</p> <p>Medicare Payment Advisory Commission, (2011) Trends in risk adjusted skilled nursing facility rates of community discharge and potentially avoidable rehospitalization 2000-2008. Washington, DC. MedPac.</p> <p>O'Malley, A.J., D.J. Caudry, and D.C. Grabowski. 2011. "Predictors of Nursing Home Residents' Time to Hospitalization". Health Services Research. 46 (1):82-104.</p> <p>Ouslander, JG., Lamb, G., Perloe M., et al. (2010) Potentially avoidable hospitalizations of nursing home residents: frequency, causes, and costs. Journal of the American Geriatrics Society. 58(4) 627-635 and 760-761.</p>				
10	7/25/2013	<p>Public Comment from Patricia Stimac, MS,RD,LDN,NHA contact information below.</p> <p>After reviewing Skilled Nursing Facility 30-Day All Cause Readmission Measure (SNFRM) 3a Measure Information Form I have the following comments related to inclusion / exclusion criteria:</p> <p>I recommend SNFs should be accountable for readmission to the IPPS acute care hospital that occur during the SNF stay within the 30 day window. I recommend considering excluding the readmission that occurs after the patient is discharged to the</p>	<p>Patricia M. Stimac, MS, RD, LDN, NHA Spartanburg Hospital for Restorative Care Nursing Home Administrator Director of Nutrition Therapy and Quality Management</p>	<p>pstimac@srhs.com</p>	<p>Individual, Nursing Home Administrator or</p>	<p><i>Response to: Inclusion of patients discharged to the community during the 30-day risk period</i> Thank you for your comment. This measure holds SNFs accountable for the quality of discharges to the community occurring within the 30-day risk period. Readmissions occurring among discharged patients may indicate that the decision to discharge was premature, or preparation for discharge including</p>

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		<p>home setting which is outside the scope of care of the SNF. The patient population I have experience with is admitted to the SNF for skilled rehabilitation following an acute care stay for s/p hip or knee surgery and do not require a 30 day skilled level stay at the SNF. If this patient was not excluded from the criteria it appears the SNF rate would include patients that had been discharged from their care within the 30 day window.</p> <p>In addition I encourage you to include a comprehensive list of what would be considered as a planned re-admission. For example including: removal of internal fixation device. Sincerely,</p> <p>Patricia M. Stimac, MS, RD, LDN, NHA Spartanburg Hospital for Restorative Care Nursing Home Administrator Director of Nutrition Therapy and Quality Management 389 Serpentine Drive Spartanburg, SC 29303 Office 864-560-3232 Cell 864-680-9283 Fax 864-560-7565 pstimac@srhs.com</p>				<p>patient and family education was inadequate. CMS will continue to monitor the measure performance and consider future refinements</p> <p><i>Response to: Identifying planned readmissions appropriate for the SNF population</i> CMS included additional procedures relevant to the rehabilitation population along with those identified for the HWR based on communication with technical expert panels for the IRF and LTCH readmission measures. These procedures are documented in Appendix Table A3. However, CMS will continue to monitor the performance of this measure and will examine possible refinements in the future.</p>
11	7/25/2013	<p>The proposed measure, SNF 30-day All Cause Readmission Measure (SNFRM) holds a SNF responsible for any hospitalization that occurs within 30 days of the beneficiary's discharge from an acute hospital. It excludes cases that were admitted to the SNF following an intervening PAC service, so only direct discharges to the SNF are included in this measure. Second, if a SNF admission is one of several SNF admissions within the 30 day post-hospital discharge, those cases are also excluded. Several other exclusions also apply, including those who die, new enrollees, cancer</p>	<p>Barbara Gage, PhD, Brookings Institution</p>		<p>Individual Researcher</p>	<p>We appreciate your comments regarding the SNFRM.</p> <p>CMS appreciates all of these suggestions. CMS may consider the development of a 30-days post SNF discharge measure to address the issues of transition from the SNF and</p>

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		<p>patients, those who leave AMA, and those whose prior hospitalization was for prostheses fitting and device adjustment. The logic for these exclusions is that these cases are different than the average SNF case or they are more complex than the typical case. By omitting the most medically complex from this group, access is protected for cases that truly do belong back in the hospital for more intensive treatment than a SNF can provide. The one case that may be an exception to that would be the prostheses fitting. The exclusion seems reasonable if the reason for the return reason is to further adjust the prostheses. However, if the return is due to infections that could have been avoided with appropriate medical care, CMS may not want to exclude these cases. However, this would be based on reason for hospital return, not reason for prior admission.</p> <p>This measure does provide an incentive for the SNF to share responsibility with the hospital for the 30 day post-hospital window. This approach encourages better care coordination and overall quality of care for the beneficiary during this part of their episode.</p> <p>However, this measure falls short of holding the SNFs responsible for other hospitalizations the SNF could have prevented. The 30 day post-hospital window ignores the 30 day post-discharge window applied to most providers for readmission responsibility. Theoretically, good transition practices can reduce the likelihood of readmissions in the 30 days following discharge from a setting. This measure as currently proposed, applies mostly to the days in which the beneficiary is in the SNF, and covers very few of the days post-SNF discharge. If the goal is to hold the SNF responsible for the quality of the care they provide, CMS may want to</p>				<p>promote further care coordination across providers.</p> <p><i>Response to concerns about Exclusion 8: "Rehabilitation care; fitting of prostheses and for the adjustment of devices" are identified by principal diagnosis codes (ICD-9 codes) included in CCS 254, using MedPAR claims for prior proximal hospitalization. We appreciate these comments. A patient would have to have had a primary diagnosis included within the Agency for Healthcare Research and Quality's (AHRQ's) Clinical Classification Software (CCS) 254 code to be excluded for rehabilitation. CCS 254 only includes diagnosis codes related to prostheses fitting, adjustment, physical and occupational therapy. Note that only 1,979 patients were excluded for having CCS 254 as a primary diagnosis. Infections associated with prostheses as a primary diagnosis are not excluded. CMS is moving forward with this measure exclusion, harmonizing with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease</i></p>

