Public Comment Summary Report

Project Title:

Development of Potentially Preventable Readmission Measures for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs)

Dates:

- The Call for Public Comment ran from November 2, 2015 to December 1, 2015.
- The Public Comment Summary was made available on April 14, 2016.

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop potentially preventable readmission measures, in alignment with the Improving Post-Acute Care Transformation Act of 2014 (known as the IMPACT Act) and the Protecting Access to Medicare Act of 2014 (known as PAMA). The contract names are Development and Maintenance of Symptom Management Measures (HHSM-500-2013-13015I; Task Order HHSM-500-T0001) and Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance (HHSM-500-2013-13001I; Task Order HHSM-500-T0002). As part of its measure development process, CMS requested the public to submit comments on these measures under development.

The purpose of these projects is to develop, maintain, re-evaluate, and implement outcome and process quality measures that are reflective of quality care for the PAC settings, to support CMS quality missions that include the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP), the Inpatient Rehabilitation Facility (IRF) QRP, the Nursing Home (NH)/Skilled Nursing Facility (SNF) QRP, the Home Health (HH) QRP, and SNF Value-Based Purchasing. The cross-setting readmission measures will be applicable to all post-acute care settings.

Project Objectives:

- To develop an approach for defining potentially preventable readmissions (PPRs) for post- acute care (SNF, IRF, LTCH, HHA).
- To develop potentially preventable readmissions measures for multiple settings (SNF, IRF, LTCH, HHA), including standardized items and specifications such as inclusion/exclusion criteria, and patient and facility characteristics—factors associated with outcome measures (risk adjusters).
- To obtain setting-specific input on PPR quality measures' application and implementation.

Information About the Comments Received:

- Web site used: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html
- Public comments were solicited by the following methods:
  - Posting a Call for Public Comment on the CMS Public Comment website
  - Notifying relevant stakeholders and stakeholder organizations via email
  - Notifying Technical Expert Panel members via email
- Volume of responses received: CMS received 68 comment letters (note: this count does not include duplicate comments, comments that were excluded because of personal health information, and comments that were irrelevant to measure development). These comment letters were submitted by a range of stakeholder types, including post-acute care (PAC) providers and clinicians, provider associations, advocacy groups representing different PAC areas, including some patients/family members, and researchers with technical expertise in quality measurement.

Stakeholder Comments—General and Measure-Specific

1. General Comments

Summary: CMS received several comments in support of the development of these measures and the IMPACT Act domain. One commenter expressed support for the alignment between the PPR and all-cause readmission measures.

We received several general comments about the measures, including concern over provider attribution, given that multiple PAC providers are often involved in an episode of care. Some commenters felt that the PPR measures do not assess quality of PAC, but instead, measure access to care after discharge from PAC. Additionally, other commenters noted that the hospital, along with primary care physicians and the patients themselves, are important in determining the outcomes that result in potentially preventable readmissions.

Some commenters stated that the PPR measures could potentially create unintended consequences. Specifically, commenters cited concerns over limiting access to PAC services; creating perverse incentives; and unfairly impacting the finances of SNF providers (referring to the PAMA measure). Some commenters also noted that the readmission window associated with the SNFPPR (PAMA measure) may encourage providers to delay hospital readmissions to beyond 30 days. Others stated that the exclusion of direct transfers from the post-PAC discharge measures would encourage providers to transfer patients, in an effort to prevent them from being counted in the measures. One commenter suggested that the names of the measures be revised to specify that these measures are exclusively for Medicare fee-for-service (FFS) patients, and cited that changes in payer-mix (i.e., increases in managed Medicare) are relevant for some settings, such as SNFs/nursing facilities.

A number of commenters raised concerns over comparing PPR measure data across PAC settings. Some commenters requested clarification as to whether all types of facilities would be compared by one measure or whether multiple measures were being developed for each PAC type. Other commenters discussed potential advantages and challenges to comparing PPR rates within each setting.

We also received comments about the public comment process. The majority of commenters noted that the initial public comment period of two weeks was insufficient in length (note: CMS subsequently extended this to a 30-day public comment period). Some commenters expressed interest in reviewing the Technical Expert Panel (TEP) Summary Report associated with the measure development, or noted that they would like to see analytic results and then provide additional comments.

Response: CMS appreciates the supportive comments and will continue working to harmonize the PPR measures with other measures being used or developed for PAC, to the extent possible. We also appreciate the comments made regarding general aspects of the PPR measures. We recognize that there are often multiple providers involved in a PAC episode. The PPR measures are being developed to take into account the importance of care coordination. CMS agrees that the possibility of unintended consequences, such as limiting access to PAC, is an important concern in the development of these measures. We intend to conduct ongoing monitoring to assess for potential unintended consequences associated with the PPR measures. Although it may be possible to delay hospital readmissions or to transfer patients in order to exclude them from the post-PAC discharge PPR measures, CMS intends to monitor for such gaming practices.

We would like to note that the PPR measures currently under development serve as a starting point for this work, which is being conducted in phases. Future measures will calculate PPRs using different readmission windows and will enable the measures to assess patients for PPR both during the PAC stay and post-PAC discharge. At this time, we are developing PPR measures for each PAC provider type; to the best of our knowledge, there is not a single PPR measure that applies to all PAC providers. We also appreciate the suggestion to revise the measure names to reflect that these measures are for Medicare FFS patients. CMS intends to evaluate the feasibility of including managed Medicare patients in the future, as data become available for this and other measures.

CMS appreciates the commenters' concerns regarding the length of public comment period. We are cognizant of the challenges that shorter public comment periods create. The initial shorter public comment periods for the IMPACT Act measures were primarily a consequence of the timelines mandated by the relevant statutes. However, moving forward, we intend to evaluate longer public review periods as a general rule, when possible. The TEP report has been made publicly available and measure specifications, including analytic results, will be made available to the public on the CMS website and are forthcoming.[1] CMS would like to thank all commenters for their thoughtful feedback on the development of this measure.

2. PPR Definition

Summary: Several commenters provided feedback on the PPR definitions or lists of conditions for which readmissions would be considered potentially preventable. For example, some commenters felt that the definitions were too broad or were concerned about the breadth of PPR conditions, and recommended that the measure developers further narrow the definitions. One commenter suggested providing a list of potentially preventable conditions for each of the PAC settings rather than a single list, because of the broad case mix differences between settings, while another

[1] Technical Expert Panel Summary Report: Development of Potentially Preventable Readmission Measures for Post-Acute Care. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Potentially-Preventable-Readmissions-TEP-Summary-Report.pdf

commenter supported using a standard definition across the settings. Several commenters also noted their concerns over the limited evidence to support the PPR definitions, particularly evidence specific to PAC. Multiple commenters felt that the ambulatory care sensitive condition approach was not appropriate because they consider PAC patients to be more complex. One commenter suggested that we should have used a more formalized process for developing the selection criteria for potentially preventable readmissions, rather than conferring with a technical expert panel and clinical expert consultants. They suggested using the RAND appropriateness rating system (a modified Delphi approach). Commenters encouraged the measure developers to conduct more analysis in support of the development of the PPR measures and definitions.

In addition to general comments about the PPR definitions, we also received feedback on specific conditions and received suggestions to add or remove conditions. For example, commenters expressed concern over including conditions such as arrhythmia and delirium. Additionally, some commenters suggested that being held accountable for conditions unrelated to the reason for PAC admission is inappropriate.

In addition to the conditions mentioned above, there are several other examples of specific conditions that were cited in the comments. One commenter suggested that we re-categorize the inadequate prophylaxis category, and incorporate it into the inadequate management of unplanned events category. Another commenter suggested separating the electrolyte imbalance and dehydration conditions, and one commenter suggested separating atrial fibrillation and flutter. One commenter noted that the adverse drug events category could be complicated by newly prescribed drugs, which should not be considered part of a PPR if prescribed after PAC discharge.

Some commenters suggested that we incorporate caveats in the PPR definition such as new onset, history of condition, severity, chronicity, progression of condition, or contraindication. One example that was provided was of a pressure ulcer that occurs as a result of medications and that is not related to poor quality of care.

Some commenters expressed concern over possible variation in coding practices of the readmitting hospital. Another commenter suggested phasing-in the PPR conditions over time.

Response: CMS appreciates the detailed comments regarding the PPR definitions. The approach for defining PPRs for the legislatively mandated PAC measures was based on comprehensive reviews of the scientific literature, input from clinical experts, and recommendations from our TEP, including TEP members' in-person feedback and their written ratings of the conditions. CMS intends to conduct ongoing monitoring and evaluation of the approach for defining potentially preventable readmissions. We plan to make necessary changes to the PPR definitions over time, based on our monitoring and as new evidence emerges.

Based on the public comments, we revised our measure specifications to incorporate several of these suggestions. For example, we removed the inadequate prophylaxis category and combined it with the inadequate management of unplanned events category. Given the limitations of how we originally specified the adverse drug events category, as identified in the public comments, we removed this group of conditions from our definitions. With regard to specifying severity or history of conditions, we are somewhat limited in our ability to incorporate this level of detail; however, we believe our risk adjustment approach will take into account several of these factors. The PPR definition will be consistent for measures with the same readmission window, regardless of setting;

case mix differences across PAC settings will be addressed through other aspects of the measures' specifications (i.e. risk adjustment).

We also acknowledge that there may be variation in coding practices among hospitals, but believe that this variation is random and should not systematically impact the PPR rates of specific PAC providers.

3. Risk Adjustment

Summary: Several commenters raised concerns over the risk adjustment approach for the PPR measures. Specifically, commenters were concerned that the approach is insufficient or does not adequately take into account patient frailty or multiple comorbidities. One commenter stated that the risk adjustment for the PAC readmission measures is in a "nascent" and "rudimentary" phase. Commenters also encouraged CMS to take into account SES/SDS factors in the risk adjustment.

Several commenters supported the use of risk adjustment for dual eligibility and other commenters encouraged the measure developers to think more broadly about SES, considering other adjusters such as income, supply variables, housing, food, transportation, and caregiver support/living alone. One commenter argued that race is not a good proxy for SES, pointing to the NQF guidance that discourages the use of race independently, as an SES factor.[2] In particular, the Medicare Payment Advisory Commission's (MedPAC) comment encouraged further analysis to compare risk-standardized readmission rates without SES, using peer group comparisons instead.

We also received comments suggesting that specific risk adjusters be considered, including geographic/regional or facility characteristics (e.g., rurality, provider size), and adjusters for quality of care provided in the prior hospital stay. Some commenters supported risk adjustment for prior utilization; however, MedPAC did not support this, stating that providers are able to influence utilization. Several commenters suggested that CMS risk adjust for cognitive impairments/ behavioral health, whether or not the patient had a follow-up visit with a physician, and for functional status and activities of daily living (ADL) scores, in all settings. However, another commenter stated that it is inappropriate to aggregate IRF case mix groups, because of the differences across case mix groups in some rehabilitation impairment categories.

CMS also received suggestions for risk adjusters that are specific to the LTCH measure. Specifically, one commenter suggested that the measure developers adjust for multiple organ failure and left ventricular assist device (LVAD) utilization. Several commenters supported variation in the risk adjusters by provider type, particularly for LTCHs. One commenter suggested that the primary diagnosis at LTCH admission be used as a risk adjuster, as opposed to the primary diagnosis of the prior short-term acute care stay. In contrast, MedPAC urged CMS and measure developers to keep the measure exclusions and risk adjusters identical across PPR measures in order to allow for cross-setting comparisons. One commenter was concerned that risk adjustment for patient characteristics without adjusting for facility characteristics, would put providers with a disproportionate amount of high-acuity patients at a disadvantage. As an example, this commenter pointed to the fact that many PAC providers do not admit patients that require prolonged mechanical ventilation. The commenter was concerned that providers who do admit these patients would be at a disadvantage

[2] National Quality Forum (2014). Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. Available at: http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx

when their performance is compared to a providers with an average proportion of high-acuity patients.

Response: CMS appreciates the comments received regarding the risk adjustment for the PPR measures being developed. The risk adjustment approach being developed for these measures is comprehensive and captures a variety of patient case mix characteristics, including sociodemographic characteristics (age, sex, original reason for entitlement), principal diagnosis during the prior proximal hospital stay, body system specific surgical indicators, comorbidities, and prior service utilization. This risk adjustment approach was designed to harmonize with approaches developed and refined over several years and used for other claims-based NQF-endorsed hospital readmission measures by CMS in inpatient as well as PAC quality reporting programs. In response to the suggestion to use the primary diagnosis at LTCH admission as a risk adjuster instead of the principal diagnosis of the prior hospital stay, we use the prior hospital claim as the source for risk adjusters, as this provides a uniform source for this information. The use of prior hospital claims for case mix information is also consistent with the approach for several existing PAC readmission measures.

As for the role of SES/SDS factors in risk adjustment, CMS understands the important role that sociodemographic status plays in the care of patients. However, we continue to have concerns about holding providers to different standards for the outcomes of their patients of diverse sociodemographic statuses because we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations. We routinely monitor the impact of sociodemographic status on providers' results on our measures.

The NQF is currently undertaking a 2-year trial period in which new measures and measures undergoing maintenance review will be assessed to determine if risk adjusting for sociodemographic factors is appropriate. For 2 years, NQF will conduct a trial that involves temporarily allowing the inclusion of sociodemographic factors in the risk adjustment approach for some performance measures. At the conclusion of the trial, NQF will issue recommendations on future permanent inclusion of sociodemographic factors. During the trial, measure developers are expected to submit information to NQF, such as analyses and interpretations as well as performance scores with and without sociodemographic factors in the risk adjustment model.

Furthermore, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research to examine the impact of sociodemographic status on quality measures, resource use, and other measures under the Medicare program, as directed by the IMPACT Act. CMS will closely examine the findings of the ASPE reports and related Secretarial recommendations and consider how they apply to our quality programs, as they become available.

Risk adjusting for prior service use, such as the count of hospital stays, would capture both hospital admissions as well as readmissions. Though it may be possible in some instances for PAC providers to influence some of this service use, we have chosen to adjust for this factor because it is an indicator of several case mix factors that we believe are important for risk adjustment. A higher number of prior hospital stays may be indicative of a more complex or compromised clinical state. The number of prior hospital stays may also be related to otherwise unmeasured patient characteristics such as SES/SDS factors, access, and patient compliance during the post-discharge period. Having considered the suggestions to risk adjust for various facility-level characteristics, we intend to limit our risk adjustment to patient-level factors.

We agree with comments to consider risk adjusting for functional status, and note that we have included such adjustment where Medicare claims data currently permits. CMS is working towards the goal of having standardized functional status data across PAC settings. As these data become available, we intend to evaluate their use as risk adjusters in future versions of this measure.

We appreciate MedPAC's general recommendation that the set of potentially preventable hospital readmission measures for PAC should be standardized in terms of its definitions, specifications, and risk adjustment. We agree that comparing PPR rates across PAC providers is critical. We approached this measure development in such a way that allows for differences in the specifications, to account for differences in the patient populations.

We would like to emphasize that the PPR definition (i.e., list of conditions for which readmissions would be considered potentially preventable) is consistent for measures with the same readmission window, regardless of setting. Specifically, the post-PAC discharge PPR measures that are being developed to meet the requirements of the IMPACT Act, all contain the exact same list of PPR conditions. Although there are some minor differences in the specifications across the IMPACT Act measures (e.g., years of data used to calculate the measures and some of the measure exclusions), the PPR measures are closely aligned. There are substantial differences in the types patients treated across PAC and differences in the processes that lead patients to each specific setting of care. As a result, we believe that each PPR measure's risk adjustment model and inclusion/exclusion criteria should vary in order to account for patient case mix.

The area where we allow for the most variation in the measure specifications across the PAC settings is risk adjustment. The statistical approach for risk adjustment is aligned; however, there is some variation in the particular risk adjusters being used. This variation is necessary to ensure that the estimates account for factors of particular relevance in a setting. For example, the LTCH measure includes a risk adjuster for prolonged mechanical ventilation. Evidence suggests that this is an important predictor of readmissions for beneficiaries in the LTCH setting and that not accounting for this clinical characteristic would be inappropriate. Ventilator use in other PAC settings, however, is less common.

Based on public comments received, we revised our measure specifications to include testing for additional risk adjusters specific to the LTCH measure, such as multiple organ failure.

4. <u>Usability</u>

Summary: CMS received several comments regarding the usability of these measures. Some commenters noted that because the measures are technically complex and are calculated on claims data, there are barriers to reproducing and understanding the measures. Some provider organizations commented that they would require beneficiary-level claims data in addition to their facility/agency-level readmission rate, to have data that would be more "actionable" from a quality improvement perspective. One commenter expressed support for using CASPER reports in these measures.

Others indicated that there are too many readmission measures and questioned CMS' intended use for these measures. For example, some commenters asked what the role of the PPR measures would be given that CMS has already developed and implemented all-cause readmission measures (i.e., would the PPR measures exist in addition to existing all-cause measures or replace them?). Some commenters requested clarification regarding the implementation dates and minimum

number of qualified patient-stays/episodes per facility/agency required for public reporting. Several comments encouraged CMS to seek NQF endorsement for the PPR measures. One commenter noted that the measures should undergo review by the Measures Application Partnership (MAP) before they are included in any value-based purchasing program. The commenter also encouraged CMS to conduct field testing prior to using the SNFPPR measure for SNF VBP Program.

With regard to data sources, some commenters noted there are inconsistencies in the number of years being used to specify each measure (i.e., 1 year for SNF, 2 years for IRF and LTCH, and 3 years for HH). Some commenters noted that pooling multiple years of data would result in measures that are less sensitive to performance improvement. One commenter preferred calculating PPR rates monthly, to improve the usability of the data. Consistent with the comments encouraging CMS to use data on function in the risk adjustment process, some commenters suggested that assessment data be used for calculating the measures and risk adjustment as well.

Response: CMS appreciates the comments received regarding the usability of the measures and the internal initiatives to improve the quality of care reflected by them. We are not aware of any other data source aside from Medicare claims data that could be used to develop these legislatively mandated measures. CMS also understands the importance of providing quality feedback to providers in a timely manner, but notes that using more than one year of data for the HH, IRF, and LTCH measures is necessary to ensure their reliability and broad reportability. As we deploy our quality feedback reports and preview reports for these measures, we will bear in mind the need for sufficient detail to support facility quality improvement efforts.

The PPR measures were submitted for review by the NQF-convened MAP in 2015. CMS intends to submit these measures to the NQF for endorsement consideration in the future.

5. <u>Comments on the Statistical Approach and Interest in Analytic Results</u>

Summary: Some commenters had concerns over the statistical approach used for these measures, specifically noting that the approach is not easily understandable and lacks transparency. One commenter preferred the use of an observed to expected statistical approach rather than the predicted to expected approach. Another commenter did not support the use of a shrinkage estimator. Several commenters were concerned about the statistical reliability of the measures for small providers, given that PPRs occur less frequently for these facilities/agencies.

We also received several comments that recommended the measures be further developed and specified. Some commenters requested to see modeling or testing results. Others suggested that validity testing, such as field or pilot testing, be conducted to assess the measures, or that the measure developers conduct follow-up studies after the implementation of the measures. One commenter who expressed interest in seeing analytic results, acknowledged the legislative mandates' tight timelines, but urged CMS to make sure that the testing would not be "short-changed" in the process.

Response: We thank the commenters for their input regarding the statistical approach for these measures. CMS and the measure developers acknowledge that the approach can appear complex, but emphasize that the technical aspect of calculating the measures is needed to ensure that comparison of facilities/agencies in each setting type is fair. The statistical approach being developed is the same as that used in other NQF-endorsed measures that were adopted for

inpatient and PAC quality reporting programs. CMS and its measure development contractors will continue to make available details on the PPR measures' methodology as well as results of testing.

With regard to the methodology of multi-level modeling producing shrinkage estimators, the approach has been reviewed by a committee appointed by the Committee of Presidents of Statistical Societies. In its White Paper report, the committee approved CMS's approach as a valid modeling approach with preferred statistical characteristics.[3] CMS has applied the methodology in several other quality measures, including the NQF-endorsed all-cause unplanned readmission measures for PAC and the hospital readmission measures used in the Inpatient Quality Reporting (IQR) Program. Not using the risk adjustment modeling would render providers with small numbers of eligible patient stays excessively vulnerable to the influence of random variation in performance, limiting the value of the public reporting of their measure performance.

At this time, CMS has not officially determined a minimum reportable case size for the PPR PAC measures. Consistent with the IQR Program readmission measures, our approach for the all-cause readmission measures for PAC has been to use all eligible stays/episodes in the calculation of the measures, but to consider the use of a minimum threshold (e.g., 25 eligible stays during the measurement period) for the purposes of public reporting.

6. Measure Exclusions

Summary: CMS received comments related to the measure exclusions. These included comments that suggested excluding stays/episodes where the patient was discharged to hospice care or had another indication of end-of-life circumstances, to not exclude beneficiaries under 18 years of age, and for the home health measure, to exclude patients for whom the readmission diagnosis was not the same as the diagnosis from the index hospitalization. We received specific comments related to excluding intervening stays for SNF and including/excluding stays based on new site neutral cases for LTCHs. One commenter also suggested removing the home health measure's exclusion of stays for the fitting of prostheses/adjustment of devices.

Response: We appreciate the comments related to the measure exclusions and will continue to carefully consider them as we move through the measure development process. The selection of exclusion criteria is important because excluding certain types of patients may suggest that the outcome being measured is not relevant. For the purposes of the PPR measures, we are aligning our exclusion criteria with the all-cause measures and across the measures as much as possible. We have no plans to limit the measures based on payment rules used in PAC, such as the site neutral determination in LTCH, because the measure outcomes are not constrained by the payment rules.

7. Readmission Windows

Summary: We received feedback regarding the readmission windows associated with the PPR measures. Some commenters were confused by the multiple measures and readmission windows. Several commenters were concerned about the overlapping readmission windows for the two SNF

[3] The COPSS-CMS White Paper Committee. Statistical Issues in Assessing Hospital Performance. January 2012. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/Statistical-Issues-in-Assessing-Hospital-Performance.pdf

measures. Other commenters, including MedPAC, stated that not developing a within-stay PPR measure for each of the PAC settings was a "substantial omission."

Several IRF provider associations suggested that the IRF within-stay PPR measure should account for the three-day, short-stay and transfer care policies that exist in the IRF Prospective Payment System. Commenters noted that given these policies, including the three days following an IRF admission in the readmission window for the PPR measure would create an additional disincentive (beyond lower payment) for admitting healthier patients who need fewer than three days of care in the facility, and can encourage facilities to deny admission to higher acuity patients who are likely to be readmitted to an acute care hospital.

Response: CMS appreciates these comments and would like to emphasize that these PPR measures are a starting point for this work. As CMS has previously stated, this work is being conducted in phases and the measures presented in the measure specifications posted for public comment reflect the current PPR measures under development. At this time, CMS is only developing a PPR within-stay measure for IRFs. CMS currently lacks sufficient data to calculate a within-stay LTCH readmission measure. When appropriate data are available, we intend to revisit this issue.

With regard to excluding readmissions during the first three days of an IRF stay, CMS would like to clarify that the policy cited is for IRF payment determination and is not related to measurement of quality of care. PAC providers assume the responsibility of all admitted patients. This measure focuses on care transitions and coordination which is relevant to all patients, including those with shorter lengths of stay. Furthermore, excluding readmissions during the first three days of an IRF stay may result in transferring patients back sooner in order to exclude patients from the measure.

8. Patient/Family Choice

Summary: A few commenters stated that patient and family choice can also influence or determine a hospital readmission. In particular, commenters mentioned that providers' decisions to readmit patients are sometimes the result of practicing defensive medicine in light of malpractice concerns. In addition, some commenters noted that PAC providers should not be held accountable for readmissions that are caused by poor patient compliance with medical advice and provider instructions.

Response: We appreciate the comments received regarding patient/family choice and patient compliance. We would like to clarify that these measures are intended to assess *potentially preventable* hospital readmissions. The PPR rate is not expected to be 0; however, the focus of the measures is to identify excess PPR rates for the purposes of quality improvement.

9. ICD-10 and the Planned Readmission Approach

Summary: Several commenters requested that CMS provide the lists of conditions for which readmissions may be considered potentially preventable using ICD-10 codes, given that the ICD-10 implementation went into effect in October, 2015.

One commenter asked for clarification on the appendix tables and the planned readmission approach included in the Draft Measure Specifications document.

Response: CMS appreciates the opportunity to provide clarification regarding these comments. The measure development contractors have developed preliminary ICD-10 cross-walks for the lists of conditions. CMS will make this information available in the future.

With regard to the planned readmission approach, we direct readers to the draft document containing the technical specifications for the measure, which is available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Draft-Measure-Specifications-for-Potentially-Preventable-Hospital-Readmission-Measures-for-PAC-.pdf.

Preliminary Recommendations

CMS and the measure development contractors appreciate the comments received for the potentially preventable readmission measures for post-acute care. The general comments about the measures as well as the specific input we received on the PPR definitions, risk adjustment and statistical approach, measure exclusions, readmission windows, usability, and other aspects of the measures' specifications were informative to the measure development.

Overall Analysis of the Comments and Recommendations

The comments and feedback received provided useful input for the development and implementation of the PPR measures. We appreciate the comments and will take them into consideration as we complete the measure development.

Public Comment Verbatim Report

The following table details the verbatim comments received. We did not make any changes or edits to the content. However, we did exclude two comments because they contained information that was private or disclosed personal health information (PHI). Additionally, we received comments that were irrelevant to measure development, and excluded those as well.

ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
1	11/4/2015	Thank you for posting the Draft Measure Specifications and inviting review and comment. Our comments are offered from the perspective of a rural non-profit home health agency located in central New Hampshire. We offer the following: We appreciate that the measures are considered across the continuum of care so that all PAC providers can be united on the same quality metrics. This facilitates more thoughtful collaboration in the transfer of care from one Post-Acute provider to another. From our perspective, your methodology appears to be sound in calculating the rate of readmission. However, it is unclear how measures and standards will be considered when a patient has multiple co-morbid conditions. For example, if a patient has CHF, hypertension, renal failure and COPD, how will you calculate the "expected" readmission rate? In our clinical experience, the greater the number of comorbid conditions, the more challenging the management of the patient. In the document we could not find specific exclusions related to home health care. Yet, home health has several unique situations in which the home health provider is unable to continue the plan of care for reasons outside the provider's control. Examples include: a patient who relocates to a location outside the home health agency's territory (i.e., to a daughter's home) during the episode of care, the home health patient ceases to be homebound during the 60 day episode and thus no longer qualifies for home health under Medicare, or the patient tells the agency they no longer desire service—essentially the home health equivalent of "discharge against medical advice." There are frequent scenarios in which the patient has not met the goals of care but one of these situations arises, forcing the agency to discharge the client. Because of this, we suggest a set of home health exclusions from the data base when any of the 3 situations listed above arise. The agency is saying that they did not complete the plan of care, but they were unable to continue the plan of care because the patient: a) relocated outside the service area, b) was no longer homebound or 3) declined further agency service. Finally, we suggest that you consider the possibility that a co-existing behavioral health diagnosis may affect readmission rates and	Margaret Franckhauser, MS MPH RN, Chief Executive Officer Central New Hampshire VNA & Hospice	mf@centralvna.org	Home health agency

(continued)

ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		consider this as a risk adjustment factor. In our agency experience, we find that clients who lack capacity to self-manage disease and cycle repeatedly to the hospital often have co-existing and serious behavioral health disorders. While we and other providers (including ambulatory health) intervene in an attempt to stabilize these clients, there is no "quick fix." Behavioral health retraining is measured in a time horizon far exceeding 30 to 60 days. A review of the data addressing the co-existence of behavioral health conditions should reveal whether or not this co-variable might be a predictor of readmission. If so, we suggest that this be taken into account when considering the measures.			
2	11/4/2015	1. Follow up with care team with in first week of discharge home. Home nurse or Extended Care facility upon discharge instead of home with family. Obtaining prescriptions given at discharge within 24 hours and taking the medications, using a pill box to remain organized. Text or call to provider within 24 hours of discharge, and then daily until first visit to report fevers, redness, drainage and questions.	Tracy A. Berg, MD PS	spokanesurgeons@gmail.com	Individual provider
3	11/4/2015	Patients that qualify for hospital admission should not be included in denominator, if a condition can't be safely managed in a home setting and requires 24 hour acute care for treatment and management it is not appropriate to include in this as preventable admission. Patient safety is important, not just data collection and cost reduction. Patients that need cardiac monitoring, some infusions vs. PO medications, and surgery, are not appropriate for home health. There also should be a rural demographic consideration, in areas where there is a lack of Primary care providers.	Nina Kaiser RN, BSN PHN MBA COS-C, Quality Coordinator Lakeside Home Heath Sutter Care at Home	kaisern@sutterhealth.org	Home health agency
4	11/5/2015	My comment is, working with outpatient pulmonary rehab for 15 yrs. Made me realize that any patient with or without COPD, EMPHYSEMA, can minimize their hospitalization if they go to the rehab and exercise. I have worked with thousands of patients and they all have the same outcome, they have no hospitalization for yrs and yrs. Six months or more on rehab really help. If doctors will send their patient to rehab not home health we can save a lot of money from hospitalization. Home health is a waste of money according to my patients. These patients needs to move not to sit on their chair and wait for the nurse to come and take their vital signs and you pay.	Dyesebel Alvaro	leah@pinnaclepulmonary.com	Individual provider

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5	11/5/2015	I am a nursing home administrator in Lakeland Florida. One area that is often overlooked in these measures is patient choice. Unfortunately we often find ourselves in the position of discharging a resident back to the hospital at the insistence of the resident or the family. We are very diligent about informing our stakeholders about the dangers of going back to the hospital versus treating in house, but sometimes they just feel as if the hospital can do more for them. These types of discharges definitely skew the discharge numbers for my facility as I am sure they do for many. It would be great if there was a way to isolate or correctly account for these instances.	Michael Bradley, Administrator Valencia Hills Health and Rehabilitation Center	admin@valenciahillshr.com	Nursing home
6	11/5/2015	Why do we need to create the measures when the hospitals will not send nursing homes referrals if readmission are out of acceptable margins? The hospital selections will insure performance. Why should CMS further encroach upon something that the hospitals will take care of regardless of what CMS does?	James Dugger, MHA LNHA, Administrator Apache Junction Health Center	jdugger@apachejunctionhealthcenter.com	Nursing home
7	11/5/2015	The greatest difficulty we see from a SNF is the patient comes to us in a complex frail condition and is still not stable. If the ON-CALL doctor is contacted it is usually a person he has never seen and will not take any liability for and tells you to just send them to the ER. If a person is discharged home from the SNF, doesn't want home health and then returns to the hospital within the 30 days neither the SNF nor the Hospital should be held responsible.	Michael D. Van Sickle, Chief Operating Officer Bethany Lutheran Home	Mike@bethanylutheranhome.org	Assisted living community
8	11/5/2015	A number of the proposed denominator exclusions are befuddling. It seems as if, the collaborators took great lengths to minimize the denominator pool, which would potentially have an adverse impact on the outcomes. For instance, excluding patients that expire within 30 days. They are relevant, it demonstrates that frail, critical nature of the types of patients that PAC providers are taking care of. Not only does it contract the denominator, it lowers the risk adjusted, predicted number of unplanned discharges. Your TEP and Dr. Kramer have unfathomable audacity in their identification of the extensive list of potentially preventable conditions. If this list of extensive conditions are so "preventable" with proper management of chronic conditions, infections, etc.; then why are these individuals showing up in acute care settings from the community? If they are so preventable, then it would only seem just, that these measures be applied to primary care physicians, Medicare Advantage programs, ACO's	Tony Farinella, NHA MHSA Manager of Transitional Care & Physician Services Gulf Coast Health Care	tfarinella@gchc.com	Long-term care provider

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		and the patients themselves be held equally accountable. After all, according to your technical expert panel they are "preventable." I am going to presume that my previous statement will not be wildly accepted by CMS. As such, I would like point out other flaws in the design of the proposed measures. For the most part, the current reimbursement for the majority of PAC providers would fall woefully short, to provide the comprehensive level of care these conditions would require to avoid re-hospitalization. The current reimbursement structure does not provide for the intensive resources required to meet these expectations. These would include at a minimum, but not be limited to; enhanced diagnostic capabilities such as on-site CT scans, MRI's, X-ray, Doppler, continuous electronic monitoring of vitals, etc., additional nurses to assess and treat these conditions, Advanced Nurse Practitioners, on-site access to Physician Specialists, etc. Further, your proposal leaves out two important participants in accomplishing your desired outcomes: the patient and the physician. Many patients are non-compliant or have unhealthy lifestyles that have contributed to their "chronic condition." Again, referring back to my earlier point of "preventable" conditions. What if a PAC provider has implemented all of the clinically sound management approaches for COPD, has adequately educated the patient and the patient continues to smoke or refuses to take their prescribed medication? Is it fair that the PAC provider be held accountable for the patient's blatant disregard for their own health? Even more so, what if the patient or family member insists that the patient be re-admitted back to the acute care setting for any number of reasons? Where does your proposal address this circumstance? Shall the PAC provider refuse to transfer the patient because they are providing the appropriate care, then we would be in violation of federal and state regulations regarding resident rights and be subject to malpractice actions by the patient and family. In addition, your proposal leaves out the physicians. PAC providers have limited abilities to implement physician services to the level necessary for eliminating these so called preventable conditions. Beyond access and			

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		availability, physicians (and extenders) are the only ones able to prescribe medications, treatments, etc. What if they refuse or are delayed or choose a different medical approach or to enact the proper medical procedures, thus causing a re-hospitalization? What if they are not on call and another physician who is unfamiliar with the case, orders the PAC provider to send the patient to the ER in order to avoid legal action by the patient or family. You may choose to continue to ignore this aspect, but it is factual. Defensible medical practice is real in this country, as CMS, MedPac and the ACA all have avoided any attempts to address tort reform. Your limitation on select health care providers is beyond worrisome. It is theoretically and legally flawed by existing scopes of practice and other considerations. In closing, I urge you to not hastily implement a program that is flawed in design and scope and will not be capable of achieving its desire outcome. The actual providers, physicians and patient advocate groups should be brought into the panel of discussion. Yes, there are avoidable conditions when properly managed, by all stakeholders!			
9	11/6/2015	Any risk adjustment of the metric should be able to de reproduced by public resources. Today, for example, risk adjustment of hospital re-admissions includes elements such as physician visits which is not publicly available. Providers want to be able to risk adjust their performance and the performance of their competitors. Usage of the VRDC may be the appropriate vehicle to accomplish and would be in the spirit of CMS's efforts for data transparency.	Rich Chesney Healthcare Market Resources, Inc.	rchesney@healthmr.com	Healthcare marketing company
10	11/7/2015	As a medical director in a large managed care organization we deal with preventing hospital readmissions as one of our number one priorities. For any risk bearing entity with CMS being the largest, infrastructure within the organization is key. Infrastructure needs to appropriately utilize a "boots on the ground" approach along with leveraging technology which provides actionable real time communication during the vulnerable hand off period of a discharge from acute care to a post acute care setting. What we have found is that hospitals mandate medical providers to create a discharge summary within 14 days of the patient discharge. Unfortunately, the norm is to complete these tasks near the 14th day as physicians and medical providers feel overwhelmed with the volume of patients they are seeing in order to generate their income. As hospital discharge summaries are needed for billing and coding for hospitals and	Bhavik V. Thakkar, MD DocToc	doctoc.com@gmail.com	Patient health information smartphone platform

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		insurance company's revenues to identity severity of illness, they offer little during the transitions of care. In lieu of this leveraging a mobile first solution will provide the real time communication needed to prevent these readmissions. DocToc is the only solution which can provide this. DocToc (www.doc-toc.com) provides a meaningful hand off by a provider in the acute care setting within an encrypted secure environment. They can send a communication which is templated to prevent variance in what needs to be communicated. This singular message can be delivered to as many end recipients in the ambulatory setting allowing for the acute care provider to be efficient and improve the quality of care provided. Once the audio file is completed it is transcribed in real time and all end recipients are notified of a pending message. This can be retrieved at any time on their mobile device or desktop. Statistics can be provided in real time on a dashboard outlining for example how quickly each recipient is reading their new messages, what the principal problems are, length of stay, status inpatient versus observation, medication lists, labs and radiology completed, follow up plan, brief hospital course. These are the key elements which need to be tracked to prevent readmissions.			
11	11/9/2015	Hi There—can you tell me the plan for incorporating ICD-10 into the PAC PPR readmission measure?	E. Liza Greenberg, RN MPH, Interim Vice President, Quality and Performance Improvement Visiting Nurse Associations of America	LGreenberg@vnaa.org	Home health association
12	11/9/2015	The opportunity to allow people with disabilities and chronic conditions, to stay in their homes with proper supports, results in a higher quality of life. We do know that baby boomers for the most part want to "age in place" and many are volunteering in their communities. Most people want to help caregivers however do not know how. People like to volunteer at hospitals in various capacities. As the trend moves medicine to a social model of care respite is a key long term community service/support. We believe that caregivers need to identify their support network at the "point of entry," by this I mean as soon as they know they will become a caregiver or will need a caregiver. Examples for instance are an adult with a chronic disabling condition, or an aging parent who now will have to rely	Lois Sheaffer, Director REST	lsheaffer@marklund.org	Respite care program

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		on their children or spouse for care. Just before diagnosis these potential caregivers are living a "typical" life with friends and family connections at work, church, membership organizations, and through leisure activities. At this time caregivers can name a small network of people who they believe could support them in their caregiving journey. We know that the named supporters want to help but may be uncomfortable caring for or communicating with the care recipient without training. If hospitals would be a REST (Respite Education and Support Tools) training hub for respite volunteers, caregivers could send their supporters to be trained and then can truly get a break when needed decreasing the need to re-admit their loved on to the hospital. I'd like for you to imagine a discharge planning meeting at a hospital with the caregiver leaving to take their loved one home. Imagine that they have identified people that they know and love who have taken the 8 hour REST Companion course. As they leave the hospital yes, they know their life as they knew it is going to change however, they have a safety net, people who care about them and want to support them are right by their side. These people are not going to cost the government money and might actually save federal and state dollars by decreasing the possibility of hospital readmission, reducing caregiver stress related conditions and delaying the long term care placement of the care recipients. If the caregivers at cannot identify a support network of friends and family, then the hospital can provide REST Companions to work with the family during the transitional phase and possibly beyond that point as they bond with the caregiver and care recipient. REST is a train-the-trainer course that prepares individuals to conduct respite training, equipping REST Companions to provide respite, in order to support caregivers. There is evidence to support the effectiveness of the REST program, with participants overwhelmingly responding that the program prepared them to feel confident in providing quality respite to families. The REST program will be an evidenced based respite training program by summer of 2016.			

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		REST will also: • **Enhance private programs community profile:** – Pulling human capital from various areas (churches, vol. orgs, Colleges and Universities, as well as support groups) – Naturally creates networks of support for Caregivers. • **Increase Sustainability:** – A volunteer respite system of trained people will increase access to more regularly scheduled respite (breaks): – Decrease stress related conditions in caregivers – Delay of long term care placement or re-admission to the hospital – Increase life satisfaction for the caregivers • **Use Best Practices:** – REST Core competencies align with the National Respite Guidelines and allows for a nationwide standard of training. – REST is based on experiential learning and is customizable so that organizations and communities can make it their own. – Pre/Post surveys from volunteers indicate that they feel more equipped to serve caregivers thru respite after receiving the REST training – No medical background needed for Trainers or Volunteers. – Train-the-Trainer model allows for a comprehensive distribution of training for companions and increases the frequency of training opportunities.			

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13	11/10/2015	I have a lot to say about this subject from the Post acute care point of view. This are few of my thoughts. 1. We need to do a better job at diagnosing rather than putting a bandaid and have people coming in and out of the ER or discharging them to SNF with poorly diagnosed issues. Discharging patients from the hospital to SNF needs to be closely evaluated most Nursing Homes do not have adequately trained staff and RN support to care for acute multiple chronic diseases. Nursing homes need to be pressured into changing the staffing level to adequately manage acuity and they must do a head to toe assessment on every acute care patient every shift (at least 2 times a day, focus spot checks is not sufficient) in order to trend subtle changes in condition that currently go undetected until a crisis happens. A proactive disease management program must be implemented to properly manage multiple co- morbidities. We must consider setting up more transitional care units specialized in Chronic Disease Management. They need to be hospital based to adequately staff it manage these patients. SNFs are unable to change their approach to care due to payment and wanting to meet minimum requirement through loopholes. We should consider setting up specialty skilled nursing units with clinical pathways that include community and post-acute discharge follow ups focused to keeping people out of the hospital. The technology is already available; we need to push top and middle management to embrace the changes to meet the needs. Community education related to End of life, palliative care and hospice benefits to improve early referral and allowing for better choices rather than wasting resources with multiple re-admissions and frequent ER visits. Lastly, we need to really look at the over use of pharmaceutics that are causing more harm than good. Decreasing the drugs will decrease cost and improve health. We need to go back to the basics.	Sandra Lourido, RN MSN PHN DABRM HTP CDONA SL Consulting	rn.consultant.sl@gmail.com	Nurse consulting

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14	11/10/2015	LeadingAge appreciates the opportunity to comment on the Proposed Measure: Potentially Preventable Readmissions for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long Term Care Hospitals and Home health Agencies. The LeadingAge Community includes 6,000 not-for-profit organizations in the United States, 39 state partners, hundreds of businesses, research partners, consumer organizations and foundations. We promote home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, continuing care communities, and nursing homes, as well as technology solutions and person-centered practices that support the overall health and wellbeing of seniors, children, and those with special needs. Dedicated to expanding the world of possibilities for aging, LeadingAge advances policies, promotes practices and conducts research that supports, enables and empowers people to live fully as they age. We support CMS' overall intent to address potentially avoidable readmissions from post-acute settings and concur with the all-cause methodology. We also support the diagnostic categories that are excluded from the measurement, as well as the overall measurement design to risk adjust for clinical acuity and co-morbidities. It is noted that the prediction equations are based on a logistic statistical model with a 2-level hierarchical structure, and facility effects are modeled as belonging to a normal distribution. While this approach makes sense for average sized providers with "typical" rates of admissions and readmissions, we are concerned that this distribution may not be accurate for providers with small numbers of admissions per year (less than 20) and thus readmissions may not fall under predicable rates. This is also a problem for those providers who may have greater volumes, but who serve patients enrolled in Medicare managed care plans and are thus excluded from the calculations. Appendix A (conditions considered potentially preventable for the 30 day post-PAC) and Appendix B (conditions considered potentially preventable for the within-stay window) are, for the most part, appropriate diagnoses	Cheryl Phillips, MD, Senior Vice President, Public Policy and Health Services LeadingAge	cphillips@LeadingAge.org	Association focused on aging

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		for which optimum clinical management should reduce the risk of readmission. However, in the specifications provided by RTI on page 7 "dehydration conditions" are listed as an exception to the principle diagnosis requirement to be deemed "potentially preventable." Dehydration and the various related codes are commonly "add-on" admission diagnoses for a wide array of clinical presentations in the elderly. Volume depletion, in acutely ill elders, may occur within hours. Furthermore, it is also frequently overused by admitting clinicians, based on physical findings (dry skin, dry mucous membranes, etc.) that are not reliable markers of dehydration in the elderly population. Therefore, we would ask that if the primary diagnosis does not fall under one of the "potentially preventable conditions," the presence of "dehydration' or volume depletion does not trigger inclusion in the count. Arrhythmias are included in Appendix A. While readmissions for previously diagnosed arrhythmias may be based on inadequate management, new onset arrhythmias are not, and PAC providers cannot predict or "manage" arrhythmias that have not presented themselves, or which are related to idiopathic or previously undiagnosed cardiac conditions. We would ask that new onset arrhythmias be excluded from this set. Appendix B includes Acute Delirium as a potentially preventable condition for within-PAC stay. There is little, if any evidence that would support that delirium is entirely preventable, particularly in post-surgical patients, patients with multiple serious conditions, and those with underlying dementia. Secondly, a measure of quality should be recognition of delirium. Unless the readmission is related to another condition on this list, we do not feel that delirium, by itself, should trigger inclusion as a potentially preventable readmission. We strongly support the activity of daily living severity scores as inclusions in the risk-adjustment for Home Health readmission measures. Functional assessment is, and should be, an essential adjustment to the risk prediction for readmission. In addition to function, the presence or absence of in-home caregiver support for those with functional dependency is a strong predictor of readmission rates, and not something that home health providers can "manage" outside of the Medicare HH benefit.			

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		Lastly, we do support the inclusion of sociodemographic status as part of the risk adjustment. Not only are dually-eligible individuals often greater risk because of their co-morbid conditions and functional needs, but have little community resources or supports to mitigate these risks. They represent a very heterogeneous subpopulation that is quite different than non-Medicaid beneficiaries with the same primary diagnoses.			
15	11/11/2015	We will be preparing comments, but I have a question. Will this measure go through NQF endorsement?	Lane Koenig, PhD, President KNG Health Consulting	lane.koenig@knghealth.com	Health care consulting
16	11/11/2015	In crafting our comments, we have a clarifying question on how the measures will be calculated. Page 15 of the draft specifications state that "to aid interpretation, the provider-wide standardized risk ratio, SRRj, is then multiplied by the overall national raw readmission rate for all provider stays, $\bar{Y}$, to produce the provider-wide risk-standardized readmission rate (RSRRj)." Is $\bar{Y}$ the overall national raw readmission rate for provider stays in ALL post-acute care settings or is there a different $\bar{Y}$ for LTCHs, SNFs, IRFs, and HHAs? For example, in calculating RSRRj for LTCH facility j, will you multiply SRRj by $\bar{Y}$ calculated for provider stays in all LTCHs, SNFs, IRFs, and HHAs or is $\bar{Y}$ calculated only for provider stays in all LTCHs?	Lane Koenig, PhD, President KNG Health Consulting	lane.koenig@knghealth.com	Health care consulting
17	11/13/2015	Thank you for the opportunity to comment on the draft measure, Potentially Preventable Hospital Readmission for Home Health. VNAA is a national trade association that supports, promotes and advocates for mission-driven providers of home health, hospice and palliative care. VNAA's 130 members are nonprofit home healthcare and hospice agencies from all regions of the country from rural to urban. Our members serve communities in over 33 states, through 600 branches. We appreciate the thoughtful approach that has gone into development of the measure, and in particular, application of a valuable risk adjustment strategy. Home health agencies have a crucial role in supporting patients after facility discharge, focusing on patient education, self-management, and clinical improvement. We note, however, that home health functionally	E. Liza Greenberg, RN MPH, Interim Vice President, Quality and Performance Improvement Visiting Nurse Associations of America	LGreenberg@vnaa.org	Home health association

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		serves as an intermediary between the patient, primary care providers, and other providers (such as specialists and hospitals). Home health clinicians are fully accountable for identifying clinical problems, coordinating treatment changes with a physician or nurse practitioner, and even making follow up appointments. Importantly, home health clinicians do not prescribe the treatments that may be needed to keep a patient out of the hospital. The PCP has an accountable, continuous relationship with the patient. Many patients admitted to home health are fragile, with progressive chronic diseases such as congestive heart failure or COPD that are not curable. After discharge from home health, if the patient suffers an exacerbation, it is appropriate and necessary that the patient seeks medical attention for treatment modification. Patients who cannot access the PCP or other accountable provider may visit the emergency department (ED) or be readmitted. Thus, readmissions after home health episodes are indicative more of access / intervention barriers to medical care than to home health services. Many readmissions in this population are attributable to disease progression, not a failure in home health services. It is not reasonable to think that the medication management, rehabilitation therapy, and education offered by home health clinicians in the absence of medical treatment will prevent exacerbation of a progressive chronic condition. We also note that the concept of patient centered care means that clinicians can assess patients, educate them, and make recommendations, but that patients may legitimately choose not to follow clinical advice. Many, many elderly seniors choose not to adapt their homes or make other changes even after a home health clinician has assessed risk, referred the issue to a PCP and worked with the patient and caregiver on a plan to reduce falls risk. Further, over the course of 30 days following discharge, frail patients who received rehabilitation services to regain physical function/stability may again become unstable. Given this framework of patient-centered care and home health accountability, we make the following suggestions: • Follow up with a physician after the home health episode should be a risk adjuster for home health readmission. Patients who do not have follow up contact with a PCP (as evidenced by a claim) may be more likely to readmit whether or not high quality home health services were provided;			

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		• Use of community resources or use of other support services by the patient should also be a risk adjuster. Patients who do not have adequate support services to remain at home (because of rural living, financial issues, or choice) may be more likely to readmit; • We have a general concern about the level of evidence used to support this measure. While there is some evidence regarding readmissions 30 days after hospital discharge, there is little evidence supporting the concept of PPR for 30 days after discharge from home health, particularly for the broad array of clinical conditions encompassed in this measure; • We recommend that the measure be narrowed to accountability for 1-2 conditions for which there is strong evidence that home health interventions can impact readmission potential up to 30 days after the home health discharge; • If the measure moves forward with a broad PPR definition, we believe home health measures of PPR should capture only readmissions related to the condition for which the patient was referred, or at most, only conditions which are identified in the referral and assessed through OASIS. This is a reasonable approach given the lack of consensus on what is a PPR and attribution of accountability for the PPR. Home health should not be accountable for issues such as infection, which may well be attributable to the discharging facility, or skin breakdown, which may be related to care after discharge from home health; • We do not believe fall after home health is a PPR if the patient had a risk assessment and prevention plan (such as rehabilitation services); similarly we do not believe medication errors are attributable to home health if the medication changed after home health discharge, or the risk was identified and documented during the episode and an accountable treatment provider did not change the medication plan; • We recommend developing an attribution scheme for patients who are admitted to multiple PAC providers, such as a patient discharged to SNF and then HH. (This needed because some conditions—such as infections—may not manifest immediately; and, patients with short stays could conceivably be within a 30 day post-discharge window for multiple acute and PAC providers);			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		• We recommend considering exclusion of readmissions for patients who are subsequently discharged from the acute facility to hospice; • We recommend excluding patients who die within 30 days of the home health episode, indicating a fragile individual who potentially should have been managed with greater intensity in hospice; • We strongly recommend that the measure be re-specified for ICD-10 coding and that it be tested and validated with new codes prior to implementation; • We concur with the stated concern that the measure has potential to create unintended consequences. It may create incentives for providers to avoid the most frail or unsupported patients, as these individuals are most likely to readmit. Application of the measure may reduce access to home care for very frail or at risk populations; • We note and agree with proposed risk adjusters specific to home health, and encourage CMS to use prior PAC utilization and ED use as risk adjusters.			

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18	11/13/2015	Cerner Corporation, a leading supplier of electronic health record, clinical and revenue cycle information systems, and EHR vendor for a large contingent of US based hospitals, critical access hospitals, and eligible professionals appreciates the opportunity to submit comments on certain of the provisions of the *Development of Potentially Preventable Readmission Measures for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs).* We offer comments on the following provisions: **Planned Readmissions procedure codes and diagnoses** We appreciate CMS has identified intended work to map the procedure and diagnosis codes to the ICD-10 format. ICD-10 is the current procedure and diagnosis coding requirement, and the appendices within this RFI need to be updated as soon as possible to meet the new standard. We feel analysis of claims data after 10/1/2015 is impossible to determine potential impacts without updates to the reference material in the current appendices. **30-Day Post-Discharge Exclusions** We request clarification on the 30-day Post Discharge exclusion 11: "HH episodes where the patient authorization code is missing." We are unsure of the "patient authorization code" reference. Is this the OASIS treatment authorization code on the HH claim? Please clarify. Otherwise, we agree with the current proposed exclusion criteria. **Appendix A—Conditions to define PPR 30-days post PAC discharge. Appendix B—Conditions to define PPR within PAC stay** We request clarification of Influenza being listed as an infection. Influenza is primarily classified as a virus, though contagious, and not an infection that may be treated clinically with antibiotic therapy. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3880301/ We request clarification on the manner in which CMS facilities will track patients with influenza and potentially the complications especially of the elder population. http://www.who.int/biologicals/vaccines/influenza/en/	John Travis, Vice President and Compliance Strategist Cerner Corporation	jtravis@cerner.com	Electronic health record supplier

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		If CMS is looking to decrease the influenza rate by tracking or enforcing vaccinations, we recommend using quality data submitted by PAC facilities rather than including it as a PPR condition. • SNF submits MDS measures N003.01, N004.01 and N005.01 indicating percentage of residents vaccinated • IRF submits IRFPAI measure O0250 A/B/C indicating individual patient receipt of influenza vaccination as well as NQF#0680 indicating percent of residents assessed and given seasonal influenza vaccine. • HH submits process quality measures from their OASIS submission of M1040 and M1045 indicating influenza given or reason not given. We ask CMS review these reasons and reconsider the inclusion of all Influenza diagnosis as PPR conditions. **Overall Comments on the Proposed Program** We request CMS to provide the 2016 PPR determination period. Does the collection period start 1/1/2016? Will the appendices be updated with current ICD-10 procedures/diagnoses before the 2016 PPR determination period? We feel a delay in updating the appendices will hinder the PAC facilities ability to analyze claims data in the 2016 PPR determination period. All Medicare claims submitted after 10/1/2015 require ICD-10 reporting. We request CMS provide a PPR baseline report for PACs from the data used to develop the measures, as referenced in this request for comment. • SNF PPR measures—CY2013 data • IRF/LTCH measures—CY2012–2013 data • HH measures—CY2011–2013 data We request CMS provide PPR reporting for PAC facilities during the 2016 data collection period, before the data is used to implement a Value Based Purchasing (VBP) program. We understand this may be too late for the Skilled Nursing Facility VBP which is required for October 2016; however, this will assist the other PAC facilities in monitoring their discharges during the collection period.			

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19	11/13/2015	On behalf of the 90,000 physical therapist, physical therapist assistant, and students of physical therapy members of the American Physical Therapy Association (APTA), I would like to submit the following comments in response to the Draft Specifications for Potentially Preventable Hospital Readmission (PPR) Measures for Post-Acute Care. Physical therapy is an integral service provided to Medicare beneficiaries all post-acute care settings. Physical therapists furnish medically necessary services to patients to improve their overall health, function and to optimize their quality of life. Across the post-acute care settings, physical therapists provide physical therapy services to patients through a plan of care to engage and optimize the patient's participation in achieving shared goals of improved functional performance, reduced risk of injurious falls, and reduced risk of acute hospitalization thereby promoting long-term health and wellness. Physical therapists provide an examination that includes the history, systems review, and tests and measures to determine the patient's therapeutic, rehabilitative, and functional status and any environmental factors that may impact the patient's activity and/or participation. Through the evaluative process, the physical therapist develops a comprehensive plan of care to achieve the goals and outcomes of improved function. The physical therapist also instructs patients and caregivers in areas that will help to address specific impairments, activity limitations, participation restrictions, and environmental factors. This may include instruction in the use and performance of therapeutic exercises, functional activities and assistive or adaptive devices, including prosthetics and orthotics. Additionally, the physical therapist assists in the determination of therapy services following discharge. Physical therapists play an integral role in the prevention of acute hospital readmissions as essential members of the health care team facilitating transitions in care for patients. Physical therapists, in conjunction with other of the health care professionals, assist in discharge planning, including the determination of the most appropriate setting for a patient	Heather Smith, PT MPH, Director of Quality/Sharon L. Dunn, PT PhD OCS, President American Physical Therapy Association	heathersmith@apta.org	Physical therapist association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		taking into account their medical status, functional status, prognosis and other factors, such as their home environment and family support. The need for coordinated efforts across the continuum of care is imperative in reducing preventable readmissions. Comments on the Draft Measures APTA supports the goal of improving the quality of health care. Physical therapists are committed to providing high-quality, timely care and to the promotion of evidence-based and patient-centered practice. Furthermore, APTA feels that it is essential that we move towards a common set of quality measures across the across the continuum of care. APTA supports the implementation of readmissions measures across the care settings, as approximately 20% of all Medicare patients are readmitted within 30 days of an acute care discharge and readmissions account for an estimated $17 billion in health care spending. APTA is pleased to see that the draft specifications for these measures align with existing methodologies of other readmissions measures. We believe that potentially preventable readmissions measures will focus providers on those patients who are expected to have successful transitions to the community follow in discharge from the respective post-acute care settings. However, the APTA does have some concerns regarding the proposed measure methodology. These concerns are discussed below. APTA believes that a patient's level of function does impact the potential for readmissions. Recent evidence indicates that patient function is associated with increased risk of 30-day all-cause hospital readmissions and may be an important factor in preventing readmissions for Medicare seniors that is not currently accounted for in measure methodologies[1]. APTA is pleased to see "activity of daily living" scores included in the risk adjustment methodology, however, we note that this is only included for those patients in the home health setting. We would encourage measure developers to include this as a risk adjustment variable in all readmissions measures. APTA appreciates that CMS has strict deadlines for the implementation of measures under the IMPACT act, however, as these measures will be new to the respective post-acute care settings we encourage that settings have the ability to review this data as early as possible in order to understand the data and, more importantly, so that the respective setting have time to implement strategies to decrease readmissions where necessary. As many of these settings do not always receive feedback on the			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		readmissions of their patients post-discharge, this data will be new to many facilities. Additionally, skilled nursing facilities and inpatient rehabilitation facilities will be trying to manage two measures, one within stay, and one post-discharge. APTA recognizes that the overall goal of IMPACT is for PAC providers (HH, IRF, SNF and LTCH) to collect and report standardized and interoperable patient assessment data, quality and resource use measures. We acknowledge that during the initial IMPACT implementation years that there will be a transition period which will include the addition of new measures into all of the post-acute care settings. We believe that achieving a standardized and interoperable patient assessment data set and stable quality measures as quickly as possible will allow for better cross-setting comparisons as well as the evolution of better quality measures with uniform risk standardization, thus achieving the true aim of IMPACT. [1] Greysen SR, Cenzer IS, Auerbach AD, Covinsky KE. Functional Impairment and Hospital Readmission in Medicare Seniors. *JAMA Intern Med*. 2015;175(4):559-565.			
20	11/13/2015	I have been working in long term care for over 30 years as an administrator; currently I lead a small not for profit community in the foothills of California. While I agree that we, as a society, need to develop guidelines to help reduce the costs associated with re-admission, I am gravely concerned these guidelines might go too far and hurt our seniors. If we are not careful, the impact on patient care for our seniors, coupled with reduced reimbursement could have negative consequences to this frail population. It is also important to understand, while developing these guidelines, that we (the providers) are often caught in the middle, being at the mercy of the resident's attending physician's directives. This is especially problematic when our attending physicians are not available and we must call an "on-call" doctor. As it is, only a handful of physicians, in a geographic area, are even willing to serve as attending physicians for the elderly. Asking them to adopt additional guidelines, that impact how they treat their patients, is difficult as best. So while these updated guidelines will impact our financial operations, we have only minimal control over	Sandra Haskins, Executive Director Gold Country Health Center	sandy.haskins@rhf.org	Assisted living community