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		consider a 30 day post-SNF discharge rehospitalization measure also.				(ESRD), home health agency (HHA) and long-term care hospital readmissions measures. CMS will continue to monitor the measure performance and consider future refinements.
12	7/26/2013	<p>Comments Regarding Proposed Rehospitalization Measure Steven Levenson, MD, CMD Long-term and postacute medical director and consultant to CMS Nursing Homes Division</p> <p>I appreciate the amount of work that went into the development of this measure and the effort to provide substantial detail in this document.</p> <p>It took a while to read through this document and its heavy emphasis on research studies and statistical correlations. The following pages of comments cover a number of things about clinical reality that should have received greater emphasis, but would not likely be found in research articles and administrative data sets.</p> <p>Having a quality measure related to rehospitalization is desirable. However, it should be understood clearly what it means and how it can be used to judge performance and improve care. In that regard, this document only hits the fringe of the target.</p> <p>The introduction notes that in 2008 the readmission rate for five potentially preventable conditions was 18%. It notes further that those five conditions are responsible for approximately 3/4 of all readmissions under Medicare.</p>	Steve Levenson, MD, CMD			<p><i>Response to: Future Measure Development (clinical reality versus statistical findings)</i></p> <p>CMS appreciates the reviewer's thorough review and in-depth comments regarding the SNFRM. In the future, CMS may consider the development of a 30-days post SNF discharge measure to address the issues of transition from the SNF and promote further care coordination across providers. Patient safety is CMS' top priority, and CMS plans on monitoring data very closely to ensure that adverse events are minimized. CMS has included as part of its provider education strategy the notion that hospital readmissions are not a "never event," but rather that hospitalization should not be the first response to changes in SNF patient condition. CMS seeks to reduce hospitalization rates as a way to encourage post-acute providers to improve the quality of care provided</p>

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		<p>It should be noted that several authors published studies almost 20 years ago that identified the many comorbidities that can occur in postacute patients, including those allegedly who are allegedly sent to postacute care “for rehabilitation.” It is puzzling as to why little or none of this is mentioned in this document, when it has been around for almost 2 decades and should be readily available in a Medline search.</p> <p>For example, Bernardini and others noted (see attached) that approximately 3 dozen complications commonly develop in postacute patients. These are both universal and enduring. The same complications arise in postacute patients in 2013 as were noted several decades ago. But if these are not anticipated, recognized, or handled properly they may result in hospitalization. Therefore it is puzzling as to why five conditions are singled out, or why Medicare has focused only on those five diagnoses, or why Medicare chooses to focus on primary diagnoses instead of on a broader and more clinically relevant approach.</p> <p>Please see attached for a copy of these articles.</p> <p>In each case, the primary diagnosis for admission to the hospital may or may not still be the primary issue when a patient gets to a postacute care provider. The reason for complications or rehospitalization may or may not have anything whatsoever to do with the primary diagnosis.</p> <p>Please see the attached table that identifies some key categories of reasons for potentially preventable rehospitalization along with</p>				<p>within their institution, not as a way to reduce access to care or compromise quality clinical care. Finally, CMS will continue to monitor the SNFRM performance including opportunities to improve model specification, analyzing differences among facility performance, investigating complementary measures which potentially improve interpretation of SNFRM values and considering future measure refinements that may address multiple data sources (e.g., administrative claims, assessment data).</p> <p><i>Response to: Concerns regarding use of comorbidities, system-specific surgical indicators and secondary medial diagnoses for risk adjustment.</i></p> <p>The proposed readmission measure is a risk-standardized readmission measure that adjusts for case-mix differences based on the clinical status of the patient at the time of admission to the SNF. That is, the measure is risk-adjusted for certain key variables that are clinically relevant or have been found to have strong relationships with the</p>