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		how the physician directs patient care. It is important that our physicians, who serve the frail and elderly, are brought into the decision making process! I also reviewed the prediction equations, which are based on a logistic statistical model with a 2-level hierarchical structure, with facility effects being modeled as belonging to a normal distribution. I am concerned that this distribution may not be accurate for providers with small numbers of admissions per year (less than 20). Their readmissions may not fall under predicable rates and could impact them significantly. This may also be a problem for those providers who may have greater volumes, but who serve patients enrolled in Medicare managed care plans and are thus excluded from the calculations. I also reviewed Leading Age's (our professional association) outline of how this could impact us as providers, and impact our residents. These issues could be problematic to both, so I have included a reprint of several of them in this letter: • *Appendix A (conditions considered potentially preventable for the 30 day post-PAC) and Appendix B (conditions considered potentially preventable for the within-stay window) are, for the most part, appropriate diagnoses for which optimum clinical management should reduce the risk of readmission. However, in the specifications provided by RTI on page 7 "dehydration conditions" are listed as an exception to the principle diagnosis requirement to be deemed "potentially preventable." Dehydration and the various related codes are commonly "add-on" admission diagnoses for a wide array of clinical presentations in the elderly. Volume depletion, in acutely ill elders, may occur within hours. Furthermore, it is also frequently overused by admitting clinicians, based on physical findings (dry skin, dry mucous membranes, etc.) that are not reliable markers of dehydration in the elderly population. Therefore, we would ask that if the primary diagnosis does not fall under one of the "potentially preventable conditions" that the presence of "dehydration' or volume depletion does not trigger inclusion in the count.*			

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		• *Arrhythmias are included in Appendix A. While readmissions for previously diagnosed arrhythmias may be based on inadequate management, new onset arrhythmias are not, and PAC providers cannot predict or "manage" arrhythmias that have not presented themselves, or which are related to idiopathic or previously undiagnosed cardiac conditions. <u>We would ask that new onset arrhythmias be excluded from this set.</u>* • *We strongly support the activity of daily living severity scores as inclusions in the risk-adjustment for Home Health readmission measures. Functional assessment is, and should be, an essential adjustment to the risk prediction for readmission. In addition to function, the presence or absence of in-home caregiver support for those with functional dependency is a strong predictor of readmission rates, and not something that Home Health providers can "manage" outside of the Medicare HH benefit.* My skilled nursing is a small non-profit unit in a rural community. As such, I think we do a great job coordinating with both our local hospital and our physicians to control (and even reduce) hospital re-admissions. In fact, our hospital has participated in hospital re-admission goals and has rallied the providers in our community to work on this issue for almost three years. However, I do know, that in larger communities, where there are more hospitals, larger health care systems, more managed care, a larger number of physicians, and many more frail and elderly, they struggle on how to coordinate reductions. So I urge great care in making decisions unilaterally for the country without acknowledging the uniqueness of each community, county, state, and region, and considering the impact these changes will have on them! It is important to conserve our resources! However we cannot make decisions without assessing the risk to our frail and elderly citizens. Thank you for your careful consideration of my thoughts, and the thoughts of those other providers. We are out here in the trenches. It is our community members that will be affected by guideline changes.			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
21	11/13/2015	Madonna Rehabilitation Specialty Hospital is located in Lincoln, Nebraska, and provides specialized programs of care to chronically and critically ill and medically complex patients who are Medicare beneficiaries. We have carefully reviewed the draft specifications for the *Potentially Preventable Hospital Readmission (PPHR) Measures for Post-Acute Care* and have concerns regarding the ability of the measures to allow unbiased estimates of care quality differences across post-acute care (PAC) settings. In many ways, our concerns noted below are grounded in the treatment of long-term acute care hospital (LTCH) as a post-acute care setting under IMPACT when LTCHs, unlike other PAC settings with the exception of inpatient rehabilitation facility, meet the requirements for acute care hospitals. As a result, LTCHs treat a higher acuity patient than other PAC providers. These aspects of LTCHs make it challenging to compare outcomes between LTCH and PAC settings. <u>Limitations in the measures hinder cross-setting quality comparisons</u> a. The PPHR measures are constructed by multiplying a standardized risk ratio by the unadjusted average rate of readmission in the specific PAC setting's population. The average readmission rates used in the calculation are not adjusted for patient clinical differences between PAC settings. As a result, the differences in the PPHRs between PAC settings (e.g., LTCH, SNF, IRF, and HHA) may reflect differences in patient clinical differences rather than differences in care quality. There exist significant differences in patient severity and acuity across PAC provider settings. For example, patients treated at LTCHs include the most medically complex and resource- intensive cases within the Medicare population. In 2006, approximately 37% of LTCH cases grouped to the highest APR-DRG severity score, while this percent ranged from 4 to 7% for other post-acute care (PAC) providers.[1] Patients treated in LTCHs often possess multiple comorbidities and require specialized care. For example, 28.0% of LTCH patients with digestive system	Susan Klanecky, MSN RN CRRN CCM, Vice President of Patient Care Madonna Rehabilitation Specialty Hospital	sklanecky@madonna.org	Inpatient rehabilitation facility

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		problems had at least three major complications or comorbidities compared to 2.2% of patients with digestive system problems in other PAC settings.[2] These differences in acuity may contribute to large differences between the unadjusted average readmission rates for LTCHs compared to the rates for other PAC settings. For example, according to RTI analysis of 2012–2013 Medicare claims data, the unadjusted unplanned 30-day mean readmission rate among LTCHs with at least 25 index stays was 24.3% whereas the comparable rate for inpatient rehabilitation facilities was 12.4%. While focusing on PPHRs may close some of this gap, patients admitted to LTCHs may be more susceptible to some of the PPHRs than other patients. b. The PPHR measures require a short-term acute-care stay within 30 days prior to a PAC admission (#5 on pg. 9). This requirement would mostly exclude patients discharged from LTCHs to less intensive care settings in calculating the readmission rates of those less intensive care settings. For example, if a patient is discharged from a short term acute care (STCH) to a LTCH and spends more than 30 days in the LTCH before being discharged to a skilled nursing facility (SNF) (STCH-7LTCH (more than 30 days)-7SNF), that patient would not be included in calculating readmission rates for that SNF. Patients who transition from more intensive care settings (such as LTCHs) to less intensive care settings (such as SNFs and HHA) are likely to have higher observed and unobserved severity relative to those who transition from acute care stay to the less intensive PAC setting directly or within a 30-day period. Therefore, this requirement would cause the PPRH measure for the less intensive care settings to be based on a limited and less severe portion of their broader population, potentially exacerbating the differences in patient acuity across PAC settings described in point (a). We recommend that this requirement is changed so that episodes in which a patient moves through the continuum of care following discharge from an acute care hospital are not systematically			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		excluded from the measure sample. This could be done looking back at contiguous inpatient stays prior to admission to the PAC admission (pre-PAC episode). Any admission to a short-term acute care hospital within that pre-PAC episode would serve as the anchor stay. These cases would be included in the measure even if the STCH stay occurred more than 30-days prior to admission to the PAC. This revised requirement would ensure that the PPHR measures are based on a patient population that has experienced a STCH stay without selecting a less severe portion of the population for the measure computation. c. In defining potentially preventable hospital readmissions (PPR), the draft measure specifications do not distinguish across PAC settings. The draft measure specifications cite studies on PPRs from SNFs and inpatient rehabilitation facilities, but do not cite any studies on PPRs for LTCHs. It would be important to include PPRs that have been identified for the LTCH setting and using PPRs that are specific to each PAC setting in constructing the measure. <u>Concerns Regarding Risk Adjustment</u> In comparing between LTCH facilities, we are concerned that the risk adjustment variables will not adequately capture patient differences and may lead to different likelihoods of readmission. Without sufficient risk adjustment, differences in readmission rates may be due to differences in patients' clinical characteristics and may not be attributed to differences in care quality across providers. a. The risk adjustment variables include the principal diagnosis only for the prior short-term claim. However, the principal diagnosis for the LTCH stay may differ substantially from the principal diagnosis associated with the prior STCH stay. For example, while the primary diagnosis for the prior STCH stay may be a certain type of surgery, the reason for the LTCH stay may be an infected wound, pressure ulcer or other type of complication associated with the surgery. We recommend that the risk adjustment variables for the LTCH PPHR measure include principal diagnosis associated with the LTCH stay.			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		b. We are pleased to see the inclusion of days in prior acute intensive care unit/cardiac care unit (ICU/CCU) as a risk adjustor. In a previous study, it was found that LTCH care is associated with lower mortality and/or payments for patients with at least 3 days in the ICU/CCU.[3] The same study also showed that LTCH care is also associated with lower mortality and/or payments for patients with multiple organ failure in four of the five major diagnostic categories studied. We recommend that an indicator for having at least two organ failures be included in the risk adjustment variables. [1]Koenig et al. The Effects of Long-term Care Hospitals on Outcomes, Utilization and Payments for Medicare Beneficiaries. November 7, 2013. Final Report prepared for the National Association of Long Term Hospitals. [2]Lane Koenig, Berna Demiralp, Josh Saavoss, and Qian Zhang, "The Role of Long-term Acute Care Hospitals in Treating the Critically Ill and Medically Complex: An Analysis of Nonventilator Patients," *Medical Care* 53(7) (July 2015): 585. [3]Lane Koenig, Berna Demiralp, Josh Saavoss, and Qian Zhang, "The Role of Long-term Acute Care Hospitals in Treating the Critically Ill and Medically Complex: An Analysis of Nonventilator Patients," *Medical Care* 53(7) (July 2015): 587.			
22	11/15/2015	• Development of a Discharge to Community Quality Measure for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs) • Development of Potentially Preventable Readmission Measures for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs) In reference to the above two initiatives, I feel that what is lacking in both two referenced and many of the other initiatives is a lack of the development of Project Management educational design for mid-level positions that would not necessarily require nursing degrees.	Susan Buckley	strategicdesign@hotmail.com	Individual

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		This would free up nurses for more medical, technical and clinical work as opposed to the more simple aspects of following a patient's course through various levels of continuous care and intervention. Job boards are filled with open positions for nurses to address these positions, with the addition of various clinical duties. In my view, the assignment of a " patient project manager" i.e., "Patient Advocate" "Community Health Coordinator" or service coordinator could and would support the patient; the initial period of transition often requires numerous phone calls, contacts and various initiatives to put in place a care network. The Hospital to Home initiative is an excellent example; if it were to be expanded and developed to support continuity of care as above, as administrative positions, it could fulfill discharge to community, and other initiatives, and act as an employment incubator for potential industry employment, and training for more skilled positions. There is high demand for skilled and educated employees, but not as much opportunity for those entering the healthcare professions. The position I envision could be filled by people with diverse backgrounds, talents and skill sets, as well as those with medical and clinical training. They could do "leg work": contacts, service implementation: they could check off the list of imperatives needed to be sure that patient is getting what they need before and after discharge. Utilizing community assets, especially those in high unemployment and low income areas could be addressed through funding and development of specific training initiatives. Training that can fulfill many needs in a community, enhancing both individual and population health. The home health aide pilot training program that have been carried out in various states is another excellent example of targeted employment and educational design to meet community needs. And this kind of initiative does speak to both cost cutting and resource utilization.			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		In today's environment and climate, many aging people need advocacy to assist them with navigating the continuously more complex health care environment. In short they need "somebody" but not necessarily a clinical or medical person, or even a social worker, and families are likewise overwhelmed with assuming care for post acute patients. Through embracing the Affordable Care Act and IMPACT Act mandates, we ask the people of the Health Care Industry to improve performance, control and exceed expectation of outcomes, expand objectives, and cut costs. Not unreasonable goals, considering the billions of dollars of costs attributed to health care. In the pursuit of these lofty goals, I think it is important to address the simplest methods of fulfilling our objectives, and to integrate them into the wellbeing of the patient. Anxiety is one of the greatest burdens of ill health, injury or age. Anxiety is alleviated by support, interaction and communication. If by creating simple care coordination- management positions, we create not just care quality continuity, but community health improvement as well as community life improvement, are we not acting in the spirit of the Act that we are responding to?			
23	11/16/2015	Thank you for the opportunity to submit comments on the development of a post-acute care Potentially Preventable Hospital Readmission measure. The Association for Home & Hospice Care of North Carolina and the South Carolina Home Care & Hospice Association offer the following comments on behalf of our home health agencies. Our home health agencies have long strived to keep patients independent at home and prevent costly, unnecessary hospitalizations. We support the goal of the IMPACT act to align quality measures across post-acute providers and to promote patient-centeredness in quality efforts. We support the designation of a single hospital admission/readmission measure as the target for home health agencies that would be available on their CASPER reports, publically reported on Home Health Compare, and considered for Medicare value-based purchasing initiatives. The availability of multiple quality measures derived from OASIS and Medicare	Heather P. Jones, MPH CHES COS-C, Associate Vice President of Quality Initiatives & State Relations, SC Association for Home & Hospice Care of North Carolina/ South Carolina Home Care & Hospice Association	heatherjones@homeandhospicecare.org	Home health association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		claims is confusing for agencies as the calculations of these measures are complex and it is time consuming for agencies to understand and to be able to educate their staff and referral sources on them. We support appropriate risk-adjustment of this quality measure to take into account the unique characteristics of the agency's patient population. We support the inclusion prior emergency department use in the calculation specifically for home health agencies as we believe that it is an appropriate indication of patient stability. We support the further study of risk adjusters specifically dual eligibility as we believe that it is a good proxy for other social demographic determinants. We support the inclusion of this measure in the CASPER reports to provide agencies with data on their performance.			
24	11/16/2015	I am writing on behalf of the Pennsylvania Homecare Association's home health member agencies to submit feedback and questions on the draft measure specifications for potentially preventable readmissions (PPR) being developed by RTI International and Abt Associates (hereinafter "the contractors"). The standardization of data across post-acute care settings required by the Improving Post-Acute Care Transformation Act of 2014 (IMPACT Act) will enable consumers to make more informed choices when it comes to post-acute care. Our members look forward to the ability to better understand the value of their care and make meaningful comparisons between these settings. Below is a summary of the feedback our home health agencies (HHAs) have to offer on the draft. <u>Focus on Admissions from Hospital</u> PHA appreciates the proposed list of broad exclusions that will allow the PPR scores to narrow the focus on home health patients admitted directly following an acute care stay. These patients are more likely than those admitted from the community to benefit from home health care, regain independence in the community, and avoid rehospitalizations. Our members have found that patients admitted from the community rather than an inpatient acute setting are more likely to have unmanaged chronic conditions and healthcare needs that are complicated by other economic or social factors. Most importantly, the exclusions help the PPR measure	Janel Gleeson, Esq., Public Policy Director Pennsylvania Homecare Association	JGleeson@pahomecare.org	Home health association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		tell a true story of the HHA's ability to rehabilitate patients and get them back on their feet and healthy in their homes. <u>Proposed List of Diagnoses</u> Home health providers are well known for their ability to help the patient learn to manage his or her chronic conditions and avoid hospitalizations. Take for example CMS' recent Independence at Home demonstration, which was found to save the Medicare program more than $25 million in its first year. Patients in the demonstration received individualized home health care to manage chronic conditions and prevent avoidable and costly hospitalizations, saving on average $3,070 per participating beneficiary. Our members are confident that they will perform well in the PPR measure when it comes to conditions like congestive heart failure, COPD and asthma that can be controlled by the patient after discharge with adequate instruction and management tools provided during the home health episode. On the other hand, our members are concerned that many conditions on the list of potentially preventable diagnoses (influenza, dehydration, urinary tract infection) place unreasonable expectations on the agency's ability to control the patient's actions and choices after discharge. An individual can catch the flu by chance, having nothing to do with proper discharge planning or care instructions. Similarly, discharged patients can easily become dehydrated based on their diet choices in the month following home health care. While the HHA can teach the patient how to avoid these illnesses and disease complications, there is no control over his or her actions post-discharge when it comes to communicable diseases or dietary choices. <u>Adverse Drug Events</u> Another concern from the list of potentially preventable hospital readmissions in Appendix A of the draft is the inclusion of adverse drug events. PHA urges the contractors to modify this diagnosis to include only adverse events tied to medications that the patient was using at the time of discharge from the post-acute provider. One can easily imagine a scenario in which the HHA discharges the patient, the patient sees his community physician two weeks later for a follow up and is prescribed a new medication. Without proper instructions from the community physician, the individual could end up in the hospital within the 30-day window through no fault of the HHA. Our members strive to educate patients and families upon discharge about proper dosage and side			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		effects. In fact, Pennsylvania agencies score better than the national average when it comes to improving patients' ability to correctly administer their own medications (54.3% in PA, 53.2% nationally), but we can only control education on the list of medications before us at that time. It would be unreasonable to hold the agency responsible for drug interactions involving a drug the patient was prescribed after discharge. Suggested Amendments to the Draft PHA suggests the following amendments to the draft: 1. **Add to the list of exclusions for the HHA measure any patient that was admitted to the hospital for a diagnosis that was not the principal diagnosis of the preceding home health episode.** This would ensure that the HHA was aware of the condition and responsible for providing the patient with treatment, education and follow up tools, and so poor PPR performance would be a direct reflection of the HHA's care. **Add to the list of exclusions any patient that was connected to telemedicine tools by the HHA prior to discharge.** If a patient is offered telemedicine devices by the HHA which were installed in the home and connected to the community physician for monitoring and compliance, the HHA should not be held accountable for later readmissions tied to the condition the tools are meant to address. Questions for Clarification The contractors left two key questions unanswered in the draft. We encourage them to issue a clarification for comment prior to finalizing the measures. 1. **What information will be used to determine the readmissions at the "average" home health agency?** The measure is calculated using as the denominator the patient's expected trajectory after discharge from the average HHA, but the draft does not offer details on how the average agency will be selected. One assumption is that the average will be calculated based on the previous three years of claims data. PHA asks the contractors to please clarify.			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		Which date will be used to determine the patient's discharge from home health? PHA appreciates the contractors minimizing the administrative burden on providers by utilizing data that is already submitted in the usual course of business. The draft points to Medicare inpatient claims as the source of data for calculating the post-acute care measures, however it is unclear where the date of discharge will originate. The hospital record might not show an accurate date of discharge from home health, given that transfers directly to the hospital will be excluded from the measure. The HHA's final claim to Medicare will show the date of the last skilled visit for that patient, but that might not coincide with the actual discharge from care. Will this data follow the patient's Medicare identification number?			
25	11/16/2015	On behalf of the Rehabilitation Institute of Chicago ("RIC"), we appreciate the opportunity to comment on the project titled "Development of Potentially Preventable Readmission Measures for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs)." We appreciate your attention to our comments, questions and recommendations. RIC operates a research-based health care system specializing in providing comprehensive rehabilitation services to the physically disabled through an array of diagnostic and therapeutic services. Its mission is rooted in its dedication to providing the highest quality patient care and outcomes through integrated research, scientific discovery, and education. As part of this system of care, RIC currently operates a 182-bed licensed IRF hospital and provides a wide scope of outpatient services from its primary location at 345 E. Superior Street in Chicago, Illinois as well as multiple additional locations through wholly-owned or other alliance structures with other hospital systems throughout Illinois and in northwest Indiana. Over the years, RIC has earned an international reputation for excellence in patient care, medical research, and professional training. In 2015, for the twenty-fifth year in a row, RIC was ranked by U.S. News & World Report as the leading rehabilitation hospital in the United States. In fact, RIC is the only hospital in the country of any kind that has earned this	Sangeeta Patel, MD MPH/Peggy Kirk, Senior Vice President, Chief Clinical Operating Officer Rehabilitation Institute of Chicago	spatel@ric.org	Inpatient rehabilitation facility

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		ranking for twenty-five consecutive years. RIC serves patients from around the globe; during the past year, approximately 60,000 patients from all fifty states and nearly forty-five countries received care from RIC. RIC is also the Northwestern Feinberg School of Medicine's Department of Physical Medicine and Rehabilitation physiatry residency program, which is one of the largest and most sought after programs of its kind in the country. RIC has eight federally designated research programs, including designations as: a Rehabilitation Research & Training Center; a National Center for Medical Rehabilitation Research; the Midwest Regional Spinal Cord Injury Care System; a Rehabilitation Engineering Research Center dedicated to stroke research; the nation's only Outcomes Rehabilitation Research & Training Center; a Rehabilitation Engineering Research Center for technologies for children with orthopedic disabilities; a Rehabilitation Engineering Research Center for manipulation and mobility technologies; and a Rehabilitation Engineering Research Center for computers and robots in therapy. The Center for Medicare and Medicaid Services (CMS) has requested public comment on the development of a cross-setting Post Acute Care (PAC) measure for potentially preventable readmission measures. In these comments, RIC responds to the two measures for IRFs: the Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facilities (referred to below as the "IRF post-discharge measure") and the Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facilities (referred to below as the "IRF within-stay measure"). Page number citations are to the document titled Draft Measure Specifications: Potentially Preventable Hospital Readmission Measures for Post-Acute Care ("Draft Measure Specifications")[1]. [1] Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Draft-Specifications-for-the-Discharge-to-Community-Quality-Measure-for-Skilled-Nursing-Facilities-SNFs-Inpatient-Rehabilitation-Facilities-IRFs-Long-Term-Care-Hospitals-LTCHs-and-Home-Health-Agencies-HHAs.pdf (accessed November 12, 2015) [Note: this link is no longer active].			

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		1. ***Certain Conditions Identified as Preventable*** Some of the diagnoses that the Draft Measure Specification identifies as preventable are not preventable for certain patients. Examples include: • *Urinary tract infections and kidney infections*. Patients with neurogenic bladders should be excluded if re-admitted for these infections. Patients with neurogenic bladders require catheters whether indwelling or intermittent which leaves them at high risk for infection. There have been well documented instances where the rush to remove catheters to prevent infections has resulted in dire consequences for this population. • *Arrhythmias*. Patients who do not have this diagnosis at admission to the IRF but subsequently develop it during admission should be excluded from the measures. The Draft Measure Specification states this diagnosis is included as a result of "inadequate management of other unplanned events." (Page 29.) However, arrhythmias may occur de novo, and some patients may be at high risk for developing them irrespective of their acute or PAC care. • *Pressure ulcers*. Certain patients have pressure ulcers that are unstageable, or take medications that inhibit wound healing such as chemotherapy or steroids. Readmissions of such patients should be excluded from the measures. • *Pulmonary embolism or venous embolism*. Readmissions of patients with contraindications to prophylaxis, or of patients who develop the condition despite adequate prophylaxis, should be excluded from the measures. RIC has instituted a protocol where every patient at risk is assessed at admission to ensure that they are on anticoagulation prophylaxis unless contraindicated. Patients on anticoagulation are then carefully monitored to ensure there is an appropriate therapeutic response. We investigate every patient who develops a DVT and PE while in our care and have found that 100% of the patients who developed them were either on appropriate anticoagulation or were unable to be due to a documented contraindication.			

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		2. ***Cancer Exclusions*** For the post-discharge measure and the IRF within-stay measure, the denominator excludes IRF Medicare patients with fee for service (FFS) coverage for whom the prior short-term acute-care stay was for nonsurgical treatment of cancer. RIC has the following comments relating to this exclusion: • The IRF within-stay measure would exclude those patients whose prior short-term acute-care stay was for nonsurgical treatment of cancer. (Page 9.) We believe this exclusion should be expanded to include patients whose prior short-term acute care stay was for any treatment of cancer (surgical or nonsurgical). While we agree the treatment of cancer is a major contributing factor for non-preventable unplanned readmission to the acute care hospital, so is the very course of the disease. Additionally, it is not unusual for a patient with cancer following surgical intervention to be admitted to an IRF and then begin medical treatment (radiation, chemotherapy) at some point during their stay. As the proposal is currently written, non-preventable readmissions to acute care would appear to be included, since it is the only treatment during acute care that provides for the exclusion. • The Draft Measure Specifications states that "patients for whom the prior short-term acute–care stay was for nonsurgical treatment of cancer are excluded because these patients were identified as following a very different trajectory after discharge, with a particularly high mortality rate." Based on this premise, CMS may wish to consider excluding other conditions with similar trajectories. In RIC's experience, those conditions may include end-stage multiple sclerosis, motor neuron disease (i.e., ALS), and Alzheimer's dementia. 3. ***Chronic Conditions*** The IRF post-discharge measure would penalize IRFs for readmissions for chronic conditions that are preventable primarily based on outpatient medical management. These conditions include asthma, chronic obstructive pulmonary disease, congestive heart failure, arrhythmia, and acute renal failure (not related to dehydration). Patients with these conditions who are admitted to an IRF are not admitted for these conditions.			

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		CMS should think carefully about imposing a new requirement on IRF providers that would negatively impact such providers because of re-admissions of chronic conditions. Penalizing IRF providers for chronic condition readmissions will effectively penalize IRF providers for not providing a type of care that they are not expected to provide. IRF providers who develop programs to help reduce chronic condition re-admissions will likely be duplicating efforts by acute care facilities and general practitioners, among others, to reduce such re-admissions. RIC supports the goal of reducing re-admissions due to chronic conditions, but questions whether IRF providers are best positioned to be responsible for achieving that goal. 4. ***Risk Adjustment*** RIC agrees that the proposed potentially preventable readmission (PPR) measures should be risk-adjusted. RIC has the following comments relating to the proposed risk factors: • One risk adjustment variable is described as "Comorbidities from secondary diagnoses on the prior short-term claim and diagnoses from earlier short-term stays up to one year before PAC admission (these are clustered using the Hierarchical Condition Categories [HCC] groups used by CMS." (Page 13.) This description is confusing and requires further clarification, particularly with respect to the use of HCC groups. • More specificity is needed about how co-morbidities are taken into account for purposes of risk-adjustment. Additionally, tier 1, 2, and 3 co-morbidities, as well as patient use of ventilator, should be included as co-morbidity factors. • For the post-discharge measure and the IRF within-stay measure, the Draft Measure Specification provides an IRF PAC-specific risk adjustor that is described as "[a]ggregates of the IRF Case-Mix Groups (CMGs) for IRF patients." (Page 14.) RIC does not believe it is appropriate to aggregate IRF case mix groups, as there are many differences across CMG groups for some categories. Additionally, some IRFs treat a more fragile patient population than other IRFs, and therefore the CMG should be risk adjusted on a per-IRF basis than across all IRFs.			

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		• The methodology used for risk-adjustment is difficult to meaningfully replicate. For example, the risk adjusted weights, as well as the PAC variance component, and the other elements of the proposed measure are not explicitly identified. RIC requests that CMS be fully transparent in its methodology, so that RIC and other providers may fully understand the methodology and provide appropriate comments in response. • The Draft Measure Specifications explains that CMS plans to test dual eligibility and race as risk adjusters for sociodemographic status. (Page 14.) RIC supports including these factors in the risk-adjustment analysis. The Draft Measure Specification also notes that additional variables may be tested. CMS may also wish to consider including a caregiver/social support factor. • RIC respectfully requests that CMS make its test results and regular updates regarding risk adjusters available on its website. 5. ***Other comments on the IRF within-stay measure*** • For the IRF within-stay measure, the Draft Measure Specifications sets the within-stay observation window from admission through the day of IRF discharge and the day after. (Page 10.) While CMS mandates a preadmission screen, the focus of the screen is whether or not the patient needs the intensive rehabilitation care provided in an IRF. While performing this screen, PM&R physicians attempt to assess the medical "readiness" of the patient. However, PM&R physicians generally and appropriately rely on the acute care specialist to determine when the patient is medically stable enough. On rare occasions, a patient will be admitted to the IRF and found to have an undiagnosed condition or unexpected medical event necessitating a readmission. This is not related to the care provided in the IRF. RIC suggests revising the within-stay observation window to start two days after admission, as re-admissions to acute care during this initial PAC period are often related to actions by the acute care facility, such as missing a diagnosis or inadequately treating a patient.			

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		• The Draft Measure Specifications explains that the IRF within-stay measure was based on pooling two consecutive calendar years of data, from 2012 and 2013, due to small sample sizes. (Page 16.) It is not clear whether CMS will report IRF outcome measures using two consecutive calendar years or one calendar year. We understand that small sample sizes may necessitate using two years of data to report measures. While this helps overcome the sample size barriers, it makes results less actionable and improvement interventions that are conducted within a year less visible.			
26	11/16/2015	Kindred is pleased to have the opportunity to comment on the proposed set of quality measures related to potentially preventable readmissions for skilled nursing facilities, inpatient rehabilitation facilities, long-term acute care hospitals and home health agencies. Kindred Healthcare is the leading provider of post-acute care services, to patients in 2,723 hospitals and post-acute care settings in 47 states. We are focused on delivering post-acute care throughout the full continuum of care, including 95 long-term acute care hospitals, 90 nursing and rehabilitation centers, 18 inpatient rehabilitation hospitals, 101 hospital-based acute rehabilitation units, 626 Kindred at Home home health, hospice and non-medical home care sites of service, and with RehabCare as a trusted contract partner in 1,773 unaffiliated sites of service. With the aging population and rapid increase in the number of chronically ill and medically complex people, Kindred Healthcare understands the importance of appropriately managing patients with multiple chronic conditions and end of life care. In order to support recovery and wellness for our patients, Kindred has developed the clinical expertise and capabilities across the continuum of care to deliver the right care in the right setting over an entire episode. Our priority is to provide the care interventions and services that allow individuals to stay in the comfort of their home or community—and avoid a costly hospital stay or emergency room visit. Kindred Healthcare supports the development of measures to promote the delivery of high quality care to patients, and appreciates the interest in measures of utilization that are a proxy or marker of quality in health care delivery. This is consistent with Kindred's endorsement of the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of*	Marc Rothman, MD, Chief Medical Officer Kindred Healthcare	marc.rothman@kindred.com	Inpatient rehabilitation facility

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		2014, which served as an important foundation to pursuing step-wise reforms necessary for value-based post-acute care reforms. In this letter, Kindred Healthcare highlights the following comments and concerns on the potentially preventable readmission measures for post-acute care laid out within the IMPACT Act. **Concern with Using the "Predicted Actual."** The numerator definition and methodology of calculating a "predicted actual" lacks transparency, makes the data unactionable and is of questionable benefit. Kindred Healthcare recommends CMS use the actual rate divided by the expected rate to calculate the readmissions rate. **Concern with Source for List of Potentially Preventable Conditions.** The measure specifications acknowledge that the evidence specific to post-acute care potentially preventable readmissions is limited (see p. 5 of the measure specifications document). The diagnosis codes identified as potentially preventable are based on the ambulatory care sensitive conditions that the Agency for Healthcare Research and Quality (AHRQ) has developed. AHRQ's list identifies conditions for which hospitalizations should be preventable if such conditions are well managed in ambulatory care settings. The list is not specifically targeted at conditions for which readmissions from post-acute care should be preventable. Likewise, the most widely validated research on preventing hospital admissions among nursing home residents is targeted at long-stay custodial residents, not the short-stay post-discharge population who frequently move between multiple post-acute care settings. We are concerned that there is little evidence regarding the ability to prevent a subsequent post-acute care readmission for the ambulatory care sensitive conditions that are the basis of the list of diagnosis codes in the measure specifications. Kindred Healthcare recommends closer analysis of the evidence base for this measure and that modifications be made accordingly. **Insufficient Risk Adjustment.** CMS should consider including both Functional status and post-acute utilization in the risk adjustment methodology. Risk adjustment does not include functional status, one of the strongest predictors of hospitalization, and is not currently included in the risk adjustment model as described. In addition, the IMPACT Act specifically calls for functional status assessment and reporting as part of the standardized post-acute care processes, and it is a central focus of the CARE tool. Patients that require care in more than one post-acute care setting undergo multiple transitions across sites of service and likely have			

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		more complex medical needs, increasing their risk of rehospitalization. The measure as described in the specifications would not distinguish among patients that have been to one or more post-acute care settings. Kindred Healthcare recommends adding both Functional status and post-acute care utilization in the risk adjustment for the measure. **Too Many Duplicative Readmissions Measures.** If finalized, the potentially preventable readmission measure will be the third measure for home health care that involves readmissions. There is already a measure for acute care hospitalization (during the home health episode), as well as a measure for readmissions from home health care within 30 days of discharge from the acute care hospital. There is overlap among these multiple measures that each capture readmissions. Kindred Healthcare recommends that CMS provide context for how it anticipates using or applying each measure. Increasingly, there are different applications for measures and it is unclear as yet how CMS plans to use each one.			
27	11/16/2015	The American Association for Homecare (AAHomecare) is pleased to have the opportunity to submit comments on the proposed measure specifications for potentially preventable hospital readmissions for post-acute-care. The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop the measures, in alignment with the Improving Post-Acute Care Transformation Act of 2014 (known as the IMPACT Act) and the Protecting Access to Medicare Act of 2014 (PAMA). Identifying and implementing measures such as these is an important undertaking that will assure the Medicare program transitions seamlessly to providing modern, comprehensive and quality post post-acute care for the next generation of Medicare beneficiaries. AAHomecare is the national association representing the interests of suppliers, manufacturers and distributors of durable medical equipment (DME), prosthetics, orthotics and supplies (collectively, DMEPOS). Our members manufacture and furnish technologies that allow Medicare beneficiaries to safely move from institutional care to their homes. Any set of measure designed to understand factors that might result in, or potentially prevent, hospital readmissions under any circumstance is incomplete unless they also examine the availability and proper utilization of home medical technologies.	Kimberly S. Brummett, MBA, VP for Regulatory Affairs American Association for Homecare	kimb@aahomecare.org	Medical equipment supplier association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		A. To prevent post-acute hospital readmissions, Medicare must examine the entire continuum of care. Access to appropriate post discharge DMEPOS technologies and services helps to reduce unnecessary hospital readmissions. Beneficiaries with chronic conditions receive their care under separate benefit buckets that make it difficult to see when care is excessive, inadequate or merely substandard. Recent Medicare "innovation" initiatives, including this project, are an attempt to overcome these hurdles. But as far as we can see, not one of these initiatives examines the entire continuum of care and whether a beneficiary's ability to consistently access timely, comprehensive, quality DMEPOS technologies post-discharge reduces or prevents post-acute hospital readmissions. We suggest that it is not possible to "manage" a chronic condition, especially one like COPD, which is among those identified in the report, after an individual has been discharged from an acute or post-acute stay. Post-acute facilities have limited ability to manage or influence the care that beneficiaries with chronic conditions receive post-discharge. Those who have the most ability to impact utilization are the patient and chronic care providers and suppliers, overseen by the beneficiary's physician. It makes no sense to penalize the post-acute provider without first making a concerted effort to understand the role that DMEPOS technologies have in reducing or preventing hospital readmissions. In addition to understanding how access to DMEPOS technologies reduce hospital readmissions post-acute-care, an effective strategy would be to focus on engaging beneficiaries and providing them with the proper chronic care infrastructure, including access to appropriate DMEPOS and physician services. **B. The availability of DMEPOS technologies and services post-discharge is an important marker for potentially preventing hospital readmissions for beneficiaries with chronic conditions.** For the most part, the diagnoses included in the tool are too broad to serve as meaningful measures, and we recommend you consider refining them. But in keeping with our comments above, we offer some pertinent observations. Beneficiaries who receive DMEPOS post-discharge often have a home assessment at the time the supplier delivers the DMEPOS. Measures that examine post discharge injury prevention are not useful on			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		their own, because as we have noted, the post-acute provider cannot manage a chronic condition after the beneficiary's discharge. A comprehensive analysis of the sort we described above would identify fall hazards in the home as potentially preventable hospital readmission measures and consider whether a beneficiary has access to a home assessment post-discharge. Approximately 50% of Medicare beneficiaries are discharged to home health agencies and therefore receive a home assessment. The remaining 50% have no resources can be evaluated under this model. DMEPOS suppliers are often in the beneficiary's home even when home health is not prescribed and could offer an opportunity for additional oversight on issues within the home. Other potentially preventable fall measures include the availability of, and training on the use of, walking aids, for example. Effective fall prevention tools like grab bars for bathrooms are not covered by Medicare, but may be covered by state Medicaid programs or should be considered for coverage under Medicare. Including greater specificity in your measurements to capture the beneficiary's access to chronic care support like DMEPOS and physician services provides a true picture of what drives hospital utilization post discharge from post-acute-care. The diagnosis codes listed for COPD and CHF are, again, too broad to be truly useful as stand-alone measures. But home medical technologies for these chronic conditions are very important in reducing hospital readmissions for beneficiaries with these conditions. Accessibility to these technologies post discharge would serve as a potentially preventable hospital readmission measure. Appropriate access includes the involvement of the patient's physician, the appropriate diagnostic tests, and assessments and follow-up by the homecare provider. All of this requires coordination or resources while the beneficiary is in the post-acute facility and by his or her chronic care team, the physician and DMEPOS supplier, post discharge. Any tool measuring drivers for unnecessary hospital readmissions should examine the difficulty in qualifying beneficiaries for DMEPOS technology based on confusing and nebulous coverage policies. Meeting these requirements makes it very difficult for discharge planners to obtain medically necessary DMEPOS for their patients and for DMEPOS suppliers to actually furnish the equipment patients need. Access is impeded by overly complex qualification criteria.			

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		Whether appropriate access is available necessarily includes an assessment of whether individuals fail to qualify because of burdensome or technical flaws in the qualification process. And because CMS views the DMEPOS industry as suppliers of commodities, not clinical care, the on-going care beneficiaries receive post discharge is compromised by the lack of reimbursement for respiratory therapists, dieticians and other key players in assessing and monitoring beneficiaries in their homes. **C. DMEPOS technologies are essential to managing beneficiaries with chronic conditions and reducing the number of all hospital readmissions.** In summary, it is impossible to overstate the importance of furnishing beneficiaries who have chronic condition with the appropriate equipment and services to manage their condition post discharged from post-acute-care. Numerous recent studies show that homecare technologies are effective for managing the health needs of the chronically ill while reducing the costs associated with inpatient care.1 The product innovations brought about by DME manufacturers, and the care and oversight furnished by suppliers to beneficiaries in their homes allow Medicare to harness technology that ensures beneficiaries receive effective care quickly and safely without incurring expensive hospital readmissions. Again, AAHomecare believes the proposed measures are incomplete because they do not account for DMEPOS technologies' role in reducing post-acute-care hospital readmissions. We recommend that you consider expanding the focus of the measures as we suggest above.			
28	11/16/2015	This is in response to the CMS call for public comment on the Development of Potentially Preventable Hospital Readmission Measures for Post-Acute Care. The call for public comment period was open from November 2nd closing on November 16th; but the notice wasn't sent out until November 4th. While we would have liked to review these measures and provided comments, a little over one week in business days is far too short a time period in which to complete this process. This is one of several calls for public comment that have come out in rapid succession with extremely short response periods. In order to solicit thoughtful responses from the public on these important issues, a more reasonable comment period is required.	Arnold E. Clayman, PD FASCP, VP of Pharmacy Practice & Government Affairs American Society of Consultant Pharmacists	aclayman@ascp.com	Pharmacist association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
29	11/16/2015	Thanks very much for your quick responses. We do intend to respond in the near future, but it will not be today. I will try to facilitate our response as soon as possible. One question we had was: Does a diagnosis identified upon hospital readmission (e.g., from a SNF) have to match a diagnosis received at the SNF? (e.g., if a resident was admitted to the SNF from an acute care hospital without a diagnosis of UTI, but is readmitted to an acute care hospital within 30 days for a principal diagnosis of UTI, is UTI still deemed to be potentially preventable, as part of the measure]? Another example would be hypertension- if this was listed as a diagnosis in hospital discharge records (but it was not the reason for hospital admission), and the resident is readmitted to the hospital for a hypertensive crisis, would this be considered a PPR? We raise this question to understand whether a SNF would be held accountable for a diagnosis at readmission that was not related to what the SNF resident was treated for, at a facility. Thanks in advance for your clarification!	Terry O'Shea, Pharm.D. CGP, Senior Director-Consultant Performance Omnicare, Inc.	Terry.Oshea@omnicare.com	Pharmaceutical company
30	11/16/2015	The American Academy of Physical Medicine and Rehabilitation ("AAPM&R" or "the Academy") appreciates the opportunity to submit comments to CMS on RTI's Project entitled, "*Development of Potentially Preventable Readmission Measures for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long- Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs)*" (commonly known as "post-acute care" or "PAC") and the specific document under review entitled, *"DRAFT Measure Specifications: Potentially Preventable Hospital Readmission Measures for Post-Acute Care."* AAPM&R is the national medical society representing more than 8,000 physiatrists, physicians who are specialists in the field of physical medicine and rehabilitation. Physiatrists treat adults and children with acute and chronic pain, persons who have experienced catastrophic events resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, rheumatologic conditions, musculoskeletal injuries, and individuals with neurologic disorders or any other disease process that results in impairment and/or disability.	Paul Smedberg, Director of Advocacy and Government Affairs/Thiru Annaswamy, MD, Chair, Evidence Based Practice Committee American Academy of Physical Medicine and Rehabilitation	psmedberg@aapmr.org	Inpatient rehabilitation facility association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		Physiatrists coordinate, supervise and provide medical rehabilitation services in a wide variety of settings including all of the post-acute care settings impacted by this draft set of measures. While physiatrists have had a close affiliation with Inpatient Rehabilitation Hospitals and Units for decades, physical medicine and rehabilitation (PM&R) physicians are increasingly present across the post-acute care continuum. As such, physiatrists are not aligned with any one PAC setting and, as a result, can act as an impartial medical decision-maker to help direct patients to the most appropriate setting and intensity of rehabilitative care to meet the individual medical and functional needs of patients. There may seem to be some incongruity for a physician society to comment on a set of facility-based PAC quality measures, but the fact is that physiatrists and members of the rehabilitation provider team are the professionals serving patients in these settings. While the measures themselves reflect the facilities' performance and may well lead to financial consequences for these facilities if they either achieve or fall short of these measures, it is physicians and other rehabilitation professionals who ultimately determine the outcomes for patients served in these PAC settings. AAPM&R continues to support overall measure standardization in PAC settings, but we must raise strong objections to the lack of adequate time being afforded stakeholders to offer deliberate and insightful comments. A two-week comment period for this PAC readmission measure, coupled with an overlapping comment period of two weeks for the discharge to community quality measure is simply unacceptable. These are important measures that, once established, will drive the standard of future post-acute care. Yet the measures are largely untested and dependent upon concepts and processes that are currently not attainable, such as risk adjustment. With this in mind, we offer a series of specific comments and questions for consideration by CMS and its contractors, RTI, International and Abt Associates. 1. Selection of Measure Sets The work being performed under this project derives from implementation of two federal laws, the Improving Post-Acute Care Transformation Act of 2014 (IMPACT Act) and the Protecting Access to Medicare Act of 2014 (PAMA). The six measures under consideration include four measures that assess potentially-preventable readmissions			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		("PPRs") within a 30-day window following discharge in each PAC setting (LTCH, IRF, SNF and HHA), one measure that assesses potentially-preventable readmissions in SNFs for 30 days post discharge from an acute care hospital, and the final measure which assesses potentially-preventable readmissions during the IRF stay itself. Academy Comments: Assessing PPRs for 30 days post discharge from four separate settings of PAC will enable CMS to assess and compare rates of readmission between PAC settings, thereby identifying which types of providers are more apt to contribute to the wasteful spending that derives from a truly unnecessary hospital readmission. Therefore, the Academy supports separate measures in each of these settings. However, at some point in the future, as the silos of PAC settings begin to break down—apparently by design—a uniform measure that assesses PPR post-discharge from the acute care hospital (regardless of which PAC setting the patient is referred to) may become more relevant. In addition, there is a separate measure for IRF patients during their rehabilitation stay and the document suggests that this measure is being developed for use in the IRF Quality Reporting Program (QRP). We question why CMS has not included a similar measure for Long-Term Acute Care Hospitals and believe that such a measure would be just as valuable as the "within stay" measure being applied to IRFs. Finally, the SNF-related measure does not align with the other measures in that the window for observation is 30-days post discharge from the acute care hospital, not within the PAC stay or following the PAC stay. This non-alignment makes the two measures applicable to SNFs out of sync and could lead to confusion and lack of clarify in terms of the PPR data. 1. PAC Post-Discharge Measure Exclusions The document details a significant list of exclusions from the PAC post-discharge measure sets. These exclusions exist to ensure the data collected under the measure are not skewed by factors that do not accurately reflect PPRs. For instance, the document states that patients who die in PAC settings will be excluded because the measures are not relevant for these patients. In addition, juveniles, individuals who are discharged against medical advice, and patients who are not consistently enrolled in Medicare Part A are all excluded from the measure, as well as other individuals for other reasons.			

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		Academy Comments: These exclusions are important to ensure accurate measurement of hospital readmissions that are truly potentially preventable. The Academy supports these exclusions from the post-discharge measures. 2. Risk Adjustment Variables The document details a set of risk adjustment variables that are designed to normalize data on PPR by factoring into the equation the relative degree of medical acuity of patients being treated in various PAC settings. It is completely understandable that an LTCH patient on a ventilator has a higher risk of readmission to an acute care hospital than does a knee replacement patient receiving home health care. The risk adjustment methodology is an attempt to equalize those variables to more accurately measure PPRs across various levels of intensity of PAC settings. Academy Comments: Risk adjustment is critical to ensure that PAC settings that typically treat patients with comorbidities and complex conditions are not penalized for admitting such patients, even if their conditions worsen and they are readmitted to the acute care hospital. If risk adjusters are not sufficiently accurate and robust to counteract this strong incentive to avoid difficult or challenging patients, then the most vulnerable Medicare beneficiaries will be at greater risk of underservice than under the current Medicare payment systems. Achieving low readmission rates is far easier when PAC providers "cherry pick" Medicare patients. The Academy strongly supports robust risk adjusters to ensure that this PPR-based design to improve quality does not result in the opposite effect on the most vulnerable Medicare beneficiaries. A major failing of this aspect of this quality measure is that it assumes that risk adjustment is well developed and accurate, when, in fact, most risk adjustment methodologies in post-acute care are nascent and still quite rudimentary in design. The Academy is concerned that this PAC quality measure relies to such a great extent on a system of risk adjustment that is still in its early phases of development. 3. Risk Adjustment for Sociodemographic Status The National Quality Forum (NQF) recently called for adjusting performance measures for sociodemographic status (SDS) when appropriate and the document subject to comment suggests that SDS is being studied by CMS and may be incorporated into PPR measures. Academy Comments: Sociodemographic factors have a huge impact on			

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		patient outcomes and care patterns post-discharge from PAC providers, especially for persons with disabilities and chronic conditions. Disability is highly correlated with both age and socioeconomic factors and these play a major role in long-term adaptation to injury, illness, and disability. The Academy strongly supports inclusion of sociodemographic factors in the risk adjustment model for PPR measures of all types. However, a process for developing and testing risk adjustment for sociodemographic status is not currently attainable. The Academy urges CMS to work with institutions like the National Quality Forum, or similar entities, to develop a sound and accurate methodology for risk adjusting for sociodemographic status. 1. Appendix A: List of Conditions for PAC Post-Discharge PPRs Appendix A of the document encompasses a long list of conditions, diagnoses, and ICD-9 codes that would be considered potentially-preventable conditions for measures that assess patients for 30 days following discharge from PAC settings. These conditions include the following: Adult asthma, COPD, congestive heart failure, Diabetes with short term complications, Hypertension and Hypotension, Influenza, Bacterial pneumonia, UTI/kidney infection, C. Diff infection, Septicemia, skin infections, dehydration, aspiration pneumonitis, acute renal failure, adverse drug events, arrhythmia, intestinal impaction, and pressure ulcers. Academy Comments: We recognize that the conditions in Appendix A derived from analysis of Medicare claims data as well as input from a Technical Expert Panel (TEP) that considered a 30-day post-PAC-discharge window for potentially-preventable hospital readmissions. However, we are deeply concerned with both the breadth of conditions subject to the PPR measure as well as the lack of recognition of the complexity of treating patients with multiple comorbidities, which make each of these conditions listed in Appendix A more difficult to manage and treat, especially once the individual is discharged from a PAC setting. Many factors contribute to the reasons why certain patients with these types of serious conditions are readmitted to the acute care hospital following treatment in a PAC setting and many of these factors are out of the control of the PAC provider during the 30-day window. In fact, many conditions, such as DVT, begin in the acute care hospital setting and are not identified and treated until the PAC stay has begun. Even conscientious and diligent PAC providers who select an optimal discharge plan of care are not immune from readmissions of some of these patients. We, therefore, strongly urge CMS to reduce the number of conditions			

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		subject to these PPR measures, or, in the alternative phase-in these conditions over a period of years so that PAC providers can further develop care systems that are capable of addressing these patients post-PAC-discharge in a more effective and efficient manner. We also urge CMS to determine an appropriate plan for correlating the identification of potentially-preventable conditions from ICD-9 codes to ICD-10 codes, as the use of ICD-9 diminishes. 2. Appendix B: List of Conditions for PPRs Within PAC Stay Appendix B details another long list of conditions, diagnoses and ICD-9 codes that apply to "within PAC stay" PPRs. The conditions include all of the same conditions that apply to the post-discharge PPR measures but also include the following: anticoagulant complications, acute delirium, deficiency and other anemia, deep vein thrombosis, pulmonary embolism, head injury, upper extremity fracture and lower extremity fractures. The vast majority of these conditions seem to relate to two different situations where patients might be left unattended or inappropriately monitored in the facility setting, thereby encountering either (1) a fall resulting in head injury or upper or lower fracture, or (2) complications due to lack of movement resulting in DVT/PE, or other anticoagulant complications. Academy Comments: Given the fact that the "within PAC stay" PPR conditions include all of the post-discharge PPR conditions and add eight additional major conditions, the Academy has serious concerns with the breadth of conditions subject to these measures. Like Appendix A, the wide scope of the conditions underscores the lack of recognition of the complexities of treating PAC patients with multiple comorbid conditions and the fact that not all hospital readmissions of patients with one or more of these conditions are indeed preventable. In fact, the very name, "*potentially*-preventable" readmissions, suggests that there will be patients in PAC settings who are ultimately readmitted with these conditions whose readmissions to the acute care hospital could not have been prevented. We question how these instances will be accounted for in the measure? With this concern in mind, the Academy does recognize why the additional eight conditions are included in the PPR measures that will be used "within PAC stay." When patients are surrounded by a care team in the PAC setting, there should be additional expectations that exceed the expectations of care provided in the home, when providers are intermittently available. The fastest growing demographic of traumatic brain injury is in individuals over age 65. Patients who fall while unmonitored for long periods of time or who develop DVT/PE			

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		complications due to lack of mobility in the PAC setting—requiring readmission to an acute care hospital—are, in fact, indicative of the quality of care being provided in that PAC setting. While the Academy does have concerns with the scope of the conditions being assessed under these PPR measures, the fact that the eight additional conditions have been included in the "within PAC stay" PPR measures is justified. The only exception is application of these eight additional conditions to the home health setting, where it seems unreasonable to hold providers accountable to the same standard when the patient is based at home versus an inpatient PAC setting. 1. Appendix C: CMS Planned Readmission Algorithm In Appendix C, CMS has developed a flow chart that explains how hospital readmissions will be determined to be either "planned" or "unplanned." Unplanned readmissions will presumably be determined to be potentially-preventable readmissions, but this is not necessarily clear from the algorithm itself. An analysis of the algorithm suggests that hospital readmissions will be considered unplanned if the readmission is not for a bone marrow, kidney, or other organ transplant, the readmission is not for maintenance chemotherapy or rehabilitation, or the readmission does not include a potentially planned procedure. The readmission will also be considered unplanned if the principal discharge diagnosis of readmission is "acute or -complication of care" following a potentially planned procedure. Academy Comments: Algorithms are intended to distill complex decision-making into a set of easy-to-follow protocols. The Academy questions the relationship between the algorithm in Appendix C and the lists of conditions in Appendix A and B. The materials supporting these appendices are not at all clear on this important concern. In fact, the algorithm seems to raise more questions than it answers. The Academy does support specific mention of rehabilitation if CMS proceeds with this algorithm. According to Appendix C, if a patient is readmitted to undergo a course of rehabilitation, the readmission will be considered "planned," and, presumably, not considered a potentially-preventable hospital readmission. The Academy strongly supports this treatment of rehabilitation in that it will ensure that the measures do not penalize PAC providers who refer patients to intensive, hospital-based rehabilitation once their underlying condition has progressed to the point where they are able to tolerate an intensive, coordinated, multidisciplinary hospital rehabilitation program.			

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31	11/16/2015	The American Geriatrics Society (AGS) appreciates the opportunity to comment on the Draft Measure Specifications for Potentially Preventable Hospital Readmission Measures for Post-Acute Care (PAC). The AGS is a not-for-profit organization comprised of nearly 6,000 professionals dedicated to improving the health, independence and quality-of-life of all older adults. We recommend the following changes: • The AGS is concerned that the four measures assessing potentially preventable readmission (PPR) within a 30-day window following discharge from a PAC facility would attribute responsibility for a readmission to the provider who discharged the patient from the facility. We believe that this may be an inaccurate assessment, especially when patients are discharged from PAC facilities on weekends or holidays and there are covering providers who are not familiar with the patients. • The AGS suggests that CMS, RTI International and Abt Associates clarify what constitutes a hospital "readmission." For example, would hospital observation status be considered a readmission? We believe that the fate of the PAC patient who is sent back to the hospital emergency department (ED) will be dependent on the ED's facilities and providers, the region of the country, time of day, hospital census, etc. These are all confounding factors that will affect a provider's and PAC's readmissions data. • AGS notes that while the measures generate provider-specific readmission data, they do not offer providers any specific actionable feedback as to how they can improve their patient PAC readmission rates. It would be helpful if CMS, RTI International and Abt Associates could provide PAC providers with data about their patients that had 30-day hospital readmissions along with suggestions as to what could have been done to prevent the readmission. • The AGS believes that the measure for 30 day readmissions from Skilled Nursing Facilities (SNFs)—"Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facilities (IMPACT)"—should distinguish between sub-acute rehab patients and residents of long-term care as these are two distinct populations with	Anna Mikhailovich, Senior Coordinator, Public Affairs and Advocacy American Geriatrics Society	AMikhailovich@americangeriatrics.org	Provider association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		different risks and risk factors for early hospital readmission. In addition, the measure should be adjusted for the 30 day readmission rate of the initial discharging acute care hospital. Some readmissions to acute care hospitals from the SNF may be in part or solely attributable to care provided by the initial discharging acute care hospital rather than the SNF. • We are also concerned about the reliability of the statistical models when applied to SNF providers with smaller numbers of beds. The overall numbers of potentially preventable readmissions (PPRs) may be very low. • The AGS supports the cautions about unintended consequences in the draft measure specifications, specifically "that PAC providers may be deterred from admitting certain patients or types of patients with higher acuity or greater complexity, as they may be more likely to have a subsequent readmission; this behavior might occur despite the risk adjustment." We note that geriatricians and medical directors in particular may find themselves with higher acuity patients in spite of risk adjustment.			
32	11/16/2015	AHCA is pleased to have the opportunity to comment on the proposed set of quality measure related to potentially preventable rehospitalization for SNF, IRF, LTCH and HH setting. The American Health Care Association (AHCA) represents more than 12,000 non-profit and proprietary skilled nursing centers and assisted living communities. Rather than having many of our individual members who have contacted us with comments and to more efficiently provide RTI with feedback we have received from our various committee members, we have summarized their comments into this one letter in the attached document. AHCA understands the statutory requirements underpinning the development of these measures, as AHCA was a strong supporter of both IMPACT Act and PAMA. However, we believe the proposed specifications do not fully meet the statutory intent for the development and use of these measures. We also believe that modifications and data testing of the proposed measures is needed before these measures are ready for	David R. Gifford, MD MPH, Sr. Director of Quality & Regulatory Affairs American Health Care Association	DGifford@ahca.org	Provider association

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		use under the IMPACT Act or PAMA. Our concerns are outlined below with further detailed descriptions and proposed next steps to follow. 1. The name of the measures should reflect the limited population to which they apply—fee-for service (FFS) Medicare beneficiaries; particularly since in many states 40% or more of Medicare beneficiaries are enrolled in MA plans and for SNFs over half of SNF admissions and discharges are not enrolled in FFS Medicare. 2. The SNFPPR double counts readmissions with the PPR PAC measure for SNF discharges. 3. The specifications are based on ICD-9 but all providers as of October 2015 are required to use ICD-10 and no cross walk with ICD-10 is provided. 4. The numerator definition and methodology of calculating a "predicted actual" is extremely confusing, which makes the data less likely to be used and is of questionable benefit. Data showing how this approach is superior to using an actual rate divided by the expected rate needs to be provided. 5. The list of potentially preventable admissions contains diagnoses that do not meet the proposed definition of potentially preventable readmissions; therefore, these should be dropped. 6. The process for developing the list of potentially preventable admissions used existing literature but would have benefited from a more formal process such as the RAND appropriateness rating system (e.g., modified Delphi approach) rather than ad hoc TEP and consultant experts. 7. Risk adjustment does not included a. SES characteristics, an issue identified in the last round of NQF readmission measure reviews as a requirement. b. Functional status, one of the strongest predictors of hospitalizations. All the PAC settings are now required to utilize standard functional status assessment—Section GG from the CARE tool.			

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		c. The risk adjustment variables are not specifically specified with respect to data source and categories but are given as examples with just a descriptor. For example is age continuous or categorical variable and if categorical how and from what source? d. Prior utilization variables indicate they "vary by measure" but how they vary by measure is not provided. 8. Exclusions are confusing and need some modifications a. The denominator exclusions appear confusing and overlapping so that it is unclear if discharges from IRF or LTCH to SNF or HH are included in the IRF and LTCH denominator. Similarly, if SNF discharges to HH are included. b. We agree that AMA discharges from PAC provider should be excluded but so should hospital discharges that are AMA but end up in PAC provider. 9. The varying windows of time to be in each PAC measures makes any comparison across settings difficult and also mutes changes in improvement or decline to a greater extent for HH with 3 year window compared to IRF & LTCH with 2 year window vs. SNF with 1 year window. 10. The list of related to other NQF endorsed measures (pg. 19) is incomplete and only compares to CMS or RTI endorsed measures. All other NQF endorsed measures should be included. 11. We agree with the expansion of unplanned readmission diagnoses from YALE's list, but will this also be applied to the SNFRM and hospital readmission measures?			