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		<p>effective strategies. This information is based on 16 years of intense data-driven focus on the area of unplanned transfers and 30 day rehospitalization in a large postacute provider with numerous facilities in many states.</p> <p>Facilities differ widely in the quality and quantity of the discharge summary that comes with the patient upon hospital discharge. They also differ widely in the capacity and consistency of staff reading the discharge summary, communicating with the attending physician in the postacute facility, identifying all pertinent issues and risk factors, and going beyond the often limited or organ system or diagnosis specific information that they receive from the hospital at the time of transfer.</p> <p>I am concerned about the discussion on page 3 related to racial disparities. This discussion appears to try to relate readmissions to the suspicion of racial disparities. However, experience shows that various ethnic groups may be more willing or demanding of being sent to the hospital than others. In fact, our own experience shows that we have facilities where lower-class and lesser educated individuals believe that they are better off in the hospital and or that they are entitled to be sent to the hospital when they get ill. Therefore hospitalization may actually be related to personal preference or demand that is more prevalent among certain socioeconomic classes, and not necessarily to racial disparities of care. However since that hypothesis does not appear to have been considered in these studies, it is not surprising (but it is unfortunate) that these kinds of conclusions are being put forward without looking at other possible explanations.</p>				<p>outcome, including age group, sex, comorbid diseases, history of repeat admissions. The model does not control for system-specific surgeries in isolation, but additionally controls for primary medical conditions and comorbidities for individuals with these surgical procedures in their prior proximal hospitalization. CMS acknowledges that quantifying individual risk for readmission is complicated and dependent on interactions of many factors measureable and unmeasurable. CMS will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to: Include Dialysis Status as Risk Adjuster.</i></p> <p>The proposed readmission measure is a risk-standardized readmission measure that adjusts for case-mix differences based on the clinical status of the patient at the time of admission to the SNF. That is, the measure is risk-adjusted for certain key variables that are clinically relevant or have been found to have strong relationships with the outcome, including age group, sex,</p>

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		<p>On page 3, it discusses the AHQR list of ambulatory-sensitive diagnoses, indicating that rehospitalization can be prevented by appropriate prevention and early intervention for these diagnoses. Again, as noted above, postacute care patients often have many comorbidities that were either not identified, not considered important, or not addressed, or all of the above, during a patient’s hospitalization. Therefore, the AHRQ [AHRQ] premise about ambulatory sensitive diagnoses is somewhat flawed. There are other major reasons for return to hospital that have little or nothing to do with the primary diagnosis or reason for initial hospitalization.</p> <p>Again, on page 4, there are statements about statistical associations between rehospitalization and various facility characteristics (for-profit, hospital-based, and chain) and with staffing. However, these conclusions are questionable, as association is not the same as causation and the studies cited do not appear to consider other issues such as the ability of staff to assess, document, report, and manage symptoms and comorbidities. This is actually discussed later on in this document being reviewed here. In addition, there is no clarification of how staffing allegedly leads to increased hospitalization. Nor is there consideration of issues such as hospitals discharging patients prematurely while still medically unstable, or after putting the patients on dangerous and inappropriate medications that cause or exacerbate symptoms, or failure to explain adequately what happened during hospitalization or what the postacute care facility should be aware of, monitor, or consider in providing the care.</p>				<p>comorbid diseases, history of repeat admissions. CMS will investigate in the future if including additional data elements such as dialysis status would produce substantive improvement of the model.</p> <p><i>Response to: Role of Physicians in Decision to Hospitalize and facility/staff characteristics related to decision to hospitalize</i> CMS acknowledges the reviewers’ important comments and notes significant challenges associated with accurately specifying ‘ decision roles’ in a hospital readmission measure. CMS will continue to refine the model specification to include these and other important influences on hospital readmissions, as data are available during annual measure maintenance.</p> <p><i>Response to: Transitional Care</i> We appreciate these comments. CMS is moving forward with this measure exclusion, based on TEP recommendations to hold SNFs accountable for readmissions occurring within the first 48 hours of a SNF admission. One of the primary</p>

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		<p>In many cases, it is clear upon reading the discharge summary (or what there is of it) that some of the practitioners taking care of these patients during hospitalization had no idea what they were doing with syndromes such as falling and confusion, or with issues such as anemia or dizziness, as demonstrated by their failure to diagnose and manage correctly and their use of medications that are included on various lists of medications not to be used or that have clear and unmistakable major warnings (amiodarone, metoclopramide) or their failure to consider medication-related adverse consequences in the differential diagnosis of the problems that led to hospital admission, thereby failing to fix underlain causes and instead passing on the problem to the postacute care setting. The failures of hospitals throughout the country to do basic things correctly and completely continues to be major issues that deserve prominent mention but do not appear to have been covered at all in this document. I have intimate knowledge of hospitals in several states (Maryland and Idaho) as well as the literature. The issues are universal and continue to be highly problematic and should not be underestimated. It is impossible to gauge nursing home quality without recognizing the scope of problems created by hospitals before and at the time of transfer.</p> <p>On page 5, the list of modifiable factors is incomplete. The same issues of concern (inaccurate diagnosis, incomplete problem management, etc.) certainly are found in nursing homes as well, but it is unbalanced and unfair to not make a prominent mention of the importance of “garbage in / garbage out” when it comes to talking about what happens to patients before admission to nursing homes for postacute care.</p>				<p>purposes of the measure is to encourage improved transitions at discharge and choice of discharge destination.</p> <p><i>Response to: Study/design flaw/body of evidence.</i> CMS acknowledges the reviewers comment and will take the comment into consideration as final documents are compiled.</p> <p><i>Response to: Quality Measure Validity and correlations with other quality measures (e.g., pain, staffing).</i> CMS will consider future refinements to the SNFRM measure with attention to association with complementary quality measures.</p> <p><i>Response to: Exclusions (e.g., intervening post acute stay; cancer treatment; rehabilitation care).</i> We appreciate these comments. CMS is moving forward with this measure exclusion based on the TEP recommendation and to harmonize with the hospital-wide readmission (HWR), inpatient rehabilitation facility (IRF), end-stage renal disease (ESRD), home health agency (HHA) and long-term care hospital</p>

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		<p>Under study design/flaws, the document does not mention one of the major flaws of many of the studies from the literature; specifically, the limited scope of the researchers' initial hypotheses leads them to fail to identify or give credence to major issues that differ from their limited initial hypotheses. Therefore, their conclusions may not identify real issues that they didn't look for in the first place. That should be included in the document as a major limitation of all of these studies.</p> <p>On page 7, in the paragraph starting "the body of evidence," once again the studies may be consistent but that is at least in part because they have consistently narrowed their attention to only a few things. Therefore, their findings are limited to some extent by the limited scope of initial hypotheses across the board.</p> <p>On page 11, under the heading "quality measure validity," item number 2, it states that NQF #0676 and NQF #0678 "also indicate better quality." Then, at the end of the paragraph admits that there is very low correlation among the various quality measures. Given all that and the questionable relevance of all of these measures two key issues related to quality of care, it is hard to understand how it can be stated that those measures indicate "better quality." That is a loose use of the term.</p> <p>On page 12, under the heading "validity of quality measure," it is unclear why there is a statement that correlations for both the outcome measures of self-report pain was "unexpectedly" negative. While the Minimum Data Set places much emphasis on isolated pieces of information such as self-reported pain within a time frame, these items have relatively little meaningful clinical correlation. There are many other important aspects of pain</p>				<p>readmissions measures. CMS will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to: Racial Disparities/SES/education/cultural background</i></p> <p>This measure is not specifically adjusted for factors such as race, SES, or English language proficiency. We believe such additional adjustments are not appropriate because the association between such patient factors and health outcomes can be due, in part, to differences in the quality of health care received by groups of patients with varying race/language/SES. Differences in the quality of health care received by certain vulnerable groups may be obscured if the measures risk-adjust for socio-economic status or ethnicity. In addition, risk-adjusting for patient SES, for instance, may suggest that hospitals with a high proportion of low SES patients are held to different standards of quality than hospitals treating fewer low SES patients. Our analysis indicates that better quality</p>

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		<p>besides just self-report, and therefore there is no reason to be surprised about the lack of correlation.</p> <p>Furthermore, also on page 12, while the five star rating system includes items that are politically popular, there is no actual reason to find any correlation with just about any aspect of practice in nursing homes. It is widely stated that “staffing” correlates with quality, but it is still a nebulous issue after decades of trying to define and clarify the term and its implications.</p> <p>On page 14, it is difficult to understand the rationale for several of the exclusions, including: #1 - in realty, intervening postacute care stays are relevant to quality even if they cannot be attributable to any one facility #5 - proximal hospitalization for the treatment of cancer. The word “cancer” spans a wide spectrum of illnesses and severity of illness. The concept of “medical treatment of cancer” covers a substantial spectrum of possible interventions, ranging from surgery to chemotherapy to simply giving antibiotics for infection. Therefore it is difficult to understand clinically why these patients should be excluded, any more than patients in any other category just based on a specific diagnosis. There are any number of other illnesses and conditions where a patient may be more unstable or the treatment equally problematic compared to patients with cancer. #8- it is challenging to understand why there should be an exclusion for patients admitted for a specific aspect of rehabilitation care. Rehabilitation care is not a clinical diagnosis, and it means many different things depending on the facility. Some facilities give rehabilitation care that includes a broad</p>				<p>of care is achievable regardless of the demographics of the hospital's patients.</p>

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		<p>spectrum of medical, nursing, and other interventions while others focus primarily on providing therapies. It is hard to think of a valid clinical reason for excluding such patients based on what is primarily a marketing label and not a valid clinical entity.</p> <p>On page 19, there is another discussion of so-called secondary medical diagnoses and their us[e] as covariates. While this may seem statistically appropriate, the clinical reality is that many so-called “secondary” diagnoses are actually things that were just not considered to be immediately as important as the primary diagnosis at the time of hospital admission. There is also a huge problem of misdiagnosis and omission of diagnoses in hospitals. For example, if the patient was on the surgical service for hip fracture and had major medical diagnoses such as anemia or hypothyroidism, those issues may be completely overlooked or inadequately or incorrectly diagnosed and managed during their hospital stay. Hospitals also vary widely in the extent to which they do an accurate and complete job of documenting all diagnoses for a given patient and in the quality and content of their discharge summaries and other information sent to postacute care facilities.</p> <p>On page 20, there is a listing for end-stage renal disease and a comment about it increasing the risk for rehospitalization. In reality, patients with end-stage renal disease in postacute care not infrequently have complications related to dialysis (clotted catheters, bleeding, or other similar issues, not necessarily of their underlying kidney disease. This ought to be acknowledged and taken into account with this particular diagnosis.</p> <p>Also on page 20, there is a line item for “principal diagnosis as</p>				