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		Minor Corrections a. TEP did not reach consensus as there was no voting by TEP (pg. 5). Also, there is no TEP report to understand what issues were controversial or did not reach consensus. b. Agree that The SNFRM was adopted in 2016 final rule for SNF VBP but it also was adapted and finalized in the 2016 SNF PPS rule for use in the SNF QRP program (pg. 2). c. The SNFRM is a cross setting measures as it captures readmissions that occur after a SNF stay but before 30 days (pg. 2). d. The PAMA Act does not require or specify that admissions after SNF stay be included in the measure (pg. 2); rather the congressional intent appears to be to link payment with SNF performance, we argue that the SNFPPR measure should only be a within stay measure. This would also align with the IRF within stay measure and be consistent with IMAPCT Act intent to compare performance between PAC providers. AHCA's detailed description and recommendations on Potentially Preventable Readmission (PPR) Measures for PAC providers. 1. The name of the measures should reflect the limited population to which they apply—fee-for service (FFS) Medicare beneficiaries. By only using Medicare Part A claims to calculate the PAC PPR measures; the measures only reflect care for FFS individuals. In many states, over 40% of Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans, and will be excluded from the measures. Also, PAC care for non-Medicare beneficiaries is increasing. Measures posted on CMS Compare websites are being used by both MA plans, hospitals and commercial insurance to make network decisions and discharge decisions. In addition, consumers who are not Medicare FFS beneficiaries are using the CMS websites to make care decisions as well. Using a quality measure based on FFS beneficiaries only as a proxy for quality of PAC providers for all other patient types makes sense, if data shows that the FFS measures produce similar results to measures with all payor populations. However, this is not the case. When SNFs are compared on the SNFRM measure (a fee-for-serve only measure) with another NQF endorsed rehospitalization all payor measure (NQF #2375), over 30% of SNFs differ in ranking by 3			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		deciles or more. Also, the rate of rehospitalization varies differ on average by an absolute 3% between the two measures. **AHCA Recommendations:** a. Change the name of the measures to reflect that they only apply to FFS and CMS should add footnote when the measures results are reported, that these measures do not reflect the rehospitalization rates of patients with other insurance besides FFS Medicare. b. Expand the SNFPPR measure to include all payors or at least MA plan beneficiaries. c. The SNFPPR double counts readmissions with the PPR PAC measure for SNF discharges. The SNFPPR measure counts readmissions that occur during a fixed window of time (30 days) after FFS patients are discharged to a SNF, regardless of the location the FFS beneficiary resides at the time of readmission. So individuals discharged from the SNF before 30 days but who are hospitalized for a PPR condition, will be counted. However, the PPR PAC measures count all PPR admissions during the 30 day window after discharge from the PAC provider. Thus, the PAC PPR and the SNFPPR measure double count individuals who are discharged from a SNF but readmitted within 30 days of the hospital discharge. Also, the SNFPPR measure is inconsistent with the other measures. The IRF within stay measure does not count readmissions after IRF discharges within 30 days. The rationale provided by CMS with the development of the SNFRM measure to include readmissions after SNF discharge was to promote collaboration between the SNFs and the other providers after discharge and improve the discharge planning process. However, now that CMS is moving to create a 30 day post PAC discharge PPR set of measures, having a hybrid measure based off of the SNFRM measure does not make sense. It also is inconsistent with the congressional intent of the SNF VBP contained in PAMA act of 2014. The SNF VBP creates a financial incentive for SNFs to reduce rehospitalizations. The statute applies to SNFs and describes SNF care but does not specify or imply a SNF VBP that also includes care after the SNF. In fact, congress later defines such in the IMPACT Act of 2014 that is the basis for the proposed PAC PPR measures.			

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		AHCA Recommendation: For the SNFPPR measure to be used in the SNF VBP, change the measure to be a within stay measure similar in construction to the IRF within stay measure. That is only count readmissions that occur during the SNF stay not those occurring after the SNF stay. The specifications are based on ICD-9 but all providers as of October 2015 are required to use ICD-10 and no cross walk with ICD-10 is provided. All of the PPR are defined by ICD-9 codes and many of the risk adjustment variables are also defined by ICD-9 codes, however effective October 2015 all Medicare Part A bills must now use ICD-10 codes. There is no cross walk provided for these measures between ICD-9 and ICD-10 codes. Also, since the window of time for the measures are 1 year for SNF, 2 years for IRF & LTCH and 3 years for Home Health, the measures will likely need to use both ICD-9 and ICD-10 measures. Nonetheless, the measures implementation to comply with IMPACT Act will include care delivered after October 2015, requiring the use of ICD-10 measures. Thus, the specification of these measures is incomplete to fully comment on the appropriateness of the measures. **AHCA Recommendations:** ICD-10 codes for use to define PPR and risk adjustment variables need to be provided since when the measures are used, they will require the use of ICD-10 measures. The numerator definition and methodology of calculating a "predicted actual" is extremely confusing, which makes the data less likely to be used and is of questionable benefit. In the SRR the predicted actual is divided by the expected actual. Both the predicated actual and the expected actual have a numerator. The document does not make it clear how the numerator and denominator of these two measures used in the PPR calculation are defined. On separate note, the rationale for using a methodologic approach of using predicted actual PPR vs. an actual PPR is not clearly presented nor evidence showing if the rationale is supported by comparing the results when a predicted actual is used vs. an actual rate. The use of predicted actual is complex and confusing. It does not yield data that is easily understood or verified. This makes the data less useful to providers. The use of predicted actual in the hospital readmission measures has raised a number of questions and criticisms. This approach will have the effect of			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		shifting providers with small sample sizes and outlier rates toward the mean. This may make sense for some providers but not for others. **AHCA Recommendations:** a. RTI/CMS should use the actual rate as the numerator in the SRR equation rather than the predicted actual. b. RTI/CMS should show data that demonstrates how this approach is superior to using an actual rate divided by the expected rate. Are the relative rankings of SNFs different between the two methods and if so by how much? The list of potentially preventable admissions contains diagnoses that do not meet the proposed definition of potentially preventable readmissions; therefore, these should be dropped. AHCA generally agrees with definition used to identify PPR readmissions: *"for certain diagnoses, proper care and management of patient conditions (in the facility or by primary care following discharge) along with appropriate, clearly explained and implemented discharge instructions and referrals, can often prevent a patient's readmission to the hospital. Identifying these PPR conditions will assist healthcare providers' efforts to improve quality of care and coordination across the care continuum. … A potentially preventable readmission refers to a readmission that should be avoidable with adequately planned, explained and implemented post discharge instructions including establishment of appropriate follow-up ambulatory care."* However, many of the listed diagnoses in our opinion do not meet this definition, or hospital coding practices makes their use inaccurate or attributing the readmission following PAC discharge to the PAC provider is inappropriate for these conditions. Holding PAC providers accountable for readmissions after discharge for some of these diagnoses which are not preventable with "perfect" care and discharge planning is inappropriate. Some of these diagnoses will not meet the definition that they "should be avoidable." They may be avoidable in some cases but the definition suggest that they should be avoidable more often than not when the optimal care and planning is implemented. Non-compliance by patient and their caregivers with treatment instructions is common even when "clearly explained and implemented discharge instructions and referrals" are made by the PAC provider. However, under the current PPR definition and conditions, admissions			

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		related to non-compliance will count against the PAC provider. Also, some of these conditions are not preventable but are included in the list based on the AHRQ Ambulatory Care Sensitive diagnosis that could be cared for in the community with appropriate availability of primary care physicians as well as care started early. However, this concept does not apply for a PPR measure following PAC discharge to the community. The PAC provider can't not manage these conditions in the community as they are not responsible for the care at this point. Secondly, the concentration of primary care providers and ambulatory services is outside of the control of PAC providers but one of the stronger predicators of readmission rates from the community. For example, many cardiac events are not preventable nor should they be managed in the community. Thus, inclusion of A-fib does not make sense. The following diagnoses, we do not believe can be prevented from occurring through optimal PAC care or ideal transition of care programs. For the SNFPPR measure for use in the SNF VBP, the list of diagnoses also suffers from some of the same issues and managing these conditions in the SNF setting would be inappropriate. For example, a-fib would be inappropriate to manage in a SNF. **AHCA recommendations:** a. Delete the following diagnoses from the PAC PPR measures. i. Delirium (from community) ii. Delirium (during SNF stay) only when new diagnosis since many hospital discharges have delirium which takes a long time to clear and could be listed by a hospital on readmission. iii. A-fibrillation and flutter as well as other cardiac events (form community and SNF) are not preventable and inappropriate to manage in SNF or community setting. Also, how does chronic A fib diagnosis distinguish from acute A-fib. iv. UTI (from community) v. Dehydration of electrolyte imbalance has concerning verbiage. Is concerned about dehydration being included in the term.			

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		vi. Aspiration pneumonitis is also problematic. When there is an episode or the virus that causes vomiting. This comes on suddenly. There is no way of preventing people who are vomiting from aspirating. Concerned about residents that don't want thickener or modified diet. (from community and SNF) vii. Hypertension and hypotension diagnoses are poorly coded by hospitals and not sure what they mean when listed as primary diagnosis. viii. Sepsis is commonly over-diagnosed in hospital for coding to help justify admission and avoid payment denials. ix. 008.45 intestinal infection under dehydration (as secondary but have dehydration by itself. Norwalk virus is not preventable. It is highly infectious and public health efforts have not shown it can be easily prevented. Often it occurs from contaminated individual exposing others such as food handler or family member or staff visiting who is asymptomatic so prevention is difficult. x. Acute renal failure—should be new from admission xi. Aspiration pneumonia—should be new from admission xii. Iron deficiency anemia—iron deficiency of chronic disease is extremely common. It is not clear why someone would be admitted and discharge from hospital for iron deficiency anemia. This suggest hospital coding problem as the hospital could not find another diagnosis leading to the hospital stay. Given infrequent use as primary diagnosis, we recommend dropping. xiii. Cervical fractures with osteoporosis (for lower ext fractures)—these spontaneous fractures are not preventable. The process for developing the list of potentially preventable readmissions used existing literature but would have benefited from a more formal process such as the RAND appropriateness rating system (e.g., modified Delphi approach) rather than ad hoc TEP and consultant experts.			

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		AHCA appreciates the approach RTI used to identify a candidate list of PPR using prior studies and measures. However, these measures were developed to evaluate the care for the overall health care system, health care community provide or the community environment has on hospital admissions. Applying these diagnoses to a PPR quality measure holding specific PAC providers accountable for readmissions after discharge often may not make sense. Also, while there may be wide agreement that a diagnosis should be classified as PPR, the coding practices of hospitals makes using that diagnosis in a PPR quality measure questionable. These issues were raised during the TEP meeting; however, the process for seeking TEP input was informal, over short period of time. A method used to achieve agreement from panel of experts would add credibility to this process. The RAND appropriateness methodology (i.e., modified Delphi approach) that has also been used in the development of ALCOVE quality measures, would be a more appropriate method to assure less controversy over proposed PPR diagnoses. **AHCA recommendation:** a. A modified Delphi approach rating each diagnosis for use as PAC PPR should be used. b. This approach should also be used to develop an initial candidate list of risk adjusted co-variates, which can then be tested for significance in the risk adjusted models. Risk adjustment does not included: a. Social Demographic Characteristics (SDS). The failure to include SDS characteristics in the last round of rehospitalization measures submitted to NQF resulted in almost no measure reaching NQF consensus. As a result, NQF Consensus Standards Approval Committee (CSAC) now requires adjusting performance measures for SDS unless evidence can be shown that such adjustment is not necessary. The currently proposed set of measures does not adjust for any SDS characteristics. Thus, it is hard to evaluated and comment on the proposed measures without knowing the full complement of risk adjustment variables. Since these measures examine potentially preventable readmissions after discharge from PAC and many individuals will be in the community, SDS characteristics could play a significant role in explaining variation in PPR between providers.			

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		AHCA recommendation: PPR measures need to evaluate the need for using SDS risk adjustment before proposing the use of these measures. b. Functional status. Functional status is one of the strongest predictors of hospitalizations. All the PAC settings are now required to utilize standard functional status assessment—Section GG from the CARE tool consistent with the IMPACT Act. The PPR measures are part of the IMPACT Act which talks about using data from standardized data assessments. For example, COPD is a risk factor for hospitalization but does not represent a uniform risk. Functional status for individuals with COPD explains most of the risk, often making COPD no longer a risk factor in multi-variate models. The risk adjustment should include functional status. **AHCA recommendation:** The risk adjustment model needs to include functional status, which is available using the mobility and self-care sections from the CARE tool, which are now required in all PAC assessment tools as section GG. c. Specifications for the risk adjustment variables The risk adjustment variables are not specifically specified with respect to data source and categories but are given as examples with just an overall descriptor. For example, is age a continuous or categorical variable and if categorical how and from what source? Without knowing how the risk adjustment variables are specified, it is hard to evaluate the proposed measures. **AHCA recommendation.** RTI should provide specifications for all the risk adjustment variables including data sources and coding parameters. d. Prior utilization variables indicate they "vary by measure" but how they vary by measure is not provided. The list of prior utilization variables for use in the risk adjustment model are neither specified nor denoted as to which PAC PPR measure they apply to. Without that information it is not possible to adequately comment on the proposed measures. **ACHA recommendation:** A table that indicates which "prior utilization variable" will be used for which PAC PPR measure is needed.			

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		e. Primary care concentration The potentially preventable rehospitalization measure is based on the AHRQ Ambulatory Care Sensitive rehospitalization measure. This was developed to identify hospitalizations for conditions that with "appropriate care" and access to primary care providers could either be prevented or managed in the ambulatory setting. The measure was intended to look at the capacity a community has in caring for population of residents. A strong predictor of hospitalization rates, is the concentration of primary care providers in the community. The purpose of the PAC PPR measure is to look at the impact care and transitions of care for have on readmissions following PAC discharge. It is not to assess the capacity in the community (e.g., primary care availability). Therefore, a measure of primary care availability (e.g., concentration of primary care physicians in the community) should be include as a risk adjustment variable. **AHCA recommendation:** The concentration of primary care physicians in a community should be added as a risk adjustment variable. Exclusions are confusing and also need some modifications The denominator exclusions appear confusing and overlapping so that it is unclear if discharges from IRF or LTCH to SNF or HH are included in the IRF and LTCH denominator. Similarly if SNF discharges to HH are included. On page 8, it states "*stays ending in transfers to the same level of care or acute hospitals are excluded."* What is considered the same level of care? Would going from a SNF to an LTCH be considered the same level of care? Would going for a HH to SNF be considered the same level of care? Further, it goes on to states "*SNF/IRF/LTCH/HH patients who are transferred at the end of a stay to another SNF/IRF/LTCH or short term acute care hospital*" are excluded because the intent of the measure is to follow patients deemed well enough to be discharged to a less intensive care setting. However, wouldn't going from an IRF to a SNF signify a transfer to a less intensive setting and thus need to be included in the scope of the measure? We agree that AMA discharges from PAC provider should be excluded but so should hospital discharges that are AMA but end up in PAC provider should also be excluded.			

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		AHCA Recommendation: a. Clarify the exclusions to show how discharges from one PAC to another PAC are included or excluded. A timeline diagram may be more effective to show the various flow of a patient from hospital to PAC to various settings following PAC setting are treated in all the different measures. b. Add to exclusions hospital AMA discharges. The varying windows of time for each PAC PPR measures The varying time windows makes any comparison across settings difficult and also mutes changes in improvement or decline to a greater extent for HH with 3 year window compared to IRF & LTCH with 2 year window, which is greater vs. SNF with 1 year window. We understand the need to expand the time window to increase the denominator size to meet minimum number to achieve better reliability. However, having differing windows of time will unfairly mute real changes, particularly among providers with large number of admissions and discharges. For example, providers with a 25% reduction or increase in their rate over a 12 month period (a rate of change that is shown consistent with For improvements in care in the literature) would only see a 12.5% change if the window is 12 months, 6.25% change if the window is 2 years and 4.125% if the window is 3 years. **AHCA recommendation:** Make the window of time the same for all providers (1 year) but specify for those providers with too small a sample; that they do not have a measure since they admitted less than 20 Medicare FFS patients per year. The list of related NQF endorsed measures (pg. 19) is incomplete and only compares to CMS or RTI endorsed measures. All other NQF endorsed measures should be included. There are other rehospitalization measures endorsed by NQF. The list provided is only for RTI/CMS developed measures. The NQF and MAP process is designed to review all NQF endorsed measures not just CMS developed/sponsored measures **AHCA recommendation:** Include other NQF endorsed measures when discussing other rehospitalization measures.			

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		Aligning unplanned readmission algorithm and list of diagnoses with other RTI/CMS developed rehospitalization measure. We agree with the expansion of unplanned readmission diagnoses from YALE's list, but this revised list is inconsistent with other RTI/CMS NQF endorsed measures such as the SNFRM. Will this also be applied to the SNFRM and hospital readmission measures? **AHCA recommendation:** Align unplanned readmission diagnoses proposed here with other CMS/RTI developed and endorsed measures such as the SNFRM.			
33	11/16/2015	The Alliance for Home Health Quality and Innovation (the "Alliance") appreciates the opportunity to comment on the measure specifications for the potentially preventable readmission measures for post-acute care. By way of background, the Alliance is a non-profit 501(c)(3) organization with the mission to lead and support research and education on the value of home health care to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America. The Alliance is a membership-based organization comprised of not-for-profit and proprietary home health care providers and other organizations dedicated to improving patient care and the nation's healthcare system. For more information about our organization, please visit: http://ahhqi.org/. The Alliance supports the development of measures to support the delivery of high quality care to patients and appreciates the interest in measures of utilization that are a proxy or marker of quality in health care delivery. Of the measure specifications shared by CMS and its contractors on potentially preventable readmissions, the measure specifications for potentially preventable readmissions within 30 days of home health care discharge are of particular interest to the Alliance. In this letter, the Alliance focuses the following comments and concerns on this measure. First, the specifications appear to still be in development as testing is still going to be done and factors are being considered for critical components of the measure, such as risk adjustment. The Alliance appreciates the opportunity to review the specifications at this developmental stage. The	Teresa L. Lee, JD MPH, Executive Director Alliance for Home Health Quality and Innovation	tlee@ahhqi.org	Home health association

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		Alliance recommends that there be an additional opportunity for comment once the specifications are in a form that is closer to final. Second, the Alliance supports the limitation of the measure to traditional Medicare fee-for-service only. This scope is consistent with the IMPACT Act, and the Alliance appreciates this aspect of the measure as it will enable greater clarity on the population to focus on to achieve improvement. Third, the measure specifications acknowledge that the evidence specific to post-acute care potentially preventable readmissions is limited (see p. 5 of the measure specifications document). The diagnosis codes identified as potentially preventable are based on the ambulatory care sensitive conditions that the Agency for Healthcare Research and Quality (AHRQ) has developed. AHRQ's list identifies conditions for which hospitalizations should be preventable if such conditions are well managed in ambulatory care settings. However, the list is not specifically targeted at conditions for which readmissions should be preventable. In other words, it is not clear whether after a hospitalization such conditions are ones for which readmissions should be considered preventable. Hospitalization significantly changes the condition of a patient and may in itself make the patient more likely to experience health risks that make the patient more likely to be readmitted. We are concerned that there is little evidence regarding the ability to prevent a subsequent post-acute care readmission for the ambulatory care sensitive conditions that are the basis of the list of diagnosis codes in the measure specifications. The Alliance recommends close analysis of the evidence base for this measure, and that modifications be made accordingly. Further, as explained in the comments submitted by the Visiting Nurse Associations of America (VNAA) on these measure specifications, there are unique clinical and practical considerations that should be used to modify the scope of what is considered potentially preventable. Consistent with VNAA's comments, the Alliance also recommends removing adverse drug events from the list of diagnoses that are potentially preventable. In this year's home health prospective payment system (for 2016) final rule, CMS did not include a measure involving adverse drug events because it was not appropriate for use in home health value based purchasing. Likewise, this should be removed from this measure's list of conditions considered potentially preventable thirty days post-discharge.			

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		Fourth, patients that have used other post-acute care settings before using home health care tend to have higher severity and are more likely to be at risk for readmission. The measure as described in the specifications would not distinguish among patients that have been to only one post-acute care setting (home health) or three or more different post-acute care settings. The Alliance recommends considering this factor in the risk adjustment for the measure. Fifth, the measure specifications are based on three years of claims data and use ICD-9 codes, even though as of October 1, 2015, the standardized code set to be used is ICD-10. Because the specificity of these two code sets is significantly different, the Alliance strongly recommends that CMS or the contractor provide cross-walks to the ICD-10 codes to be considered potentially preventable. Without this cross-walk, it is difficult to understand and predict the scope of the measure. Sixth, risk adjustment for socio-demographic status is discussed and the measure developer mentions that dual eligibility status and race are anticipated as the factors for which to risk adjust. The Alliance recommends that income also be included. If there are challenges with obtaining patient level data on income, one possible approach for CMS and the measure developer to consider is to risk adjust by the average income level by zip code. Finally, if finalized, the potentially preventable readmission measure will be the third measure for home health care that involves readmissions. There is already a measure for acute care hospitalization (during the 60-day home health episode), as well as a measure for readmissions from home health care within 30 days of discharge from the acute care hospital. There is overlap among these multiple measures that each capture readmissions. The Alliance recommends that CMS provide context for how it anticipates using or applying each measure. Increasingly, there are different applications for measures and it is unclear as yet how CMS plans to use each one.			

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34	11/16/2015	The American Hospital Association (AHA), on behalf of our nearly 5,000 member hospitals and health systems—including over 3,300 institutionally based or affiliated providers of acute long-term care, inpatient rehabilitation, hospitals with skilled nursing and extended care beds, hospital-based or affiliated home health agencies, and hospitals offering a spectrum of non-institutional services—appreciates the opportunity to comment on the six potentially preventable readmission measures being developed by RTI International and Abt Associates under contract with the Centers for Medicare & Medicaid Services (CMS). The AHA believes that identifying and reducing avoidable readmissions—including those related to post-acute care—has the potential to improve patient safety, improve coordination of care across settings, and reduce healthcare spending. The experience of the field to date suggests that readmissions reduction requires participation from, and collaboration among all providers—acute care hospitals, post-acute providers, and physicians—as well as the patients and communities they serve. Well-designed measures of readmission performance hold the potential to facilitate readmission reduction efforts. The request for comment lays out the basic conceptual and empirical approach for the six measures. As the measure development process continue, we ask RTI/Abt and CMS to be particularly attentive to the following issues: • Any categories and lists of "potentially preventable readmissions" should be based on careful evaluation by clinical experts and detailed testing. We appreciate that a technical expert panel (TEP) was consulted on the list of categories and codes of readmissions considered "potential preventable." However, we strongly encourage RTI/Abt to undertake additional empirical testing to ensure there is evidence that the codes actually are associated with the identified categories. The results of such testing should be made public.	Akinluwa Demehin, Senior Associate Director, Policy American Hospital Association	ademehin@aha.org	Hospital association

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		• <u>The measures should be considered for sociodemographic adjustment using a broader set of proxies than proposed.</u> We applaud RTI/Abt's intention to examine the impact of sociodemographic factors on readmissions performance. As demonstrated in a growing body of research, sociodemographic factors—such as the availability of primary care, physical therapy, easy access to medications and appropriate food, and other supportive services—significantly influence performance on outcome measures like readmissions, mortality and resource use. These community issues are reflected in readily available proxy data on sociodemographic status, and those proxies can be incorporated into the risk adjustment models. For the six measures under development, RTI/Abt proposes to use race and dual-eligibility for Medicare and Medicaid as risk adjusters. However, we urge CMS and RTI/Abt to examine a broader set of proxies. Indeed, we believe that Census-derived data on income and educational status may be a more direct proxy than dual-eligible status. Furthermore, we urge RTI/Abt to reconsider the use of race as a risk adjustor. Indeed, the National Quality Forum's 2014 expert panel report on sociodemographic adjustment recommended *against* using race or ethnicity as a proxy for sociodemographic status. The report specifically notes that "race and ethnicity are not and should not be used as proxies for SES; rather, their effects are confounded by SES. That is, income, education, and related factors (including language and insurance) represent key contributors to racial and ethnic disparities in healthcare." • <u>The measures must be specified in ICD-10 before they are implemented.</u> We believe RTI/Abt has specified the measure in ICD-9 in order to perform measure testing on claims data collected before ICD-10 was implemented on Oct. 1, 2015. Nevertheless, we believe it is critical that the measure be specified in ICD-10 before measure development is complete. We also strongly encourage CMS to test the measure for changes in measure performance resulting from using ICD-10 instead of ICD-9 as soon as it has enough data collected under ICD-10 to do so.			

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		Lastly, while the AHA always appreciates the opportunity to comment on measures under development, we note that the these particular measures were put out for comment at the same time as two other significant CMS regulations affecting post-acute care providers—the 2016 Home Health Prospective Payment System final rule, and another proposed rule modifying the Medicare Conditions of Participation for post-acute care providers. Going forward, we urge CMS and RTI/Abt to schedule public comment opportunities in a way that minimizes overlap with other major regulations. The AHA and our members are eager to provide well informed, thoughtful comments on measures, and our opportunity to do so is optimized when those opportunities do not compete for response time with multiple other regulations.			
35	11/16/2015	• On page 12 it is stated "the provider effects are assumed to be randomly distributed around the average." What evidence is there that that statement is true, particularly considering that it appears you are mixing facility-based providers (SNFs/IRFs/LTACs) with community provider (HHAs). Or is the term "PAC provider" specific to the PAC provider in the measure being calculated; in other words, the "average" PAC facility in the denominator is average for HH providers in the HH measure, or the SNF providers in the SNF measure, etc. I'm afraid the document wasn't very clear on this point. • As a follow up, if these measures do included a "blended" PAC provider rate, the different in the length of time of the baseline period for each provider type leads to inequities in the rates of readmissions by provider groups. For example, SNFs "expected" rate is based on only the most currently available year of claims data, while HHAs 3 year baseline includes much older claims data that may not be reflective of more current practice. • It appears this measure is calculating a rate for the risk of potentially preventable hospital readmissions, not an actual rate of potentially preventable hospital readmissions that occurred. That seems misleading for a publically-reported measure. I don't know of another publically reported measure that is a risk of something versus an actual rate of something.	Catherine Gill, MS PT MHA, Senior Director North Kansas City Hospital Home Health	Catherine.Gill@nkch.org	Home health agency

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		• It would seem appropriate to also evaluate in the risk adjustment model the variance of hospitalization rate by part of the country or even MSAs. It is my experience that there are significant differences in how physicians manage patients, and their wiliness to send them to the hospital versus managing them in the community. The exclusion criteria #8 on page 9, that states "HH patients for whom the prior short-term acute care stay was for primary psychiatric diseases, or rehabilitation care…I have never heard of an acute no acute IP hospital stays for rehabilitation care. Was this meant to include stays in IRFs and hospital-based SNFs?			
36	11/16/2015	On behalf of Allina Health, I appreciate the opportunity to comment on the development of potentially preventable readmission measures for post-acute care (PAC) settings. As a not-for-profit health care system, Allina Health is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families and communities throughout Minnesota and western Wisconsin. Allina Health cares for patients from beginning to end-of-life through its 90+ clinics, 13 hospitals (urban tertiary care and community hospitals), 16 retail pharmacies, specialty care centers and specialty medical services that provide home care, senior transitions, hospice care, home oxygen and medical equipment, and emergency medical transportation services. This complete continuum of care, uniquely positions Allina Health as a leader in health care in Minnesota and western Wisconsin. We appreciate the thoughtful approach that has gone into development of these measures, and in particular, have comments for the HH setting. We appreciate the comments submitted by the Visiting Nurse Associations of America (VNAA) and would like to include our support. Many patients admitted to home health (HH) are complicated and diagnosed with progressive chronic diseases such as congestive heart failure or COPD that are not curable. After discharge from HH, patients appropriately seek medical attention for exacerbation of their chronic diseases therefore readmissions in this population can be attributable to disease progression rather than a failure in HH care. Likewise HH services and primary care providers are not always readily available and accessible	Britney Rosenau, MPH, Program Manager Allina Performance Resources: Regulatory Allina Health	britney.rosenau@allina.com	Health care system

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		to patients so an Emergency Department visit may be due to barriers in access rather than a failure in HH care. In order to account for these complexities in HH services and the patients it serves we align with the VNAA and recommend adding the following factors to the risk-adjustment methodology: • Follow up with a physician after the HH episode (as evidenced by a claim), because patients without a follow-up visit may be more likely to readmit whether or not high quality HH services were provided • Use of community resources or use of other support services as patients who do not have adequate support services to remain at home (because of rural living, financial issues, or choice) may be more likely to readmit • We note and agree with proposed risk adjusters specific to HH, and encourage CMS to use prior PAC utilization and ED use as risk adjusters In addition to the risk-adjustment methodology, we agree with the VNAA on concerns and recommended changes for the general measure methodology: • While there is some evidence regarding readmissions 30 days after hospital discharge, we have concern there is little evidence supporting the concept of PPR for 30 days after discharge from HH for the broad array of clinical conditions encompassed in this measure. Consequently, we recommend the measure be narrowed to accountability for 1-2 conditions for which there is strong evidence that HH interventions can impact readmission potential • If the measure moves forward with a broad PPR definition, we believe HH measures of PPR should capture only readmissions related to the condition for which the patient was referred, or at most, only conditions which are identified in the referral and assessed through OASIS. HH should not be accountable for issues such as infection, which may be attributable to the discharging facility, or skin breakdown, which may be related to care after discharge from HH			