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		<p>categorized using AHRQ’s single-level CCS.” From a statistical perspective, these diagnoses may be predictive. However, from a clinical perspective, it is not at all clear whether the condition or illness itself resulted in rehospitalization or some other factor that happened to arise or flare up in the individual with those diagnoses. For example, so-called “urinary tract infection” is a very common primary diagnosis for admission to the hospital. However, bacteriuria is often mistakenly diagnosed as urinary tract infection, and an alleged diagnosis used in the ER to justify readmission is incorrect (i.e., they call it “UTI” or “urosepsis” when it is neither).</p> <p>Also on page 20, it is misleading to consider “system specific surgical indicators” in the manner that they are discussed in this document. It is common for patients to be admitted to the surgical service for procedures that are not necessarily related to incidental medical comorbidities, and then to be discharged from the hospital after a stay on the surgical service to postacute care where those comorbid conditions flare up because they were simply ignored while in the hospital. For example, many patients need orthopedic surgery because they fell and broke a hip. But while they are on the surgical service in the hospital, no attention is paid to the medications or other medical conditions that caused them to fall. Of course, they were bed bound in the hospital because of the surgery. But once they get to postacute care, their balance or fall problems now become front and center. Again, as with many things in the world of quality measurement, what appears to be right statistically is misleading clinically and does not necessarily reflect what is actually happening with patients.</p> <p>On page 21, in the line item about multiple comorbidities, it is</p>				

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		<p>somewhat misleading to state that patients with multiple comorbidities will tend to have greater frailty. In fact, some patients with multiple comorbidities are stable and some patients with minimal comorbidities are unstable, because frailty depends as much or more on the number of complications or impairments that result from those comorbidities, not just on the number of conditions or illnesses. There are four possible “one to many” or “one to one” relationships between causes and consequences. The most unstable patients tend to be those with multiple comorbidities and multiple complications or consequences. However, patients with multiple complications and minimal comorbidities can also be equally or more unstable. That is, there can be lots of complications from a single diagnosis such as advanced COPD or a severe acute stroke, even though there are not many comorbid diagnoses.</p> <p>Regarding the discussion in the middle of page 21, the same concerns apply. It is true that the literature contains a fair number of studies looking at comorbidities. However, comorbidities alone are not sufficient. As discussed above, comorbidities have to be looked at in conjunction with complications or consequences such as altered gas exchange or altered nutritional status. This is explained in depth in the two studies by Rosenthal et al published in the 1990s, regarding the Nursing Severity Index. The clinical meaning of Rosenthal’s work is discussed at length in my book entitled Subacute and Transitional Care Handbook. Otherwise, Rosenthal’s excellent work has been largely overlooked in the literature.</p> <p>It is unfortunate that this document apparently has not identified those publications and others that indicate that comorbidities</p>				

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		<p>alone are not sufficient in the discussion of complex or chronically ill patients or as risk adjusters. Once again, statistical findings are often not well correlated with clinical reality. As with other quality measures, this one to requires a greater injection of clinical reality to balance out statistical findings based on research studies and administrative data.</p> <p>On page 28, once again the attempted discussions of racial disparities in relation to outcomes are incomplete and misleading. There is too much emphasis on alleged racial disparities and not enough consideration of alternate hypotheses that may reflect the realities of care. As discussed above, it is common for patients and especially families of some socioeconomic and education levels or cultural backgrounds to see hospitalization as a good thing and to request or even demand to be sent to the hospital regardless of the clinical need or in situations where the care could still be rendered in the postacute facility but the patient or family expects or demands hospitalization for relatively minor changes in condition. Again, it is unfortunate that these limited perspectives about reasons for differences in hospitalization among various ethnic and racial groups appears to be dominating the discussion.</p> <p>It should also be noted that a number of re-hospitalizations occur when patients who have been sent for postacute care are sent during their postacute care stay to a clinic or a consultant related to the hospital that sent the patient initially. These clinics and consultants often rehospitalize the patient on the spot-sometimes without even asking or telling the postacute facility-because they decide that they need to resume managing the patient. Often, such patients are stable enough to have remained</p>				

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		<p>in the postacute facility but wind up back in the hospital. This is not an unusual occurrence. This unfortunate reality of clinical practice would not be identifiable by any administrative data set and does not appear to have been identified (or even considered) by any researchers. It is most unfortunate that this document about quality measures for rehospitalization does not consider this issue at all.</p> <p>Almost two decades of experience have shown us (in a company with many postacute care facilities across many states) that a useful quality screen that can provide a foundation for improved performance is simply:</p> <p># of readmissions to a postacute care site in a time frame (Numerator) #of admissions to the postacute care site in the same time frame. (Denominator)</p> <p>However, this too has limitations and must be understood and interpreted properly. It is more of a screen than a measure. Even the best facilities have months in which the percentage of readmissions rises or fluctuates. Facilities also differ substantially in the true complexity of their patients (as defined by both causes and consequences). Once again, clinical reality differs substantially from statistical findings based on limited hypotheses and administrative data sets.</p> <p>I encourage CMS to look at all of these relevant factors before deciding what measure to use and how to interpret it. This document is a start in that direction, but the topic needs substantially more work if it is to lead to meaningful measures</p>				

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		that result in significantly improved practice and sustained improvement in rehospitalization.				
13	7/26/2013	<p>Dear RTI Team:</p> <p>Kindred Healthcare, Inc. (Kindred) appreciates the opportunity for comment on the measure for skilled nursing facilities to improve efforts to reduce hospital re-admissions, and also harmonize with the NQF endorsed Hospital Wide Re-admission Measure (NQF #1789).</p> <p>Kindred is the premier provider of post-acute care and rehabilitation services in the United States. Over the past year it has provided healthcare services to over 543,000 patients and residents at 2,169 locations throughout the country, including 116 transitional care hospitals, six inpatient rehabilitation hospitals, 204 nursing centers, 24 sub-acute units, 101 Kindred at Home hospice, home health and non-medical home care locations, 103 hospital-based inpatient rehabilitation units and a contract rehabilitation services business, RehabCare, which served 1,615 non-affiliated facilities. Ranked as one of Fortune magazine’s Most Admired Healthcare Companies for five years in a row, Kindred’s mission is to promote healing, provide hope, preserve dignity and produce value for each patient, resident, family member, customer, employee and shareholder we serve.</p> <p>We would like to highlight two specific points from our responses. A list of responses is contained in the attachment.</p> <p>We support and recognize the importance of the adoption of a quality measure to improve patient care. The proposed calculation for the re-hospitalization measure uses data entirely</p>	Kindred Healthcare (sent by Mary Van de Kamp, Senior Vice President for Quality Care and Management)	mary.vandekamp@rehabcare.com	Health care facilities	<p><i>Suggestions for Future Measures Response:</i> CMS appreciates all of these suggestions. CMS may consider the development of a 30-days post SNF discharge measure to address the issues of transition from the SNF and promote further care coordination across providers. As for a measure of death and decline, patient safety is CMS’ top priority, and CMS plans on monitoring data very closely to ensure that adverse events are minimized. CMS has included as part of its provider education strategy the notion that hospital readmissions are not a “never event,” but rather that hospitalization should not be the first response to changes in SNF patient condition. CMS seeks to reduce hospitalization rates as a way to encourage post-acute providers to improve the quality of care provided within their institution, not as a way to reduce access to care.</p> <p><i>Response to: Exclude readmissions occurring with the first 24-48 hours</i></p>

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		<p>outside of the SNF; as a result, the facility has no ability to monitor progress/improvement in real time which is the hallmark of quality improvement efforts in the SNF.</p> <p>We believe that the risk adjustments specific to claims data could be more robust with the inclusion of clinical information from the MDS specific to ADL function and dementia which are high predictors of re-hospitalization.</p> <p>Again, thank you for the opportunity to comment.</p> <p>Sincerely,</p> <p>Mary D. Van de Kamp Senior Vice President, Quality and Care Management</p> <p>Kindred responses for consideration by the RTI project team Our comments reflect the following points: I. Measure Definition As opposed to one measure this measure may better reflect quality if broken into two measures: 1. Re-hospitalization within the SNF stay 2. 30 days post-discharge If the intent is to harmonize with the NQF #1789 hospital readmission measurement, measuring 30 days post-SNF discharge would harmonize.</p>				<p><i>of admission to SNF.</i> We appreciate these comments. CMS is moving forward with this measure exclusion based on TEP recommendations to hold SNFs accountable for readmissions occurring within the first 48 hours of a SNF admission. One of the primary purposes of the measure is to encourage improved transitions at discharge and choice of discharge destination.</p> <p><i>Response to: Exclude facilities with few SNF admissions</i> CMS has not excluded facilities with small numbers from the measure, but has made an effort in the past to only report readmission rates for facilities with which we have a certain degree of confidence and to ensure patient confidentiality; we seek to remain consistent on these points.</p> <p><i>Response to: Measure developers carefully consider how methods will affect rates for small facilities</i> CMS has been cognizant of how the SNFRM methodology will affect facility rates for small facilities. Modeling methods include shrinkage</p>

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		<p>II. Exclusions</p> <p>1. We would contend that extremely short stays in SNF should either be excluded, or highlighted, as returns to acute care in under 24 or 48 hours are more likely a reflection of poor transitional care processes, not necessarily an indicator of poor care in the SNF. Transitional care is owned by multiple settings, and extremely short stays may represent a higher-acuity, less stable patient who still requires hospital care.</p> <p>2. Centers/SNFs with very low admission and discharge volume should be excluded. Low volumes of admissions and discharges can skew data disproportionately. We were unclear in the document if these were excluded in the calculations. In our 30-day rehospitalization reports, the raw data of admissions and discharges is given for facilities that admit less than 25 patients, but a rate (%) is not calculated. This agrees with statistical work done by Dr. Andy Kramer on this topic for our organization (personal communication).</p> <p>3. We endorse the exclusion of unplanned discharges. However, without the ability to validate planned or unplanned re-hospitalizations at the SNF level, the accuracy of the component of this measure is unclear and we request further study.</p> <p>II. Coding Considerations</p> <p>1. We are very concerned that this new metric entirely dependent on ICD-9 coding from acute care, to the exclusion of SNF claims reporting and standardized SNF metrics/workflow/process. There is no input from the SNF on the actual conditions/problems/diagnoses that specified admission to the SNF, there is no way to directly link re-admission to those codes. In addition, there is no link to the quality of care measures and processes that have been developed and utilized since OBRA-87, which are standard practice in all SNF's</p>				<p>estimators which shift estimates for small facilities towards the mean, reducing small facility's vulnerability to having their estimates heavily weighted by just a few numerator triggering events. CMS will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to: Use of claims to specify the SNF hospital readmission measure.</i></p> <p>CMS acknowledges the reviewer's comments and points out that the foundation and intent of the SNFRM specification was harmonization across provider settings (e.g., hospital, LTCH, IRF). This included measure specification based on Medicare claims data, examining a risk adjustment model which accounted for variation across SNFs in case-mix and patient characteristics (demographic and clinical). CMS will examine possible refinements in the future which potentially include non-claims based patient level clinical elements such as cognition and ADL function.</p>