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		• We do not believe fall after HH is a PPR if the patient had a risk assessment and prevention plan (such as rehabilitation services); similarly we believe if a medication changed after HH discharge, or the risk was identified and documented during the episode it should not be attributable to HH • We recommend developing an attribution scheme for patients admitted to multiple PAC providers, such as a patient discharged to SNF and then HH • We recommend considering exclusion of readmissions for patients who are subsequently discharged from the acute facility to hospice or die within 30 days of the HH episode; • We recommend the measure be re-specified for ICD-10 coding and that it be tested and validated with new codes prior to implementation • We have concern the measure may reduce access to home care for the most frail or unsupported patients, as these individuals are most likely to readmit, and providers will avoid seeing them			
37	11/16/2015	AMDA—The Society for Post-Acute and Long-Term Care Medicine (AMDA) appreciates the opportunity to provide input on the development of potentially preventable readmission measures, in alignment with the Improving Post-Acute Care Transformation Act of 2014 (known as the IMPACT Act) and the Protecting Access to Medicare Act of 2014 (known as PAMA). AMDA is the professional society of nursing home medical directors, nursing home attending physicians, and other professionals practicing in the post-acute and long-term care (PA/LTC) continuum. We work to ensure excellence in patient care and to promote the delivery of quality PA/LTC medicine. We appreciate the Administration's efforts to develop potentially preventable readmissions measures for multiple settings (SNF, IRF, LTCH, HHA), including standardized items and specifications such as inclusion/exclusion criteria, and patient and facility characteristics—factors associated with outcome measures (risk adjusters) as well as obtaining setting specific input on PPR quality measures' application and implementation.	Alex Bardakh, Director of Public Policy and Advocacy/Naushira Pandya, MD FACP CMD, President AMDA-The Society for Post-Acute and Long-Term Care Medicine	abardakh@amda.com	Provider association

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		AMDA's Overall Comments: 1. Potentially preventable readmissions that occur within stay are often a byproduct of the quality of care and transition that patients receive from the index hospital. CMS needs to consider including into the adjustment formula the performance of the discharging hospitals. For example, a hospital system that includes systems for geriatric assessments and holistic care, patients with hip fracture may have less frequent delirium and on the other hand hospitals that lack a focus on geriatric assessments may send patients to the facilities with undiagnosed delirium. 2. Potentially preventable readmissions are a result of many factors. Quality of care provided by the team in a setting is one main factor but many other factors that may impact readmissions and are currently not accounted for in this strategy. These include family wishes to transfer, patient choice to go back to the hospital, disease factors (e.g., a new arrhythmia in a patient with heart disease) and system factors (discharge planning, availability of testing in nursing facility etc.). Thus it is not uncommon that a complex and sick patient never gets admitted whereas a less sick patient ends up transferring back. Though we understand that current data collection systems are insufficient to provide context around patient transfers, it is crucial that CMS plans for mechanisms to generate and capture important contextual information around transfers. 3. The data cited by CMS in the "comprehensive environmental scan" is mostly based on the Ambulatory Sensitive Conditions and may not be applicable to care outcomes in the post-acute care setting. 4. The conceptual definition and framework for PPR measure is based on the premise that "potentially preventable readmissions should be avoidable with sufficient medical monitoring and appropriate patient treatment" but this hypothesis ignores the important consideration that many of the ASC diagnoses are serious chronic illnesses that are known to eventually result in a poor outcome or an exacerbation e.g., a patient with heart failure will most inevitably eventually have an exacerbation or will face mortality, no matter how well he/ she is cared for. Thus we recommend that simply using Medicare claims			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		data for "labeling" an admission as "preventable" is not a sufficient strategy. It is highly important that CMS considers mechanisms to collect contextual information around these transfers. 5. We fully support that planned readmissions are being excluded from the formula. 6. We fully support the CMS effort to empirically test the sociodemographic status (SDS) risk adjustment as it is quite clear form the literature that SDS impacts outcomes. We highly recommend that baseline functional status should also be considered as a risk-adjuster based on evidence that baseline functional performance impacts recovery potential and other outcomes.			
38	11/16/2015	On behalf of the American Medical Rehabilitation Providers Association (AMRPA), I appreciate the opportunity to submit comments on the draft measure specifications associated with six readmission measures designed for post-acute care (PAC) settings including home health agencies (HHAs), skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). These measures, listed below, were developed through the work of a technical expert panel (TEP) convened by RTI and Abt Associates to assist the Centers for Medicare and Medicaid Services (CMS) in developing such measures as required by the Improving Post-Acute Care Transformation (IMPACT) Act and the Protecting Access to Medicare Act (PAMA). We have monitored the work of this TEP closely given its charge to develop readmissions measures applicable to IRFs. AMRPA is the national voluntary trade association representing more than 500 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers. Our members formed a Quality Committee in 2009 to review and develop quality measures appropriate for IRFs and this work has included the review of readmissions measures. We have been fortunate to serve on technical expert panels convened by CMS and the National Quality Forum (NQF) focused on the development of readmissions measures on more than one	Sarah Warren/Bruce Gans, MD, Chair, AMPRA Board of Directors American Medical Rehabilitation Providers Association	swarren@amrpa.org	Inpatient rehabilitation facility association

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		occasion and we appreciate the continued efforts to ensure such a measure is appropriately developed. Overall, we think many of the elements of the measure specifications, such as the risk adjustment methodology, are appropriate. However, we wish to submit several recommendations for your consideration to strengthen the specifications. Overall, at this time we support the development of measures for each of the PAC settings independently as assessing PPRs for 30 days post discharge from four separate settings of PAC will enable CMS to assess and compare rates of readmission between PAC settings. This will enable CMS to identify which types of providers are more apt to contribute to the wasteful spending that derives from a truly unnecessary hospital readmission. However, there is increasing emphasis, both at the legislative and regulatory level, on breaking down the PAC silos. As this evolves a uniform measure that assesses PPR post-discharge from the acute care hospital (regardless of which PAC setting the patient is referred to) may become more relevant. In addition, there is a separate measure for IRF patients during their rehabilitation stay and the document suggests that this measure is being developed for use in the IRF Quality Reporting Program (QRP). We question why CMS has not included a similar measure for Long-Term Acute Care Hospitals and believe that such a measure would be just as valuable as the "within stay" measure being applied to IRFs. Finally, the SNF-related measure does not align with the other measures in that the window for observation is 30-days post discharge from the acute care hospital, not within the PAC stay or following the PAC stay. This non-alignment makes the two measures applicable to SNFs out of sync and could lead to confusion and lack of clarify in terms of the PPR data. **Readmission Measures Applicable to IRH/Us** The draft measure specification identifies two measures that would be applicable to IRH/Us including: • Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRFs (IMPACT); and • Potentially Preventable Within Stay Readmission Measure for IRFs AMRPA historically has supported readmission measures associated with a post-discharge observation window (*e.g.,* 30-days post-discharge from the IRF) and a within stay measure. However, we do not think that a "within stay" measure should be applicable until day four or after from the date of			

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		admission to the IRF. We recommend this for two reasons. First, if a within stay measure is applied too early after the date of admission to the IRF, it might provide a perverse incentive to deny admission to the IRF for fear that sicker patients who are more likely to be readmitted to the acute care hospital would negatively impact the IRF's quality score. Second, at this time the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) includes a payment policy that provides a lower payment to the IRF if the patient is transferred back to the acute care hospital before day four after admission to the IRF. Therefore, if the within stay measure as drafted does not account for this payment policy, an IRF who transfers a patient back to the acute care hospital prior to day four after admission would face double potential payment reductions; one under the payment policy associated with transfers under the IRF PPS and a second for the readmission. It is unreasonable to apply two financial penalties simultaneously for the same event. *AMRPA Recommendation:* AMRPA supports the use of two readmission quality measures for IRFs but we encourage RTI and CMS to modify the specifications associated with the "within stay" measure to reflect that it would not apply prior to day four after the date of admission to the IRF. **Source of Data for Calculation of the Measures** In the draft specifications, CMS and RTI note that two years of claims data will be used. AMRPA believes, in part given all the regulatory changes the industry has experienced with regard to the IRF PPS, that the use of multiple years of claims data is important to ensure that a change to the payment system does not inaccurately skew data CMS receives on these measures. AMRPA also encourages the use of patient-specific data such as those collected via the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI). This tool collects highly detailed information about a patient's diagnosis, comorbidities and complexities, length of stay, motor and cognitive functioning, as well as discharge destination and initial referring site. It provides additional patient data that would be helpful in characterizing and understanding IRF readmissions patterns, patient characteristics, and risk adjustment analyses.			

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		We also note the potential importance of considering additional provider-specific data, such as presence of a teaching program or rural provider status. *AMRPA Recommendation:* In addition to multiple years of claims data, CMS should also use patient characteristic data as well as provider-specific data. **Potentially Preventable Readmissions (PPRs)** Appendix A of the draft specifications includes the list of conditions considered PPRs for the measures associated with 30-days post-discharge and Appendix B lists the PPR conditions used for the within stay readmission measure. In order for the readmission to be considered potentially preventable, it must be coded as the primary diagnosis on the readmission claim. Planned readmissions are not included in the numerator. These readmissions are defined based on the definition used for the CMS hospital-wide readmission measure (NQF #1789) which were revised to include additional procedures associated with PAC. Appendix D lists the codes considered planned readmissions. AMRPA remains deeply concerned that defining PPR based on the acute care diagnosis is not appropriate for IRF patients. Specifically, the reason for admission to the acute care hospital, as represented by the ICD-9/10 code, may not be the rationale for admission to an IRF. Instead, using data from the IRF PAI might more properly demonstrate when a planned readmission to the acute care hospital is appropriate. For example, Patient A is a C6 tetraplegic that is unexpectedly admitted to acute care from the IRF for autonomic dysreflexia. Patient B, a Rancho IV BI patient, is admitted to the acute care hospital from the IRF for autonomic storming. In both scenarios, the rationale for the unplanned readmission to the acute care is rarely seen in the acute care hospital but is not uncommon in the IRF setting. In both scenarios the readmission might not have been preventable, meaning the IRF, therefore may be inappropriately penalized for an unplanned readmission. Additionally, CMS and RTI should consider when a planned admission might not be appropriate and determine how to incorporate this occurrence into its methodology. For example, there may be a planned readmission for the revision of an external fixator that should have been coordinated between the surgeon and the acute care hospital and the IRF admission staff. If the planning process occurred correctly, the revision			

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		would have taken place at a more appropriate time to avoid the readmission to the acute care hospital. We remain concerned that the inclusion of inadequate prophylaxis as a rationale for why a readmission might have been potentially preventable does not track to the current clinical literature. For example, increasingly chest guidelines are demonstrating the role of deep vein thrombosis and pulmonary embolism prevention in PAC settings. However, the literature is less clear on the ability to prevent stress ulcers in rehabilitation settings such as IRFs. Therefore, it cannot currently be said that inadequate prophylaxis is inextricably linked to PPRs in all cases. Finally, RTI and CMS should separate atrial fibrillation and flutter in Appendices A and B. At this time there are low risk procedures for reducing the risk of flutter but the same cannot be said for atrial fibrillation. *AMRPA Recommendation:* 1. Rather than using the acute hospital diagnosis code to determine PPRs for IRH/Us, CMS and RTI should use the IRF PAI. 2. CMS and RTI should consider if inappropriate planned readmissions should be included in the methodology. 3. Inadequate prophylaxis should not be a criteria used to label a readmission as potentially preventable. 4. Atrial fibrillation and flutter should be separated in Appendices A and B. **Exclusions** The draft specifications include the following exclusions for the post-discharge measures: 1. SNF/IRF/LTCH/HH patients who were transferred at the end of a stay to another SNF/IRF/LTCH or short-term acute care hospital. 2. Patients who were not continuously enrolled in Part A FFS Medicare for the 12 months prior to the SNF/IRF/LTCH/HH stay (HH episode) admission date, and at least 30 days after SNF/IRF/LTCH/HH stay (HH episode) discharge date.			

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		3. Patients who did not have a short-term acute-care stay within 30 days prior to a SNF/IRF/LTCH/HH stay (HH episode) admission date. 4. SNF/IRF/LTCH/HH patients discharged against medical advice (AMA). 5. SNF/IRF/LTCH/HH patients for whom the prior short-term acute-care stay was for nonsurgical treatment of cancer. 6. HH patients for whom the prior short-term acute-care stay was for primary psychiatric diseases, or rehabilitation care; fitting of prostheses and for the adjustment of devices. 7. SNF/IRF/LTCH patients who were transferred to a federal hospital from the PAC facility 8. SNF/IRF/LTCH patients who received care from a provider located outside of the United States, Puerto Rico or a U.S. territory 9. HH episodes where the payment authorization code is missing. 10. SNF/IRF/LTCH stays with data that are problematic (e.g., anomalous records for hospital stays that overlap wholly or in part or are otherwise erroneous or contradictory). 11. SNF/IRF/LTCH/HH patients who died during the SNF/IRF/LTCH/HH stay. 12. SNF/IRF/LTCH/HH patients less than 18 years old. The same exclusions apply to the within stay measure with the exception of transfer patients since this measure is designed to address this category of patients. *AMRPA Recommendation:* We are supportive of the recommended exclusions identified above. However, we do not support the exclusion associated with rehabilitation care for the fitting of prostheses and for the adjustment of devices. In other versions of readmissions measures, this was a blanket exclusion but it appears in these draft specifications as specific to home health. We continue to argue that this exclusion is not appropriate regardless of setting.			

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		Risk Adjustment The draft specifications adjust for the following factors: • Age; • Sex; • Original reason for Medicare entitlement (age, disability, or ESRD); • Surgery category, if present; • Receiving dialysis in prior short-term stay; • Principal diagnosis on prior short-term claim; • Comorbidities from secondary diagnoses on the prior short-term claim and diagnoses from earlier short-term stays up to one year before the PAC admission; • Aggregates of the IRF case-mix groups (IRF-specific exclusion) RTI and Abt note that the NQF recently approved adjusting performance for socio-economic status and that they are in the process of testing this for the six measures. *AMRPA Recommendation:* IRFs often treat patients with comorbidities and/or complex conditions. As such, we believe that risk adjustment is critical to ensure that they are not penalized for admitting such patients, even if their conditions worsen and they are readmitted to the acute care hospital. If risk adjusters are not sufficiently accurate and robust to counteract the incentive to avoid difficult or challenging patients, then the most vulnerable Medicare beneficiaries will be at greater risk of underservice than under the current Medicare payment systems. Achieving what may appear as high quality outcomes, such as low readmission rates, is far easier when PAC providers "cherry pick" Medicare patients. Robust risk adjusters serve in part as the foundation which ensures that this measure does not result in the opposite effect on the most vulnerable Medicare beneficiaries. AMRPA supports the risk adjustment factors outlined in the draft specifications. We have advocated for adjusting for case mix group (CMG) and as such were pleased to see it included in this draft. We also believe that adjusting for socio-economic status is important and support RTI and CMS' effort to test this inclusion in these measures. Further, the risk			

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		adjustment methodology must include a separate analysis for the risk of thromboembolic events in patients who cannot take anticoagulants, such as those with post hemorrhagic strokes. Finally, we urge RTI and CMS to include functional ability and living status as risk adjustment factors. **Conclusion** Again, we would like to thank RTI and CMS for the careful consideration of the measure specifications for these measures. We are encouraged to see many of the modifications AMRPA has been advocating for over the last several years, such as adjusting for CMG and developing measures for within stay and post-discharge from the IRF, were considered and may be adopted if these specifications are modified per our recommendations. We stand ready to partner with CMS to ensure such measures are developed appropriately and lead to improved quality of care for the patients we treat.			
39	11/16/2015	The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 230,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners are actively engaged in the Department of Health and Human Service's Triple Aim objectives of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the growth rates of health care costs. The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop potentially preventable readmission measures, in alignment with the Improving Post-Acute Care Transformation Act of 2014 (known as the IMPACT Act) and the Protecting Access to Medicare Act of 2014 (PAMA). The IMPACT Act requires the development and submission of standardized data from post-acute care settings with the intent for cross-setting quality comparison to promote patient-centeredness. This includes the requirement to develop and implement measures to reflect all-	Sharmila Sandhu, JD, Council and Director of Regulatory Affairs American Occupational Therapy Association	ssandhu@aota.org	Occupational therapist association

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		condition risk-adjusted potentially preventable hospital readmission rates. Separately, section 215a of PAMA requires that a resource use measure reflecting an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities, which must be developed and implemented by October 1, 2016, to be used in the SNF Value-Based Purchasing program. This set of potentially preventable readmission (PPR) measures for post-acute care (PAC) estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) who receive services in one of the following post-acute care provider types: skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCH), and home health agencies (HHA). These outcome measures reflect readmission rates for patients who are readmitted to a short-stay acute-care hospital or an LTCH with a principal diagnosis considered to be unplanned and potentially preventable. Six PPR PAC measures are being developed: • Four of these measures assess PPR within a 30-day window following discharge from PAC—one measure for each PAC setting (i.e., SNF, IRF, LTCH, and HH)—and are being developed to meet the requirements of the IMPACT Act. • An additional SNF measure (SNF PPR), which is being developed to meet the PAMA requirements, assesses PPR during the 30-day period following a hospital discharge to a SNF setting. • An additional IRF measure assesses PPR during the IRF stay (referred to as the within-stay window) which is being developed for use in the IRF Quality Reporting Program. Of note with respect to potentially preventable readmissions and a patient's occupational therapy needs, several recent studies consider whether returning to the community from a recent hospitalization with unmet activities of daily living (ADL) need was associated with probability of readmission. The findings from these studies indicate that this indeed may be a considerable risk factor. The studies reveal that any older patients are discharged from the hospital with ADL disability. Those who report unmet need for new ADL disabilities after they return home from the hospital are particularly vulnerable to readmission. This area is not typically addressed in a thorough manner through current discharge practices. This needs to change. Patients'			

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		functional needs after discharge should be carefully evaluated and addressed.[1] Factors such as enabling self-management and ensuring appropriate medication management and ADLs, such as cooking and eating are addressed, can have a direct effect on readmissions. [1]Glen DePalma, MS, Huiping Xu, PhD, Kenneth E. Covinsky, MD, Bruce A. Craig, PhD, Eric Stallard, ASA, Joseph Thomas III, PhD, and Laura P. Sands, PhD. Hospital Readmission Among Older Adults Who Return Home With Unmet Need for ADL Disability. The Gerontologist Vol. 53, No. 3, 454–461 doi:10.1093/geront/gns103. The profession of occupational therapy is built on delivering patient-centered care, seeking to keep the patient at the highest functional level in the least restrictive setting and to reduce caregiver burden and health care system resource utilization. Occupational therapy directly addresses the enablement of successful performance of ADLs. This focus, experience and research base in occupational therapy must be fully tapped to address this component of readmission prevention. A further issue is that Self-management is a key element in successful care, and occupational therapists are experts in motivation, task analysis, and psychosocial contexts, which all contribute to enabling positive outcomes.[2] In order to successfully re-establish or establish new routines and habits to meet health care needs, such as medication management, proper sleep hygiene, and following other medical directives, is within the scope and proven effectiveness of occupational therapy.[3] [2]Pamela S. Roberts, Marla R. Robinson. Occupational Therapy's Role in Preventing Acute Readmissions; Health Policy Perspectives, American Journal of Occupational Therapy. May/June 2014, Vol. 68. No. 3. [3]Jeanne Jackson; Mike Carlson; Deborah Mandel; Ruth Zemke; Florence Clark. Occupation in Lifestyle Redesign: The Well Elderly Study Occupational Therapy Program. American Journal of Occupational Therapy. May 1998, Vol. 52, 326-336. doi:10.5014/ajot.52.5.326 AOTA would encourage CMS to examine more fully, perhaps through pilot testing, the value of occupational therapy evaluation and intervention participation as part of discharge planning. This could identify more clearly specific ADL limitations prior to and after discharge and assure proper interventions are provided that address fully and completely the range of ADL and other activity restrictions and capacities to enable optimum			

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		recovery from the condition as well as optimum participation of the client in their own care. AOTA has reviewed the readmissions measures released for comment and makes the following general comments: • The PPR measures Numerator and Denominator definition language are consistent from previous materials. • The Readmissions Measures are based on two years of claims data. Use of multiple years is acceptable in the measure review process. • The exclusion criteria for the various measures are associated with the Yale/New Haven readmission measures. Co-developed by the Centers for Medicare & Medicaid Services (CMS) and researchers at Yale University, estimates the risk-standardized rate of unplanned, all-cause readmissions to a hospital for any eligible condition within 30 days of hospital discharge for patients aged 18 and older. The CMS/Yale measure is specified for evaluating hospital performance. AOTA would prefer for the exclusion criteria to be specified for evaluating performance in post-acute care settings. With respect to the IRF Readmission measure, AOTA makes the following comments: • IRFs are subject to a reduced payment if the patient is transferred to the acute care hospital before meeting the average length of stay for the condition. Therefore, if there is a measure that tracks readmissions occurring during the IRF stay, the IRF could be subject to two payment reductions simultaneously: one payment reduction for the transfer and a second for the readmission. For this reason, AOTA recommends that the PPR penalty only apply to IRF transfers not subject to the transfer policy. • AOTA recommends that the draft Specifications for IRF PPR measure risk adjustment consider the following factors: – Age; – Sex; – Original reason for Medicare entitlement (age, disability, or ESRD); – Surgery category, if present;			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		– Receiving dialysis in prior short-term stay; – Principal diagnosis on prior short-term claim; – Comorbidities from secondary diagnoses on the prior short-term claim and diagnoses from earlier short-term stays up to one year before the post-acute care admission; – Aggregates of the IRF case-mix groups (IRF-specific exclusion)			
40	11/16/2015	I am writing on behalf of the University of Pittsburgh Medical Center (UPMC) Community Providers Services (CPS) to submit feedback and to request for clarification on the draft measure specifications for potentially preventable readmissions (PPR) being developed by RTI International and Abt Associates. The standardization of data across post-acute care settings required by the Improving Post-Acute Care Transformation Act of 2014 (IMPACT Act) will enable consumers to make more informed choices when it comes to post-acute care. UPMC Senior Communities offers a full continuum of living options for seniors including independent living, personal care, assisted living and skilled nursing in 18 locations throughout western Pennsylvania. Several campuses also are continuing care retirement communities offering life care contracts as well as month-to-month rentals. UPMC Visiting Nurses is a Medicare Certified Home Health agency that provides home–based health care services across many counties and communities in western central Pennsylvania through an expansive network of providers. We do business under different names including UPMC/Jefferson Regional Home Health, Visiting Nurses Association of Venango County, Community Nursing and Home Health, Fayette Home Care and Hospice, and Great Lakes Home Health. Additionally, UPMC affiliate, Home Nursing Agency is a Visiting Nurse Association providing a full range of nursing, social services, and rehabilitation therapies. Collectively, UPMC health care professionals deliver a high quality, low cost effective means to meet these beneficiaries' health care needs while bringing dynamic value to the Medicare program as a whole with 3.5 and 4 CMS Star Ratings therein.	Nicole Fedeli-Turiano, Public Policy and Government Relations, Dir. UPMC Community Provider Services	fedeliturianon@upmc.edu	Provider

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		First, at the outset of our comments and from a home health perspective, we strongly believe the addition of these PPR measures would necessitate a reconfiguration of both service delivery and payment of the existing Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System (HHPPS) Rate, including the consideration of a 90-day episodic payment as opposed the current 60-day payment and incorporating care pathways proven successful in the Independence at Home demonstration and Bundled Payment for Care Improvement models. **<u>Other recommendations include:</u>** • The measure be re-specified for ICD-10 coding and that it be tested and validated with new codes prior to implementation. • Patients who do not have adequate support services to remain at home (because of rural living, financial issues, caregiver, or choice) may be more likely to readmit; • We have a general concern about the level of evidence used to support this measure. While there is some evidence regarding readmissions 30 days <u>after hospital discharge</u>, there is little evidence supporting the concept of PPR for 30 days <u>after discharge from home health</u>, particularly for the broad array of clinical conditions encompassed in this measure; • We recommend that the measure be narrowed to accountability for 3-4 conditions such as Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension/Hypotension for which there is strong evidence that HHA interventions can impact readmission potential up to 30 days after the home health discharge. If the measure moves forward with a broad PPR definition, we believe home health measures of PPR should capture only readmissions related to the condition for which the patient was referred, or at most, only conditions which are identified in the referral and assessed through OASIS. This is a reasonable approach given the lack of consensus on what is a PPR and attribution of accountability for the PPR. As described in greater detail below, we do not believe fall after home health is a PPR if the patient had a risk assessment and prevention plan (such as rehabilitation services); similarly we do not believe medication errors are attributable to SNF/ home health if the medication changed after SNF/home health discharge,			

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		or the risk was identified and documented during the episode and an accountable treatment provider did not change the medication plan. **Moreover, a recalibration in point values with HH PPS Clinical/Functional Threshold scoring and an expanded use of the existing covered services in the Medicare Home Health benefit would need to be pursued to align with the successful engagement and management of the following PPR measures: Adult Asthma, COPD, CHF, Diabetes short –term complications, Hypertension/Hypotension, Bacterial Pneumonia, Skin and subcutaneous Tissue Infections, Arrhythmia, and Pressure Ulcers.** In doing so, concerns would be minimized with respect to the potential unintended consequence of PAC providers being deterred from admitting certain patients or types of patients with higher acuity or greater complexity, as they may be more likely to have a subsequent readmission; this behavior might occur despite the risk adjustment as noted on Page 18 of the PPR announcement. This could result in barriers to access for some Medicare beneficiaries who may otherwise benefit from PAC and rigorous efforts should be pursued to conduct ongoing monitoring and evaluation for these potentially negative and unintended consequences. **HH PPS Clinical/Functional Threshold:** Respectfully, through the HH PPS regulations on CY 2016 Clinical and Functional Thresholds, CMS is ratcheting up the functional and clinical acuity scores needed to justify various levels of home health services service determined by RACs. The net result is that home health agencies see more acute patients while providing the same or less level of skilled service. As the IMPACT measures are implemented, we strongly encourage CMS to educate RACs on allowable services for Management And Evaluation of a Patient Care Plan, and on use of skilled services to maintain function or slow deterioration within Medicare coverage benefit standards. Appropriate authorization of services will enable home health agencies to more effectively meet quality requirements during the episode, and proactively manage the patient to avoid preventable relapses after the episode (as measured in the PPR and DTC measures). Similarly, the rules permit coverage for care over the long term as well as the short term, dependent only on the existence of a skilled care need. The Management and Evaluation of a Patient Care Plan is a particular qualifying skilled nursing service set out in the Medicare rules and is worthy of note:			

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		Expanded Use of Existing Service: 40.1.2.2—Management and Evaluation of a Patient Care Plan *Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.* The care coordination described in the above Medicare provision could engender successful home care-based chronic care management and is the exact type of care that is embodied in the "overall management and evaluation of care plan" skilled service under current Medicare rules. However, it is rarely applied by home health agencies out of well-reasoned fear that Medicare Recovery Audit Contractors (RAC) will retroactively reject payment for the claim. Hence, CMS should engage in nationwide education of its contractors and home health agency personnel focused on this one basis for coverage, especially with the adjunct of PPRs to its public reported outcomes. If needed, clarifying or expanded policy guidelines should be issued. Ultimately, an application of this covered service in home care can create the foundation for significant improvement in patient-centered, community-based chronic care management that benefits Medicare beneficiaries and the Medicare program bottom-line. **Secondly, in order to provide care under the current statutes in the Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate, we express formidable concerns on home health agencies being held accountable for the following PPR measures: Aspiration Pneumonitis, Acute Renal Failure, which by virtue of their names/conditions are acute in nature.** Furthermore, another concern from the list of PPR in Appendix A of the draft is the inclusion of **Adverse Drug Events**. We urge the contractors to modify this diagnosis to include only adverse events tied to medications that the patient was using at the time of discharge from the post-acute provider. One can easily imagine a scenario in which the PAC provider discharges the patient, the patient sees his/her community physician two			

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		weeks later for a follow up and is prescribed a new medication. Without proper instructions from the community physician, the individual could end up in the hospital within the 30-day window through no fault of the PAC provider. UPMC's home health agencies strive to educate patients and families upon discharge about proper dosage and side effects. For example, Pennsylvania HHAs score better than the national average when it comes to improving patients' ability to correctly administer their own medications (54.3% in PA, 53.2% nationally), but HHA can only control education on the list of medications provided to us at that time. It would be unreasonable to hold a PAC provider responsible for drug interactions involving a drug the patient was prescribed after discharge. **Thirdly, due to environmental and socio-economic factors beyond the agency's capacity to monitor 30-day post-discharge and factoring patient choice(s) that may make him/her prone to a certain condition(s), we hold strong objections to the following PPRs: Urinary Tract Infection, Septicemia, Influenza, C. Difficile infection, Dehydration, and Intestinal Impaction.** We also note that the concept of patient centered care means that clinicians can assess patients, educate them, and make recommendations, but that patients may legitimately choose not to follow clinical advice. Elderly seniors may choose not to adapt their homes, diets, lifestyle, or make other changes even after a home health clinician has assessed risk, referred the issue(s) to a PCP and worked with the patient and his/her caregiver on a plan to reduce readmission, and/or the likelihood for increased risk of the aforementioned PPRs. **<u>Recommended Revision to Exclusion List</u>** 1. **Add to the list of exclusions for the HHA measure any patient that was admitted to the hospital for a diagnosis that was <u>not</u> the principal diagnosis of the preceding home health episode.** This would ensure that the HHA was aware of the condition and responsible for providing the patient with treatment, education and follow up tools, and so poor PPR performance would be a direct reflection of the HHA's care.			