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		<p>nationwide. Unlike other accepted measures of SNF quality (Health Inspection, QM's, 5-Star, etc.), there is no process component to the new measure.</p> <p>2. Overall concern is the reliance of ICD-9 coding (administrative claims data only). This is significant as the hospital admission diagnosis is listed to track post-acute placement. Examples of that might be a re-admission for dementia with behavioral disturbance, chronic anemia, new URI. Other causes may be iatrogenic complications of the index hospitalization (like IV antibiotic toxicity, or need for new PICC line), but again those are not captured b/c of the heavy weight and trust placed on the hospital ICD-9 coding process and quality.</p> <p>3. We appreciate the recognition of the importance of the co-morbidities as a risk factor; however, this is not a consideration for new illness that may arise during the SNF stay.</p> <p>III. Data Capture</p> <p>1. We request the physicians' input on the necessity of the hospitalization and this should be measured. The SNF does not transfer a patient to the hospital on its own direction but through the direction of the attending physician. Without access, this quality improvement process would be difficult</p>				<p><i>Response to: The use of hospital-based diagnosis to track post-acute placement (readmissions).</i></p> <p>The SNFRM was analyzed with respect to both data item (variable) and measure level validity. The data elements focused on variables that are likely to be coded most consistently across hospitals and SNFs. The relationship between the SNFRM and current NH quality measures was examined as well. The SNFRM specification is based on studies which have examined the validity of using Medicare hospital claims for multiple NQF-endorsed quality measures used in public reporting and other studies which have validated claims for detection of several conditions and procedures. (see MJF Section 2b2.1 Validity Testing).</p> <p><i>Response to: Concerns regarding use of comorbidities</i></p> <p>The proposed readmission measure is a risk-standardized readmission measure that adjusts for case-mix differences based on the clinical status of the patient at the time of admission to the SNF. That is, the</p>

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						<p>measure is risk-adjusted for certain key variables that are clinically relevant or have been found to have strong relationships with the outcome, including age group, sex, comorbid diseases, history of repeat admissions. CMS acknowledges that quantifying individual risk for readmission is complicated and dependent on interactions of many factors measureable and unmeasurable. CMS will continue to monitor the measure performance and consider future refinements.</p> <p><i>Response to: Role of Physicians in Decision to Hospitalize:</i> CMS acknowledges the reviewers' important comments and notes significant challenges associated with accurately specifying 'decision roles' in a hospital readmission measure. CMS will continue to refine the model specification to include these and other important influences on hospital readmissions, data are available.</p>
14	7/26/2013	RE: CMS's Skilled Nursing Facility Readmission Measure Dear Dr. Smith, AMDA–Dedicated to Long Term Care Medicine (AMDA) appreciates the opportunity to provide comments on the Skilled	American Medical Directors' Association	(sent by Alex Bardakh, MPP Senior Manager, Public Policy	Professional Association	<p><i>Response to discussion of definitions of "avoidable" hospitalizations</i> We appreciate the commenters' insights into the identification and</p>

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		<p>Nursing Facility 30-Day All-Cause Readmission Measure. AMDA is the professional association of over 5,500 nursing home medical directors, attending physicians, and other professionals who take care of millions of disabled and frail elderly residing in the post-acute and long-term care continuum. AMDA works to ensure excellence in patient care and to promote the delivery of quality postacute and long-term care medicine.</p> <p>General Comment AMDA applauds CMS for its leadership in promoting efforts to reduce hospital readmissions, and we support the development of this measure. However, we are concerned about the use of the term “unavoidable” for the conditions listed in this measure. We outline our specific concerns below.</p> <p>Specific Comments AMDA feels that the conditions listed as “avoidable” should be monitored by CMS to ensure that they have discriminatory power. That is, if there is no statistically significant difference among nursing facilities in measures for a listed condition over time, AMDA suggests removing it from the list. Conditions showing the largest differences, and therefore having the most discriminatory power, should be provided to facilities to assist them in their QAPI processes.</p> <p>Further, AMDA feels that the list of excluded “unavoidable” conditions should also be monitored for relative differences related to quality. AMDA would like to comment specifically on the following statements in document 3b, Measure Justification, page 4: The Agency for Healthcare Research and Quality has identified a</p>	<p>(signed by Christopher E. Laxton, CAE Executive Director)</p>	<p>AMDA – Dedicated to Long Term Care Medicine P: 410-992-3132 abardakh@amda.com</p>		<p>classification of conditions as “avoidable.” CMS recognizes that these are important considerations for identifying where interventions can reduce readmissions and other poor outcomes. The current measure is designed to capture unplanned all-cause readmissions. The SNFRM focus on all-cause readmissions is harmonized with CMS’ current Hospital-Wide Readmission measure and other readmission measures being developed for other settings (i.e., inpatient rehabilitation facilities (IRF), long-term care hospitals (LTCH), home health agencies (HHA), and end-stage renal facilities (ESRD)). The issue of all-cause readmissions, as opposed to a more focused set of readmission types, has been raised in other contexts, such as the Hospital IQR measure. Section 2.2.3 of the technical report in the HWR NQF Measure Submission Form for NQF ##1789 explains our decision regarding this issue. The link is on the QualityNet Web site.¹⁷⁰ The same logic applies to the SNF setting. Discussions with technical experts have led to our</p>