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		Clarification Needed Prior to finalizing the PPR measures, we seek clarification on the following two questions: 1. **What information will be used to determine the readmissions at the "average" home health agency?** The measure is calculated using as the denominator the patient's expected trajectory after discharge from the average HHA, but the draft does not offer details on how the average agency will be selected. One assumption is that the average will be calculated based on the previous three years of claims data. 2. **Which date will be used to determine the patient's discharge from home health?** We appreciates the contractors minimizing the administrative burden on providers by utilizing data that is already submitted in the usual course of business. The draft points to Medicare inpatient claims as the source of data for calculating the post-acute care measures, however it is unclear where the date of discharge will originate. The hospital record might not show an accurate date of discharge from home health, given that transfers directly to the hospital will be excluded from the measure. The HHA's final claim to Medicare will show the date of the last skilled visit for that patient, but that might not coincide with the actual discharge from care. Will this data follow the patient's Medicare identification number?			
41	11/16/2015	The Continuing Care Leadership Coalition (CCLC) represents not-for-profit and public long term care provider organizations in New York State. The members of CCLC provide services across the continuum of long term care (LTC) to older and disabled individuals. CCLC's members are leaders in the delivery of skilled nursing care, home care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations. CCLC supports CMS's focus on improving care coordination between health care settings, and has been dedicated to improving care coordination in member nursing facilities and in other healthcare settings in collaboration with the Greater New York Hospital Association, with which we work closely. While supporting this focus, we offer the following comments identifying concerns and recommendations regarding the	Scott Amrhein, President Continuing Care Leadership Coalition	amrhein@cclcny.org	Long-term care provider association

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		proposed CMS measures related to potentially preventable readmission measures (PPRs) in post-acute care settings: As a threshold matter, we note that this effort is focused only on Medicare fee-for-service payment, and, as such, it does not fully take into account the changes in payer-mix that are taking place in tandem with current efforts around reform and innovation. We recommend that further efforts be undertaken to coordinate the proposed changes with other Federal changes and state level initiatives to ensure that the proposed measures take into account the situations in states that are moving away from fee-for-service payment, such as New York State, with its high uptake of Medicare Advantage and its movement toward Fully Integrated Duals Advantage (FIDA) programs. Based on experience under the NYS Nursing Home Quality Improvement Program, which is a value-based payment model that includes a measure for potentially avoidable hospitalizations, we note that the proposed CMS measures do not fully account for residents with triggering conditions that are appropriately treated in hospital settings, and do not account for circumstances out of the facility's control. Specifically, we note that: • The measures do not fully account for sociodemographic factors beyond race and dual eligibility. CCLC urges CMS to add comprehensive sociodemographic status (SDS) risk adjustment to better differentiate factors outside of a provider's control from those that are under its control. • The measures do not fully account for other specific situations over which the post-acute care setting does not have full control, such as instances in which a family-member demands hospitalization, or calls 911 to initiate a transfer without the facility's knowledge. • The measures do not appropriately risk adjust for factors that are unique to specific providers, such as the provision of dedicated services to specialty residents (e.g., pediatric, ventilator) who may have triggering conditions that would best be addressed temporarily in a hospital in certain circumstances. • The measures do not account for regional differences, including those within a given state, that result from factors such as geographic variance in availability of services, in cultural influences, or in medical practice.			

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		We further note that the Skilled Nursing Facility (SNF) measures do not sufficiently take into account the fact that most SNFs today provide services to both short-stay and long-stay residents and families, and that these two types of residents differ greatly in their clinical profiles and in the need for certain hospital services. Additionally, when considering the experience of patients being discharged from an inpatient post-acute care facility into the community, the measures do not fully account for major factors that have essential impact on readmissions, such as housing quality, family availability, psycho-social stability, and other supports. Finally, as the development of these measures points toward potential use in value-based purchasing models for post-acute care services in the future, it will be important for CMS to consider the concerns expressed here, among others, in order to ensure that the implementation of the measures does not create unintended consequences such as limiting access to specialty care services; limiting access to care for low-income populations; creating perverse incentives for providers; or unfairly impacting the finances of post-acute care providers.			
42	11/16/2015	The Federation of American Hospitals (FAH) appreciates the early opportunity to comment on the Draft Measure Specifications for the Potentially Preventable Hospital Readmission Measures for Post-Acute Care. We look forward to seeing additional modeling of the measure constructs as they evolve for each post-acute care setting based on comments you receive during this early round of comments. The proposed measures document did not address the review process CMS intends to follow as the measures evolve. The FAH encourages CMS and its contractors to pursue full National Quality Forum endorsement and robust field testing, plus review by the Measure Applications Partnership prior to the measures being included in any pay-for-performance program. While the FAH recognizes that CMS is under significant pressure to meet statutory deadlines for implementation of certain quality measures in the post-acute environment, it is vitally important that the testing of these measures is not short-changed. CMS and the post-acute care community need to understand clearly how the measures will work and need to identify potential unintended consequences of the measures prior to their being deployed in consequential payment programs.	Jayne Hart Chambers, Senior Vice President Quality Federation of American Hospitals	jchambers@fah.org	Hospital association

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		The FAH is pleased to see consideration of a list of potentially avoidable or preventable readmission (PPR) conditions among the skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term acute care (LTCH) patient populations. This is a good step to including PPR adjustments in all readmission measures across multiple care delivery settings. The FAH encourages the measure developers to model some of the proposed preventable conditions, and to make the modeling available to the public for comment prior to finalizing the list of conditions for these specific measures. The proposed measures are currently being specified in ICD-9, which the FAH finds odd given that these measures will be implemented well after all facilities have been required to transition to ICD-10 coding. The FAH encourages RTI to develop these measures in ICD-10 and to model the measures using ICD-10 codes. We believe there will be significant differences in the measures between coding in ICD-9 and ICD-10 and the measures will need to be calculated in ICD-10 when or if they are put into actual use. The FAH also encourages the developers to consider an adjustment for functional status in the various settings which we believe would benefit the accuracy of the PPR measures. Functional status has a direct correlation with a patient's ability to remain healthy at home after PAC services have ended, meaning that PAC providers who treat more functionally impaired patients will likely have a higher PPR rate. Accordingly, FAH recommends that RTI and CMS consider how to apply an additional risk-adjustment factor for functional status in the overall risk adjustment methodology. The discussion of the proposed measure specifications indicate the developers are considering adjustment for socio-demographic (SDS) factors. The FAH long has been a proponent of SDS adjustment for readmission and other outcome measures. However, we find it curious that CMS and its measure developers are looking only at testing for dual eligibility and race as the SDS factors. The FAH strongly believes the SDS testing needs to be broader and take into consideration community services such as access to transportation, appropriate housing and food. The FAH believes that these services outweigh race as factors that should be included in SDS adjustment and encourages CMS and its contractors to think more broadly about SDS adjustments.			

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		As CMS, RTI International and Abt Associates continue to revise and develop these post- acute measures, the FAH looks forward to future opportunities to review the results of testing and the refinements to the measures. The FAH also encourages RTI and Abt Associates to consider a longer comment period. The extremely limited time for comment on this draft of the measures was challenging given the other CMS priority documents out for comment at the same time. We strongly encourage a comment period that is longer than the nine business days allotted for this document so that thoughtful suggestions can be offered in more complete form.			
43	11/16/2015	On behalf of the Healthcare Association of New York State's (HANYS) more than 550 member hospitals, nursing homes, home health, and other health care providers, we welcome the opportunity to comment on "Draft Measure Specifications for Potentially Preventable Hospital Readmission Measures for Post-Acute Care." We have reviewed the draft measures and present the following comments: **Short Review Time** First, we are dismayed to find there is less than two weeks in which to review the draft measures and provide feedback. This gives no time to distribute to or provide members review and brief them on the details and have them provide us with feedback. HANYS asks Centers for Medicare and Medicaid Services (CMS) if there will there be a formal public comment opportunity to give additional feedback about these proposed measures? In addition, HANYS is concerned about the consistency of the methodology of these post-acute measures with that of acute care measures. The following comments are specific to this concern. **Use of ICD-9 codes** We were disappointed to find the draft measures were released referencing the International Statistical Classification of Diseases and Related Health Problems, ICD-9 system rather than ICD-10 codes. ICD-10 coding that provides information on risk factors is a positive development towards more accurately risk adjusting measures. **HANYS urges these measures be updated as soon as possible using the ICD-10 coding system and for ICD-10 codes to be released in future measures.**	Debora LeBarron, Senior Director, Continuing Care Healthcare Association of New York State	DLeBarro@hanys.org	Provider association

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		Window of Observation 30 day plus 2 Please clarify the origin and the definition of the "window of observation" that is discussed on Page 8 of the document under the heading "Denominator Details: PAC Stays Included in Measures." Here it is stated the window "excludes the day of discharge and the day thereafter (the 30 days start on discharge day plus 2)." This definition is unfamiliar to HANYS. **What is the origin of this definition? Has it been used in other measures?**			
44	11/16/2015	On behalf of the Henry Ford Health System (HFHS), I appreciate the opportunity to offer comment on the Draft Measure Specifications for Potentially Preventable Hospital Readmission Measures for Post-Acute Care. HFHS is a large, integrated health care system serving the Southeast Michigan area, including the City of Detroit and its suburbs. The System includes four acute-care hospitals, a home health agency, a very large multispecialty group practice, and a variety of other clinical services and "business units." We have active, formal collaborations with a network of SNFs that focus on enhanced care coordination and quality improvement for patients who are discharged from HFHS hospitals to those SNFs. We share CMS' concern with rates of readmission and we have worked actively, both in our own projects, and in the context of regional and national collaborative projects to find ways to prevent readmissions. We support CMS' expansion of the readmission measure set to include several post-acute-care settings, and to distinguish between all- cause readmissions and potentially preventable readmissions with distinct measures for each. The proposed measures will be generally useful and informative; the comments that follow represent either concerns about details of implementation or suggestions for technical improvements in the measures. 1. **Scope and time period.** The "readmission windows" illustrated in Table 1 on page 6 imply that readmissions within a "stay" in home health or LTCH or SNF are not meaningful or important, and we do not understand the rationale for that decision.	David Nerenz, PhD, Director, Center for Health Policy & Health Services Research/Diane L. Valade, Health Policy & Legislative Analysis, Center for Health Policy & Health Services Research Henry Ford Health System	dvalade1@hfhs.org	Healthcare system

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		Most of our own work in reducing readmissions with SNF partners focuses on reducing readmissions within the period of the SNF stay. In all four settings, the "within stay" period is the time in which the PAC providers have the clearest responsibility for patient outcomes and the greatest degree of leverage over factors leading to hospital readmission. It seems curious that these new readmission measures would not include the within-stay time period. It also seems curious that the planned measure development includes a 30-day post- stay period for all four PAC settings. This clearly IS the time period in use for the hospital readmission measure, but it is not clear that all of these PAC providers have significant control over, or responsibility for, events that could lead to readmission in the 30-day period after their treatment of and relationship with the patient have ended. The few references provided on page 5 do not clearly indicate that post-PAC readmission is a significant problem that rates are sufficiently variable across providers to serve as a meaningful quality measure, or that holding PAC providers accountable for readmissions in this time period will lead to meaningful quality improvement. The time window selections seem to be ignoring time periods and organizational relationships that are meaningful and can lead to significant quality improvement, while focusing on those where background information in published literature is sparse to non-existent. **Terminology.** While the phrases "expected" and "predicted" readmissions are explained and distinguished from each other in this document, few people other than statisticians will easily grasp and use the distinction. While many are familiar with "observed vs. expected," few, if any, are familiar with "expected vs. predicted." Regardless of the statistical justification for these terms, we strongly suggest that CMS and its contractors come up with some other language that will allow clinicians and administrators who are not statisticians to understand the reports and have an intuitive feel for the two major components. **The exclusion of patients who transfer to another PAC facility** (or to an acute care hospital) at PAC discharge (page 9) could create harmful and perverse incentives for PAC providers to transfer patients who are not doing well and are at relatively high risk of readmission. If we understand the proposed definitions correctly, a patient transferred from one HHA to another, for example, who is readmitted during or			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		after the second HHA stay, will not be counted in the numerator of either of the two HHAs. HHAs that function as distinct units of a chain of HHAs under common ownership will find it attractive to transfer patients from one to the other in situations where readmission seems likely. Beyond that, the exclusion of patients who are transferred to an acute care hospital from any of these settings seems to defeat the primary purpose of the readmission measure. For the exclusion to make sense, there has to be a clear and unambiguous definition of a "planned end" to the PAC stay that is different from an "unplanned end" driven by deteriorating patient condition, which is in turn driven by poor quality of care. **Risk adjustment.** Inclusion of the variables listed on pages 13 and 14 are good, but not sufficient to create a truly complete and fair picture of readmission risk in these settings. Recent analyses of hospital readmission data have clearly shown that a set of patient-level and community-level variable in socioeconomic and demographic domains have significant effects on probability of readmission, and are largely outside the control of PAC providers whose performance is being measured. Living alone, for example, is a risk factor for readmission, and is not something that PAC providers can ameliorate or compensate for in the 30-day period following PAC discharge. CMS and its technical vendors should carefully examine, and include where possible, variables in the sociodemographic domain in the risk adjustment model. **Use of two years or three years of data to calculate rates.** While we appreciate the problem of inferences from small samples, the use of two- and three-year time periods will make the measures very insensitive to change, particularly improvements related to QI initiatives. A measure based on three years of historical data, which themselves have some lag in processing to the point of public reporting, will probably not be informative for beneficiaries or others trying to make decisions about PAC quality. It would seem preferable to report recent rates, including rates from the most recent one-year reporting period, along with sample sizes and confidence intervals around reported rates, and either make decisions (CMS) or let beneficiaries make decisions from that information.			

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		As users of this kind of information ourselves in our partnership relationships, we would rather see recent information than aggregated three-year information. Again, we commend CMS for offering this opportunity for comment and for developing measures in this significant area of quality of care.			
45	11/16/2015	Thank you for the opportunity to provide comments on the draft IMPACT Act measure "Potentially Preventable Hospital Readmission for Home Health." The Illinois HomeCare & Hospice Council is a trade association representing home health and hospice organizations in Illinois. IHHC members have a number of concerns about the proposed measure, many of which have been expressed by our fellow associations at the national level. First and foremost, we have concerns about the number of conditions that are proposed for accountability. As noted by the Alliance for Home Health Quality and Innovation, the original set of conditions is based on a list of conditions for which *hospitalization* should be preventable developed by the Agency for Healthcare Research and Quality (AHQR). These conditions do not necessarily translate into a set of conditions for which *re-hospitalizatio*n should be preventable, particularly given the characteristics of the Medicare home health population—older, sicker, poorer and with more co-morbidities than the overall Medicare population. IHHC members are not sure that evidence exists to be sure that all of these conditions are, in fact, potentially preventable. In some instances, re-hospitalization is in the best interests of the patient. Home health providers function in a less controlled environment than do any of the other post-acute settings. Our services are delivered to individuals in their homes where they control their own diet and behavior. Onsite supervision and control are not possible. Treatments are ordered by physicians who may or may not fully understand the patient's full condition or the full range of services the home health agency offers. In addition, home health care is often the final post-acute service provided to a patient following a hospitalization after services have been received in a skilled nursing facility, an inpatient rehab facility or a long-term care hospital. These patients are often frailer and more compromised than those patients who come directly home from the hospital.	Cheryl A Meyer, MS RN PHCNS BC IHHC President Illinois Homecare & Hospice Council	cheryl.meyer@advocatehealth.com	Home health association

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		Recommendations Based on these and other concerns, IHHC has several recommendations: • RTI should significantly narrow the number of conditions included in the measure to insure that the ones included can actually be addressed by a home health agency in the environment in which medicine is practiced today. • A clear cross-walk from ICD-9 to ICD-10 should be provided so that it is possible to more accurately identify how the measure will be applied. • Risk adjustment factors including – Whether the patient has had an appointment with his or her primary care physician within 14 days of inpatient discharge; – Availability and use of community resources to support the patient at home; – Race; – Socioeconomic status, dual eligibility status, and or income; – Caregiver support capabilities; – And, prior post-acute care setting stay including length of stay. • Exclude readmissions for patients who are subsequently discharged to hospice care from the calculation; • As noted by the Alliance, the proposed measure would be the third measure of hospital readmission applied to home health agencies. The varied purposes of these measures should be clarified, and a case made for their importance in each instance.			
46	11/16/2015	As the largest provider of inpatient rehabilitation facility ("IRF") services in the nation, and the parent of Encompass, the third largest home health ("HH") provider, we appreciate the opportunity to submit comments on your work on behalf of the Centers for Medicare and Medicaid Services ("CMS") regarding the development of Potentially Preventable Readmissions ("PPR") measures for the different post-acute care ("PAC") settings. We are generally supportive of measuring PAC providers on potentially preventable readmissions and believe that much of the work performed for these measures is positive, such as the risk adjustment methodology. We believe that the PAC industry should embrace	Andrew C. Baird, Director, Government Relations/Mary Ellen Debardeleben, Associate Director, Quality HealthSouth	Andrew.Baird@healthsouth.com / Mary.Debardeleben@healthsouth.com	Inpatient rehabilitation facility

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		measures, such as these PPR measures, that help patients stay at home—a central tenant of post-acute care. Accordingly, we value these PPR measures as useful tools in advancing that goal. We have several comments that will serve as constructive additions to the development of these measures. We hope that RTI and CMS will analyze and consider these comments and how they could improve the PPR measure development for IRFs. **I. THE IRF "WITHIN STAY" MEASURE SHOULD ACCOUNT FOR THE EXISTING THREE-DAY SHORT STAY AND TRANSFER CARE POLICIES FOR IRFS** The measure specification document states that the IRF "within stay" measure "is intended to capture readmissions during the IRF stay (i.e., program interruptions where the patient is readmitted to the acute care setting) and readmissions (i.e., [sic] acute care transfers) at the end of the IRF stay." This specification does not detail precisely when the measure would begin capturing such readmissions, but the "within stay" measure should not apply until day four or after from a patient's date of admission to the IRF. IRFs are currently subject to a policy under the IRF Prospective Payment System ("PPS") that provides a uniform payment for certain cases with a length-of-stay not exceeding 3 days. This three-day window was designed by CMS to help ensure that IRFs have enough time to fully assess whether a patient admitted to the IRF remains in need of IRF services. According to CMS, "an IRF is eligible to receive the IRF short stay payment for 3 days or less if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient is no longer an appropriate candidate for IRF care on admission and the day count is greater than 3."[1] Therefore, since the IRF PPS already accounts for admission of some patients who are subsequently determined by day 3 of the IRF stay as no longer needing IRF services by reimbursing the IRF by paying a lower rate, the IRF "within stay" PPR measure should not further penalize IRFs for readmissions that occur within the same time period. There is precedent for this accommodation for short-stay policies within other PAC readmissions measures already: the existing home health "within stay" rehospitalization measure specifically excludes stays that begin with a Low-Utilization Payment Adjustment ("LUPA") (i.e., stays with four or fewer home health visits, the equivalent of short-stays in IRFs). Short stays in any PAC			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		provider should be excluded from the PPR measure because the PAC provider will not have the opportunity to meaningfully deliver care to a patient. As such, it would be unfair to attribute the cause of the readmission to the PAC provider when they are so limited in what they can do within the short-stay window. To the extent that CMS and RTI develop true "within stay" PPR measures for SNFs and LTCHs in the future, we believe those measures should also account for short stays policies. [1] CMS, Medicare Claims Processing Manual, Ch. 3, Sec. 140.3, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf. [2] *See Id*. at Sec. 140.2.4. Similarly, the existing IRF transfer policy provides that, for patients who are transferred from an IRF to a hospital, LTCH, SNF, or other IRF, and whose length of stay is less than the average length of stay for the pertinent CMG, the transferring IRF receives a per diem payment, the rate of which is calculated by dividing the typical per discharge CMG payment by the average length of stay.[2] Therefore, because this policy reduces IRF payment automatically from the normal CMG payment for cases that are discharged early, it functions to discourage IRFs from making such early discharges. If a "within stay" PPR measure were to start too early into IRF stays, these two policies would overlap and any transfers would effectively cause a double penalty—a lower payment under the transfer policy as well as a PPR "ding." Accordingly, in order to avoid applying two separate payment disincentives to a single event, an IRF "within stay" PPR measure should either begin capturing readmissions after the average length of stay passes, or currently-defined transfers that would also qualify as a PPR should no longer be counted as transfers. We recommend that RTI and CMS consider the intersections of these potentially overlapping policies and structure the IRF "within stay" PPR measure to begin on or after day four of the IRF stay, and not to conflict with the existing transfer policy.			

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		II. USE OF UPSTREAM DRGS; DIFFERENCES IN SETTING-SPECIFIC MEASURES COULD CAUSE DIFFICULTY IN DATA COMPARISONS The various PPR measure proposals each propose to rely on DRGs from the initial hospital stay as the anchor condition for a PPR in a PAC setting. We are concerned that the high level of variability in DRG coding practices amongst upstream hospitals will present problems in the resulting PAC PPR data because lack of consistency in initial DRG coding will have an effect on the number of patients at a given PAC provider are "eligible" for inclusion in a condition-based PPR measure. This dynamic would create a barrier to making sound apples-to-apples PPR data comparisons. Another issue with using DRG codes for the initial hospital stay is that such codes are often unreliable indicators as to why a particular patient is referred to a particular PAC setting, not to mention why they are eventually readmitted after the PAC stay. For example, a patient admitted to the hospital for congestive heart failure and who is treated in a subsequent PAC setting may end up returning to the hospital during the 30-day post-PAC discharge window not for reasons associated with congestive heart failure, but because he was not properly hydrating. Although this readmission would count under the PPR measure, it would not capture the actual reason the patient was readmitted. By implementing a post-PAC discharge PPR measure that is coded all the way back to the initial hospital DRG risks missing the clinical reason that was present within the particular PAC setting at the time of readmission. Similarly, we note that IRFs are the only provider for which a "within stay" measure is being developed (for the IRF QRP, not under the IMPACT Act per se). Although already in place for HHAs, we believe that such "within stay" PPR measures could also be helpful and are possible for LTCHs as well, and ask CMS and RTI to consider creating such a measure to enable more congruity into future PPR comparisons between all PAC providers. The SNF 30-day post hospital discharge measure, while covering at least some part of a SNF stay, is also incongruent because it would fail to capture any "within stay" PPRs that occur when a patient is still in a SNF 30 days after discharge from the acute hospital. Although these differences are minor, they present concerns when considering the ability of future policy makers to make direct comparisons within the PAC industry.			

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		III. RISK ADJUSTMENT FOR SOCIODEMOGRAPHIC AND FUNCTIONAL STATUS The draft specifications indicate that the PPR measures will all be risk-adjusted for multiple variables, including age, sex, dialysis status, and for the IRF measures, aggregates of the IRF case-mix groups. We support this broad range of risk adjustment, but also believe that CMS and RTI should consider including risk adjustment for sociodemographic factors and functional status as well. Recent academic literature has added evidence to the notion that readmissions back to hospitals are driven by more directly by patient status factors and not by the quality of care delivered.[3] Furthermore, The National Quality Forum ("NQF") in April began a two-year trial program of a temporary policy change that would allow risk adjustment of performance measures for socioeconomic and other demographic factors, a departure from earlier quality measurement positions that viewed sociodemographic risk adjustment as inappropriate. However, with evidence that sociodemographic risk is real and impact readmission rates, we recommend that CMS and RTI consider including it in the list of risk adjustment factors for these measures. [3] *See* Michael L. Barnett, MD; John Hsu, MD, MBA, MSCE; J. Michael McWilliams, MD, PhD, *Patient Characteristics and Differences in Hospital Readmission Rates*, JAMA INTERN. MED. 2015;175(11):1803-1812 (Sept. 14, 2015), *available at* http://archinte.jamanetwork.com/article.aspx?articleid=2434813. We also believe adjusting for functional status would benefit the accuracy of the PPR measures. Functional status has a direct correlation with a patient's ability to remain healthy at home after PAC services have ended, meaning that PAC providers who treat more functionally impaired patients will likely have a higher PPR rate. Accordingly, we recommend that RTI and CMS consider how to apply an additional risk-adjustment factor for functional status in the overall risk adjustment methodology. **IV. RISK OF CONFUSION IN MULTIPLE READMISSION MEASURES** As part of the existing IRF PPS Quality Reporting Program ("IRF QRP"), IRFs already report All-cause Unplanned Readmission (NQF #2502) and are			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		scheduled to have this measure publicly reported beginning next year. Other PAC types will also require public reporting of a general all-cause readmissions measure. We are concerned that, as required by the IMPACT Act, the eventual public reporting of these PPR measures (which are essentially a subset of the more general all-cause measures) will result in substantial confusion amongst members of the public. For example, if both measures are publicly reported, PAC providers will have one all-cause unplanned readmission rate, but likely a different PPR rate. We question whether the crucial distinctions between these two different, but related, readmissions measures will be readily apparent to members of the public who take the time to assess different PAC providers based on readmission rates. Similarly, providers may have trouble accurately understanding the purpose and ultimate use of additional readmissions measures. IRF providers already receive annual PEPPER reports and also report on the All-cause measure (NQF #2502). With the addition of a "within stay" measure and a post-discharge PPR measure to these existing readmission measures, CMS should take deliberate steps to clearly communicate the intended use for each of these four readmission tools and how they will relate to one another. Without such clarifying communication, providers may find themselves adrift in various readmissions data without a clear idea of how it is all being used by the Agency. This is another example, similar to the IRF short-stay/transfer case considerations discussed above, of the reconciliation issues that CMS and RTI must face in overlaying IMPACT Act requirements with existing PAC regulations, and insofar as CMS and RTI can eliminate the duplicative requirements of IMPACT Act implementation, including overlapping public reporting of two "flavors" of readmissions, we highly encourage them to do so. Indeed, the IMPACT Act encourages CMS to refrain from duplication in methods for data collection, and we recommend that this theme be extended to other parts of IMPACT Act implementation as well. **V. MEASURE DEVELOPMENT SHOULD ALLOW MORE TIME FOR PUBLIC INPUT** Because the IMPACT Act represents a framework through which PAC providers will be compared to one another (with major implications),			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		stakeholders have a justified interest in being able to contribute their views on the specific details of measures. Typical federal comments give stakeholder entities at least thirty days to submit comments, and oftentimes as long as 60 days. However, RTI allowed only 9 business days between the initial notice of the comment period for this PPR measure (CMS comment request email dated Nov. 4) and the final due date (Nov. 16). Similarly, RTI has given stakeholders even less of a window to comment on its Discharge to Community measure—the initial CMS comment request email was sent on Nov. 12 and comments are due Nov. 23—a total of 8 days. These measures are complex and require careful consideration, and many PAC providers will not be able to submit comments, not because they do not hold views, but because they will simply be unable to absorb and analyze these complex documents and provide meaningful feedback in such limited comment windows. This abbreviated timeline drastically limits the number and quality of external viewpoints that will be available from the very providers who will be affected by these measures, and instead empowers a small set of decision makers who would otherwise benefit from a diverse set of perspectives. Accordingly, we request that comment periods for all future IMPACT Act measure development projects be extended to at least 30 days so that stakeholders have a legitimate opportunity to review, analyze, and compose informed public comments. **VI. CONCLUSION** We appreciate the opportunity to offer these comments and look forward to working with CMS and its contractors as implementation of the IMPACT Act continues. Should CMS or RTI staff have questions regarding any of these comments or other issues, please do not hesitate to contact us at the information below.			
47	11/16/2015	The National Association for Home Care & Hospice (NAHC) is the nation's largest tradeassociation representing home health and hospice agencies including Visiting NurseAssociations, government-based agencies, multi-state corporate organizations, health systemaffiliated providers, and freestanding proprietary agencies. NAHC members serve over 3 millionMedicare home health and hospice beneficiaries each year. NACH supports developing measures that address effective care management of Medicarebeneficiaries and appreciates efforts by the Centers for Medicare & Medicaid Services inimplementing the Improving Medicare Post-Acute Care Transformation Act. We wish to offer the following comments and recommendations:	Mary K. Carr, VP for Regulatory Affairs National Association for Home Care & Hospice	mkc@nahc.org	Home health association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		In the report, the contractor states there is limited evidence of potentially preventablereadmissions (PPR) for post-acute care (PAC). The list of PPR conditions are those identified asAmbulatory Care Sensitive Conditions developed by the Agency for Health Care Research andQuality. Patients admitted to post acute care typically have a more complex clinical profile thanthose patients receiving services in an ambulatory care setting. In addition, home health patientsoften receive care in at least one PAC settings prior to admission to home health care, suggestingthat these patients are more fragile with compromised health. Additionally, the PPR condition list was developed using the International Classification ofDiseases (ICD)-9 diagnoses codes, however, the measure will be implemented using claims withICD-10 diagnoses codes. It is reasonable to assume that the PPR conditions list will be considerably more complex and may alter the validity of several of the diagnoses included in themeasure. Further, the contractor addresses the relationship of the proposed PPR measure with the current 30 day re-hospitalization measure for home health agencies (NQF #2380 Re-hospitalization during the First 30 Days of Home Health). However, it is unclear how the current 30 day rehospitalization and the 60 day acute care hospitalization measure for home health will be aligned with the proposed PPR measure. The time lines for the current measures might overlap with the proposed PPR measure and all three measures track hospitalizations. Finally, NAHC strongly supports the inclusion of sociodemographic status as a variable for risk adjustment. NAHC believes the risk adjustment model should also include variables to address income, caregiver support, and prior PAC stays **Recommendations:** • Limit the number of PPR conditions to those conditions where evidence supports that a readmission could be prevented for 30 days by a home health treatmentplan. • Crosswalk the selected conditions with ICD-10 diagnoses codes and ensure the diagnoses are tested and validated for inclusion in the measure prior toimplementation.			