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		<p>list of diagnoses considered “Ambulatory Care Sensitive”, indicating that they can be prevented with proper prevention and early intervention. Other similar lists exist, including a compilation done by MedPAC labeled “Potentially Avoidable Hospitalizations”. In the nursing home setting, these lists are interpreted as conditions that could be prevented entirely (such as dehydration) or identified in the early stages and properly treated in the nursing home (such as urinary tract infection). AMDA has concerns over the general use of the term “avoidable” in these cases and, more importantly, how dehydration and urinary tract infections (UTIs) are diagnosed – or rather misdiagnosed – in the acute-care setting. The definition of dehydration has always been contentious. Technically, dehydration is the excessive loss of total body water and must be accompanied by an elevated serum osmolality. Hypovolemia is either equal loss of water and salt, or salt in excess of water and is harder to define, but requires a BUN / Creatinine significantly above patient specific baseline, an elevated urine specific gravity and/or clinical findings such as furrowed tongue, tachycardia / low blood pressure, etc., all of which is unrelated to a medical condition already being addressed (such as severe nausea and vomiting, for which IV access could not be obtained in the nursing facility) (Crecelius, C.A. Dehydration: Myth and Reality, J Am Med Dir Assoc. Jun 2008 9(5):287-8; Thomas DR, Cote TR, Lawhorne L, Levenson SA, Rubenstein LZ, Smith DA, Stefanacci RG, Tangelos EG, Morley JE, Dehydration Council. Understanding clinical dehydration and its treatment. J Am Med Dir Assoc. Jun 2008 9(5):292-301. doi:0.1016/j.jamda.2008.03.006. Review).</p>				<p>preference in the SNF, as for the HWR measure, for using an all-cause measure rather than a measure specific to a narrow set of conditions. The latter is possible when the population being measured is narrowly defined and certain complications are being targeted. For broader measures, covering patients with multiple medical conditions, a narrow set of readmission types is not desirable. In addition, readmissions may be clinically related even if they are not related to the principal diagnosis of the patient. One of the primary purposes of the measure is to encourage improved transitions at discharge and choice of discharge destination. Some readmissions can occur that are less related to the primary condition being treated in the SNF than to the coordination of care post-discharge. For instances where the readmission is likely random, such as a car accident, we expect these events not to be systematically distributed among the SNFs. Therefore, we have chosen to reduce the all-cause readmission set by excluding readmissions that are</p>

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		<p>The frequency of the diagnosis of dehydration depends heavily on the criteria used for the diagnosis. Using only a BUN:Cr ratio greater than 20:1 produces extremely high prevalence rates of dehydration diagnoses. In an emergency department study, 48% of subjects aged over 75 were diagnosed as dehydrated on admission. Less than 3% of these subjects had a serum sodium level greater than 145 mEq/L, a percentage close to that seen in other published reports. (Bennett JA, Thomas V, Riegel B. Unrecognized chronic dehydration in older adults: Examining prevalence rate and risk factors. J Gerontol Nurs 2004; 30(11): 22-28; quiz 52-23.) When unadjusted for other contributing causes, a BUN:Cr ratio should not be used as the sole criterion for diagnosing dehydration, yet this is common in acute-care emergency departments.</p> <p>For urinary tract infections, there are two issues: misdiagnosis and measurement of quality. We strongly feel that, without exception, CMS should use the updated McGeer criteria to define UTIs in the population. A great many of our patients in post-acute/long-term care (PA/LTC) facilities are given a non-clinically-accurate diagnosis of a UTI with asymptomatic bacteriuria confirmed with a bacterial colony count of fewer than 100,000. Studies have consistently shown that some 30% of elderly PA/LTC patients with no symptoms of UTI, and as many as 50% of patients who are highly functionally impaired, have a positive urine culture on routine surveillance sampling. (Drinka, P. Treatment of bacteriuria without urinary signs, symptoms, or systemic infectious illness (S/S/S). J Am Med Dir Assoc 2009; 10: 516-519.) The more debilitated the patient, the more likely it is that asymptomatic bacteriuria will be present. Chronic asymptomatic bacteriuria is frequent in the PA/LTC setting, with a</p>				<p>frequently planned or expected. The Hospital IQR set of planned readmissions has been suggested for SNFs by further recommendations by technical experts in the field of post-acute care.</p>

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		<p>prevalence as high as 50% (Nicolle, LE. Urinary tract infection in long-term-care facility residents. Clin Infect Dis 2000; 31: 757-761).</p> <p>With respect to quality, there are many “unavoidable” reasons a frail elderly patient will develop a UTI. In this population, UTIs are most often secondary to altered immune defenses with aging (reflex past the sphincter, for example). There may also be other pathological causes: Neurogenic bladder with incomplete emptying (DM, Nephropathy, B12 for instance), strictures, BPH, and the like.</p> <p>If you have any questions or would like more information please contact Jackie Vance, AMDA Director for Clinical Affairs at jvance@amda.com or 410-992-3105. AMDA thanks you for your continued leadership in working to reduce hospital readmissions and to improve the quality of care. We look forward to working with you to implement this important measure.</p> <p>Sincerely, Christopher E. Laxton, CAE Executive Director</p>				