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		• Ensure the addition of the PPR measure does not conflict with the current home health re-hospitalization and acute care hospitalization measures. • Include in the risk adjustment model for home heath prior to implementation: – Socioeconomic status – Caregiver support – Prior PAC setting stay and the length of stay			
48	11/16/2015	The National Association of Long Term Hospitals (NALTH) is pleased to submit comments on the potentially preventable hospital readmission measures for post-acute care (PAC). NALTH is the only hospital trade association in the nation that is devoted exclusively to the needs of patients who require services provided by long term care hospitals (LTCHs). NALTH is committed to research, education and public policy development that further the interests of the very ill and often debilitated patient populations that receive services in LTCHs throughout the nation. NALTH's membership is composed of the nation's leading LTCHs, which serve approximately one-third of the Medicare beneficiaries who are admitted to LTCHs in the United States. We have carefully reviewed the draft specifications for the *Potentially Preventable Hospital Readmission (PPHR) Measures for Post-Acute Care* and have concerns regarding the ability of the measures to allow unbiased estimates of care quality differences across PAC settings. We discuss these concerns below. General Comment LTCHs differ from other post-acute care settings in key areas, making comparisons of outcomes across settings challenging. First, unlike other PAC settings, an LTCH, along with inpatient rehabilitation facilities, must meet the requirements of an acute care hospital. In addition, LTCHs must have an average length of stay of more than 25 days. Second, LTCHs treat higher severity cases than other post-acute care settings (because of the	Lane Koenig, PhD, Director of Research and Quality/Cherri Burzynski, MSN RN NE-BC, President National Association of Long Term Care Hospitals	lane.koenig@knghealth.com	Long-term care hospital association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		factors noted above). Skilled nursing facilities often will not take the types of cases treated in LTCHs because of the lack of clinical and financial resources required to appropriately care for these patients. In addition, LTCH patients often cannot handle the intense physical therapy requirements of patients sent to inpatient rehabilitation therapy because they are too sick and fragile. As another example, LTCHs frequently treat patients on prolonged mechanical ventilator with the purpose of weaning the patient. Few other PAC providers see such patients. While we understand the legislation requires the development of cross-setting measures, including LTCHs, care needs to be exercised in the development of methods as well as in the interpretation of findings related to different readmission rates across settings. Limitations in the measures hinder cross-setting quality comparisons a. The PPHR measures are constructed by multiplying a standardized risk ratio by the unadjusted average rate of readmission in the specific PAC setting's population. The average readmission rates used in the calculation are not adjusted for patient clinical differences between PAC settings. As a result, the differences in the PPHRs between PAC settings (e.g., LTCH, SNF, IRF, and HHA) may reflect differences in patient clinical differences rather than differences in care quality. There exist significant differences in patient severity and acuity across PAC provider settings. For example, patients treated at LTCHs include the most medically complex and resource-intensive cases within the Medicare population. In 2006, approximately 37% of LTCH cases grouped to the highest APR-DRG severity score, while this percent ranged from 4% to 7% for other post-acute care (PAC) providers.[1] Patients treated in LTCHs often possess multiple comorbidities and require specialized care. For example, 28.0% of LTCH patients with digestive system problems had at least three major complications or comorbidities compared to 2.2% of patients with digestive system problems in other PAC settings.[2] These differences in acuity may contribute to large differences between the unadjusted average readmission rates for LTCHs compared to the rates for other PAC settings. For example, according to RTI analysis of 2012–2013 Medicare claims data, the unadjusted unplanned 30-day mean readmission rate among LTCHs with at least 25 index stays was 24.3% whereas the comparable rate for inpatient rehabilitation facilities was 12.4%. While focusing on PPHRs may close some of this gap, patients admitted to LTCHs may be more susceptible to some of the PPHRs than other patients.			

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		[1] Koenig et al. The Effects of Long-term Care Hospitals on Outcomes, Utilization and Payments for Medicare Beneficiaries. November 7, 2013. Final Report prepared for the National Association of Long Term Hospitals. [2] Lane Koenig, Berna Demiralp, Josh Saavoss, and Qian Zhang, "The Role of Long-term Acute Care Hospitals in Treating the Critically Ill and Medically Complex: An Analysis of Nonventilator Patients," *Medical Care* 53(7) (July 2015): 585. b. The PPHR measures require a short-term acute-care stay within 30 days prior to a PAC admission (#5 on pg. 9). This requirement would mostly exclude patients discharged from LTCHs to less intensive care settings in calculating the readmission rates of those less intensive care settings. For example, if a patient is discharged from a short term acute care (STCH) to a LTCH and spends more than 30 days in the LTCH before being discharged to a skilled nursing facility (SNF) (STCH ->LTCH (more than 30 days) ->SNF), that patient would not be included in calculating readmission rates for that SNF. Patients who transition from more intensive care settings (such as LTCHs) to less intensive care settings (such as SNFs and HHA) are likely to have higher observed and unobserved severity relative to those who transition from acute care stay to the less intensive PAC setting directly or within a 30-day period. Therefore, this requirement would cause the PPHR measure for the less intensive care settings to be based on a limited and less severe portion of their broader population, potentially exacerbating the differences in patient acuity across PAC settings described in point (a). We recommend that this requirement is changed so that episodes in which a patient moves through the continuum of care following discharge from an acute care hospital are not systematically excluded from the measure sample. This could be done looking back at contiguous inpatient stays prior to admission to the PAC admission (pre-PAC episode). Any admission to a short-term acute care hospital within that pre-PAC episode would serve as the anchor stay. These cases would be included in the measure even if the STCH stay occurred more than 30 days prior to admission to the PAC. This revised requirement would ensure that the PPHR measures are based on a patient population that has experienced a STCH stay without selecting a less severe portion of the population for the measure computation.			

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		c. In defining potentially preventable hospital readmissions, the draft measure specifications do not distinguish across PAC settings. The draft measure specifications cite studies on readmission from SNFs and inpatient rehabilitation facilities, but do not cite any studies on for LTCHs. It would be important to include potentially preventable readmissions that have been identified for the LTCH setting and using readmissions that are specific to each PAC setting in constructing the measure. Concerns Regarding Risk Adjustment In comparing between LTCH facilities, we are concerned that the risk adjustment variables will not adequately capture patient differences and may lead to different likelihoods of readmission. Without sufficient risk adjustment, differences in readmission rates may be due to differences in patients' clinical characteristics and may not be attributed to differences in care quality across providers. a. The risk adjustment variables include the principal diagnosis only for the prior short-term claim. However, the principal diagnosis for the LTCH stay may differ substantially from the principal diagnosis associated with the prior STCH stay. For example, while the primary diagnosis for the prior STCH stay may be a certain type of surgery, the reason for the LTCH stay may be an infected wound, pressure ulcer or other type of complication associated with the surgery. We recommend that the risk adjustment variables for the LTCH PPHR measure include principal diagnosis associated with the LTCH stay. b. We are pleased to see the inclusion of days in prior acute intensive care unit/cardiac care unit (ICU/CCU) as a risk adjustor. In a previous study, we found that LTCH care is associated with lower mortality and/or payments for patients with at least 3 days in the ICU/CCU.[3] The same study also showed that LTCH care is also associated with lower mortality and/or payments for patients with multiple organ failure in four of the five major diagnostic categories studied. We recommend that an indicator for having at least two organ failures be included in the risk adjustment variables. [3]Lane Koenig, Berna Demiralp, Josh Saavoss, and Qian Zhang, "The Role of Long-term Acute Care Hospitals in Treating the Critically Ill and Medically Complex: An Analysis of Nonventilator Patients," *Medical Care* 53(7) (July 2015): 587.			

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		c. We support CMS' efforts to test variables for sociodemographic status for inclusion in the set of risk adjustment variables. We recommend the PPHR measures should be adjusted for sociodemographic factors based on a growing body of evidence linking sociodemographic status to health outcomes. For example, in RTI's response to inclusion of sociodemographic status factors for NQF #2512 All-Cause Unplanned Readmission Measures for 30 Days Post Discharge from LTCHs, RTI showed that the median risk standardized readmission rates among facilities with at least 47% of patients with Medicaid Buy-In was 24.2%, 1.6% higher than the median rate among facilities with less than 30% of patients with Medicaid Buy-In. This difference is equivalent to the difference in rates between a facility at the median and a facility at the 75th percentile. d. While Medicare claims data are more readily available than other data sources, they may not capture finer distinctions across patients that may affect the patients' outcomes and facility to which they are discharged. Therefore, a process to include assessment data in the PPHR measure calculations, once available, needs to be established and followed.			
49	11/16/2015	The New Jersey Hospital Association (NJHA) appreciates the opportunity to comment on the Proposed Measure: Potentially Preventable Readmissions for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long Term Care Hospitals and Home health Agencies. NJHA's membership includes more than 400 hospitals, inpatient rehabilitation facilities, long term care hospitals, skilled nursing facilities, assisted living communities, continuing care retirement communities, PACE organizations and home health agencies. As a result, NJHA views policy issues from a global perspective and with a patient-centered focus. We concur with the overall intent of CMS to address potentially avoidable readmissions from the post-acute settings and concur with the all-cause methodology. We also support the diagnostic categories that are excluded from the measurement, as well as the overall measurement design to risk adjust for clinical acuity and co-morbidities.	Theresa Edelstein, MPH LNHA, Vice President, Post-Acute Care Policy New Jersey Hospital Association	tedelstein@njha.com	Provider association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		We note that the prediction equations are based on a logistic statistical model with a 2-level hierarchical structure, and facility effects are modeled as belonging to a normal distribution. While this approach makes sense for average sized providers with "typical" rates of admissions and readmissions, we are concerned that for those providers who may have a large volume of patients enrolled in Medicare managed care plans, too many of their patients will be excluded from the calculations. Appendix A (conditions considered potentially preventable for the 30 day post-PAC) and Appendix B (conditions considered potentially preventable for the within-stay window) are, for the most part, appropriate diagnoses for which optimum clinical management should reduce the risk of readmission. However, in the specifications provided by RTI on page 7 "dehydration conditions" are listed as an exception to the principle diagnosis requirement to be deemed "potentially preventable." Dehydration and the various related codes are commonly "add-on" admission diagnoses for a wide array of clinical presentations in the elderly. Volume depletion, in acutely ill elders, may occur within hours. Furthermore, it is also frequently overused by admitting clinicians, based on physical findings (dry skin, dry mucous membranes, etc.) that are not reliable markers of dehydration in the elderly population. Therefore, we would ask that if the primary diagnosis does not fall under one of the "potentially preventable conditions" that the presence of "dehydration' or volume depletion does not trigger inclusion in the count. rrhythmias are included in Appendix A. While readmissions for previously diagnosed arrhythmias may be based on inadequate management, new onset arrhythmias are not, and PAC providers cannot predict or "manage" arrhythmias that have not presented themselves, or which are related to idiopathic or previously undiagnosed cardiac conditions. We would ask that new onset arrhythmias be excluded from this set. Appendix B includes Acute Delirium as a potentially preventable condition for within-PAC stay. There is little, if any evidence that would support that delirium is entirely preventable, particularly in post-surgical patients, patients with multiple serious conditions and those with underlying dementia. Secondly, a measure of quality should be recognition of delirium. Unless the readmission is related to another condition on this list, we do not feel that delirium, by itself, should trigger inclusion as a potentially preventable readmission.			

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		We strongly support the activity of daily living severity scores as inclusions in the risk-adjustment for home health readmission measures. Functional assessment is, and should be, an essential adjustment to the risk prediction for readmission. In addition to function, the presence or absence of in-home caregiver support for those with functional dependency is a strong predictor of readmission rates, and not something that home health providers can "manage" outside of the Medicare home health benefit. We ask for clarification of how Table C3, Table C4 and Appendix D will all be utilized together in the algorithm. In addition, we would like to see the Appendices and Tables updated for ICD-CM-10 before these measures are finalized. Lastly, we do support the inclusion of sociodemographic status as part of the risk adjustment. Not only are dually-eligible individuals often at greater risk because of their co-morbid conditions and functional needs, but they often have few community resources or supports to mitigate these risks. They represent a very heterogeneous sub-population that is quite different from non-Medicaid beneficiaries with the same primary diagnoses.			
50	11/16/2015	RML Specialty Hospital (RML) is pleased to have the opportunity to present comments on the Draft Measure Specifications: Potentially Preventable Hospital Readmission Measures for Post-Acute Care. RML is a freestanding hospital (with 2 locations) licensed in the State of Illinois and recognized by Medicare as a long term acute care hospital. RML is a 501(c)3 not-for-profit limited partnership whose current members are Loyola University Medical Center and the Advocate Healthcare Network. RML's clinical focus is on ventilator weaning (respiratory), complex medical, and wound services. Because of these programs, RML has historically maintained a very high case-mix level. During the last 12 months, our average case-mix fluctuated between 1.4–1.5 for Medicare patients. Our high case-mix level continues even after the significant case-weight decreases in the LTC-MS-DRG system from previous years. Patients are referred to RML from approximately 65 hospitals in Illinois. Most patients are normally transferred from ICUs, critical care units, burn units, and step-down units.	James R. Prister, President & CEO RML Specialty Hospital	jprister@rmlspecialtyhospital.org	Long-term care hospital

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		The purpose of this letter is to provide some general input, express concerns, and seek clarifications regarding several items contained in the above Draft Measure Specifications. RML appreciates RTI and CMS' thoughtful consideration of our comments and suggestions. As a general statement, RML is supportive of measures that can provide opportunities to improve the care and services that are offered within RML and across the entire post-acute industry. With that said, we appreciate and recognize the challenges associated with developing cross measures for all of the post-acute care industry. We must stress that in order for these "cross" post acute industry measures to be of great value, then there must be consistent comparisons based on risk adjusted indicators for each of the various post acute settings. With this comment in mind, we have a strong willingness to participate in the development process and in the assessment process. We are not yet convinced that this first effort will lead to a successful outcome. We hope that CMS recognizes the need that whatever is included in the final measurement specifications, that there should be a significant opportunity at the end of some period of time (we suggest after two years of use) to conduct a follow-up study to validate the appropriateness of the measure and identify if there are any shortcomings associated with it. OUTCOME It is identified in the descriptive information that the "outcome" reflects the readmission rates for patients who are readmitted to a short stay acute care hospital or an LTCH with a principal diagnosis considered to be unplanned and potentially preventable. The methodology utilizes a standardized risk ratio which is the predicted number of readmissions at the PAC provider divided by the expected number of readmissions for the same patients if treated at the average PAC provider. This methodology would negatively skew the measure for those providers who have high concentrations of high acuity patients, like those treated at RML. As many studies have indicated in the past, patients who are generally admitted to LTCHs have greater complexities, and have a greater likelihood of being at risk for a readmission within 30 days because of their comorbidities and because of the fact that they typically have long lengths of stay in the short stay hospital environment. An added challenge of this current definition that needs to be assessed, pertains to the new "LTCH appropriate" and "site neutral" categories of patients. The question is whether this new Measure will apply to all patients in the LTCH setting? A patient that is being discharged from an STCH to an LTCH and has a three			

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		day or greater length of stay in an ICU is considered an LTCH appropriate patient. Patients who do not have a three day ICU stay and are discharged from an STCH to an LTCH are considered to be site neutral. The proposed Measure appears to be more aligned with a traditional "site neutral" type of patient as opposed to a patient who has a three or more day ICU stay. It would be helpful if CMS and RTI could share any work that has been done to identify this as a possible reporting stratification for the Measure. One of the articles identified by RTI as a key citation was published in 2001. It would be most helpful to use more current research to identify an updated list of conditions which reflect possible reasons for readmission. The STCH codes identified in Appendix A and Appendix B are very helpful. There is a concern that patients discharged from one setting to another may have inconsistent code utilization and thus interpretation of the primary reason for admission from one setting to another. Is there a methodology that RTI is contemplating which would negate any inter-PAC setting coding challenges? The discussion regarding the numerator and denominator is helpful. A question we are trying to determine is whether the adjustment process to account for severity will actually be picked up in the risk adjustment process. It is not clear if the risk adjustment for patient characteristics with the facility effect being removed would actually be an appropriate adjustment or not. As an example, although prolonged mechanical ventilation is identified as a risk adjustment, there are many settings that do not take care of these patients and if a facility's expected readmissions are compared to the average PAC setting, it will put high acuity providers at a disadvantage compared to an average PAC provider and thus may lead to unintended consequences. It is helpful to see that the intent of this Measure is to follow a patient "deemed well enough" to be discharged to a less intensive care setting (i.e., discharged to less intense levels of care or to the community). It is noted that in the SNF PPR, patients who have IRF or LTCH admissions prior to their first SNF admission, are starting their SNF admission later in the 30 day risk window and are receiving other additional types of services as compared to patients who are admitted directly to the SNF from the prior proximal hospitalization. RTI notes that these patients are clinically different and their risk for readmission is different from the rest of SNF admissions. This concept should also be synonymous with LTCH patients			

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		as an LTCH appropriate patient must come from a short stay acute hospital and not be admitted directly from the community. We offer the following additional risk adjustment variables for consideration: morbid obesity; pre- and post-transplant, LVAD utilization, and most importantly, multisystem organ failure (based on 2, 3, or more organ systems). Under the PAC specific risk adjustors in the LTCH, it is identified that prolonged ventilation is an adjustor. Please provide the definition and source for this definition. It is stated that a lower score will indicate better quality. We believe that this is an admirable goal for the Measure, but until risk adjustment factors are sensitive enough across the various post-acute settings, the interpretation of this Measure should not be concluded at this time. Although not identified in the Draft Measure information, we are very interested in hearing from RTI and CMS how an organization will be able to monitor it's individual Measure at any given time. The ability to gather data to run the Measure is beyond the scope of most LTCHs and (we assume) other post acute providers. If it is CMS' intent to provide a calculation once per year, we do not believe that this frequency is appropriate. An opportunity to receive a monthly calculation would be a best case scenario. It should also be noted that the availability of post-acute discharge settings in any particular market can have a significant impact on the Measure. If a market has a strong continuum available to it across the post-acute space, then the Measure could make some very good comparisons. However, if there is intermittent availability of post-acute services, this will have an impact on this Measure. As always, RML would be interested in participating in the testing of this measure and strongly suggests that a pilot be initiated prior to an across the board implementation of the Measure.			

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51	11/16/2015	On behalf of the Association of Rehabilitation Nurses (ARN)—representing more than 5,300 rehabilitation nurses and more than 13,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness—we appreciate the opportunity to comment on the draft measure specifications for potentially preventable hospital readmission measures for post-acute care (PAC). Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. We continue to provide support and care, including patient and family education, which empowers these individuals when they return home, or to work, or school. Rehabilitation nurses often teach patients and their caregivers how to access systems and resources. Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding inpatient rehabilitation facilities (IRFs), hospitals, long-term subacute care facilities/skilled nursing facilities (SNFs), long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health, and private practices. ARN supports efforts to ensure people with physical disability and chronic illness have access to comprehensive quality care in whichever care setting is most appropriate for them. Specifically, as a part of its mission, ARN stands ready to work with policymakers at the local, state, and federal levels to advance policies and programs that promote maximum independence for people living with physical disability and/or chronic illness, particularly among the Medicare population.	Jeremy Scott, Health Policy Associate/Cheryl Lehman, PhD RN CNS-BS RN-BC CRRN, President Association of Rehabilitation Nurses	Jeremy.Scott@dbr.com	Rehabilitation nurse association

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		Measure Exclusions ARN is pleased the Centers for Medicare and Medicaid Services (CMS) has proposed discharge measure exclusions; however, we disagree with the proposed exclusion criteria of patients less than 18 years old. Many IRFs treat patients younger than 21 when necessary, which is reflected by the Functional Independence Measure (FIM) and IRF-Patient Assessment Instrument (PAI), both of which are used to assess patients age seven or older. ARN encourages CMS not to exclude patients under 18 years old from the discharge measures. While the time frame for the initial data collection for the project varied from one year (SNFs), two years (IRFs and LTCHs), and three years (HH) the reporting time frame for this indicator must be the same for all PAC settings. Reporting can be based on either one year of data, two years of data, etc. but it cannot vary among settings. This must be addressed by CMS and the subcontractors. ARN questions the rationale behind the exclusion for SNF stays where the patient had one or more intervening PAC admissions which occurred either between the prior proximal hospital discharge and SNF admission or after the SNF discharge, within the 30-day risk window as well as SNF admissions where the patient had multiple SNF admissions after the prior proximal hospitalization, within the 30-day risk window. The rationale states that "when patients have multiple PAC admissions, evaluating quality of care coordination is confounded and even controversial in terms of attributing responsibility for a readmission among multiple PAC providers. Similarly, assigning responsibility for a readmission for patients who have multiple SNF admissions subsequent to their prior proximal hospitalization is also controversial." ARN believes that this rationale could apply to any PAC setting and therefore, disagrees with having this as an exclusion from the SNF denominator. ARN also has serious concerns with the exclusion criteria of SNF stays with a gap of greater than one day between discharge from the prior proximal hospitalization and admission to a SNF. The exclusion criteria fails to consider a medically complex patient that is treated in an IRF and subsequently readmitted within 30 days for an issue that may have been treated as a comorbidity. Given that a prior proximal hospitalization is defined as an inpatient admission to an acute care hospital, critical access hospital (CAH), or a psychiatric hospital, and IRFs are licensed as hospitals, we believe that admission to an IRF should be considered a proximal			

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		hospitalization and disagree that patients who are clinically different should be excluded. In regards to the within-stay criteria, IRFs have been seeing a rise in the number of patients who must return to the acute inpatient care setting within 48-72 hours of admission due to the disparity between the level of care which their condition (can either be a co-morbidity or complication secondary to the presenting diagnosis) requires and the level of care which an IRF is able to provide. To this end, ARN disagrees with the within-stay criteria delineated for ARNs and believes that in these instances, re-admissions are a necessity for patient safety, and not necessarily preventable. **Measure Specifications** While ARN is generally supportive of the potentially preventable readmissions measure specifications, we have several concerns. As ARN has stated in previous comment letters, the IRF measure is based on 24 months of data while the SNF measure is based on 12 months of data. PAC facilities should not be penalized for conditions that prompt readmission which are unrelated to the patient's initial reason for admission. We also oppose CMS's proposal to require PAC providers to utilize 30-day readmission claims data to determine their readmission rates. Using claims data to calculate readmission rates will be difficult for IRFs and other PAC settings, as claims data are cumbersome to use and access. Employing a 30-day readmission rate measure will not provide meaningful insight or have an impact on quality improvement efforts if the PAC settings do not have unrestricted access to the data. **Conclusion** ARN very much appreciates the opportunity to provide comments to CMS regarding the Draft Measure Specifications for Potentially Preventable Hospital Readmission Measures for PAC. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement payment policy changes that ensure access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease.			

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52	11/17/2015	1. The measures do not address when a patient is discharged from a home health agency and using community health care assistance, but at a level lower than the skilled care they received from the home health agency. We recommend this be considered a discharge to the community and a positive outcome for the home health agency. All terminally ill non-hospice patients should be excluded from calculation of the measure. Some patients prefer to receive their 'hospice-type' care from a non-hospice provider, i.e., a home health agency, though they are still terminal.	Shari Klessig, Deputy Administrator Division of Quality Assurance Wisconsin Department of Health Services	Shari.Klessig@dhs.wisconsin.gov	State government
53	11/17/2015	• **Post Acute MSPB:** The most effective means to reduce preventable readmissions is to implement a post acute Medicare Spending Per Beneficiary (MSPB) penalty as proposed by Dr. Carol Carter of MedPac at the November MEDPAC meeting. MedPAC proposed a 30 day measurement period. I would suggest consideration for 45 days as that would allow for coverage of the gamesmanship that often accompanies such penalties being implemented. For example, patients can be re-admitted to a SNF without a hospital visit within 30 days of discharge from any Part A stay (acute or SNF). With a 30 day measurement period it is likely SNF's and acute rehabd would train their teams to do touch calls after 28 days and script to encourage/convince patients they could benefit from additional post acute services (paid for in a fee for service model). I believe 45 days would be ideal as if extended to 60 days it would likely dilute the measurement and not be as effective as intended. Overall its the most accurate means to hold post acute providers accountable for preventing avoidable readmissions and actually holding their active physicians accountable for not falling-back on the old about of simply returning patients to the acute hospital from the SNF. • **Readmission Penalty Evolution:** Hospitals are not investing in preventing unnecessary readmissions. They are allocating their limited dollars to other measures such as quality improvements and IT. Increasing the 3% penalty is highly unlikely to change this. The MSPB penalties for both acute and post acute are much more effective measures that invoke a reaction from health systems.	Josh Luke, Ph.D. FACHE, Founder National Readmission Prevention Collaborative	joshluke@nationalreadmissionprevention.com	Individual

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		• **Movement Toward All-Cause Readmission Prevention:** In regard to the existing readmission penalty, it should remain in place as a means to keep it a key indicator for hospitals. Existing leadership in hospitals is aging and struggling to adapt to a value based model. Most initiatives remain focused on driving acute volume, contrary to new alternative payment models. Thus, the readmission penalties should continue to evolve to focus more on "all-cause" as opposed to disease specific. The focus on disease specific has created pockets of focus and prioritization with the hospital, as opposed to a blanket commitment to preventing avoidable readmissions.			
54	11/17/2015	General Comments: We support the draft specifications, but believe there are multiple diagnosis codes that should be added to the list of conditions for defining potentially preventable hospital readmissions for 30-days post-PAC discharge. These comments ae in general in nature and apply to all the measures being developed. Appendix A is missing 2 major types of chronic ulcers: 1. Diabetic ulcer 2. Venous stasis ulcer Appendix B is missing the following: 1. Diabetic ulcer under diabetes short term complication 2. Venous stasis ulcer Also, we believe the following conditions should be added to both Appendix A and Appendix B, as these represent important wound conditions that can be appropriately treated in various PAC settings and are therefore potentially preventable. Infection and inflammatory reaction due to internal joint prosthesis (996.66) Disruption of external operation (surgical) wound (998.32) Other postoperative infection (998.59) Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft (996.67) Non-healing surgical wound (998.83)	Scott Reid Smith & Nephew	Scott.reid@smith-nephew.com	Medical device company

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		Hematoma complicating a procedure (998.12) Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft (996.69) Disruption of internal operation (surgical) wound (998.31) Disruption of wound, unspecified (998.30) Seroma complicating a procedure (998.13) Infected postoperative seroma (998.51) I70.231 Atherosclerosis of native arteries of right leg with ulceration of thigh I70.232 Atherosclerosis of native arteries of right leg with ulceration of calf I70.233 Atherosclerosis of native arteries of right leg with ulceration of ankle I70.234 Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot I70.235 Atherosclerosis of native arteries of right leg with ulceration of other part of foot I70.238 Atherosclerosis of native arteries of right leg with ulceration of other part of lower right leg I70.241 Atherosclerosis of native arteries of left leg with ulceration of thigh I70.242 Atherosclerosis of native arteries of left leg with ulceration of calf I70.243 Atherosclerosis of native arteries of left leg with ulceration of ankle I70.244 Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot I70.245 Atherosclerosis of native arteries of left leg with ulceration of other part of foot I70.248 Atherosclerosis of native arteries of left leg with ulceration of other part of lower left leg I70.332 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of calf I70.333 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of ankle I70.334 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of heel and midfoot I70.335 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of foot			

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		I70.338 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of lower leg I70.342 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of calf I70.343 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of ankle I70.344 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of heel and midfoot I70.345 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of foot I70.348 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of lower leg I70.432 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of calf I70.433 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of ankle I70.434 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of heel and midfoot I70.435 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of foot I70.438 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of lower leg I70.442 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of calf I70.443 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of ankle I70.444 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of heel and midfoot I70.445 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of foot I70.448 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of lower leg I70.532 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of calf I70.533 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of ankle I70.534 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of heel and midfoot I70.535 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of foot			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		I70.538 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of lower leg I70.542 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of calf I70.543 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of ankle I70.544 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of heel and midfoot I70.545 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of foot I70.548 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of lower leg I70.632 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of calf I70.633 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of ankle I70.634 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of heel and midfoot I70.635 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of other part of foot I70.638 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of other part of lower leg I70.642 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of calf I70.643 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of ankle I70.644 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of heel and midfoot I70.645 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of other part of foot I70.648 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of other part of lower leg I70.732 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of calf I70.733 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of ankle I70.734 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of heel and midfoot I70.735 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of foot			

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		I70.738 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of lower leg I70.742 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of calf I70.743 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of ankle I70.744 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of heel and midfoot I70.745 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of foot I70.748 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of lower leg I83.011 Varicose veins of right lower extremity with ulcer of thigh I83.012 Varicose veins of right lower extremity with ulcer of calf I83.013 Varicose veins of right lower extremity with ulcer of ankle I83.014 Varicose veins of right lower extremity with ulcer of heel and midfoot I83.015 Varicose veins of right lower extremity with ulcer other part of foot I83.018 Varicose veins of right lower extremity with ulcer other part of lower leg I83.021 Varicose veins of left lower extremity with ulcer of thigh I83.022 Varicose veins of left lower extremity with ulcer of calf I83.023 Varicose veins of left lower extremity with ulcer of ankle I83.024 Varicose veins of left lower extremity with ulcer of heel and midfoot I83.025 Varicose veins of left lower extremity with ulcer other part of foot I83.028 Varicose veins of left lower extremity with ulcer other part of lower leg I83.211 Varicose veins of right lower extremity with both ulcer of thigh and inflammation I83.212 Varicose veins of right lower extremity with both ulcer of calf and inflammation I83.213 Varicose veins of right lower extremity with both ulcer of ankle and inflammation I83.214 Varicose veins of right lower extremity with both ulcer of heel and midfoot and inflammation I83.215 Varicose veins of right lower extremity with both ulcer other part of foot and inflammation			

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		I83.218 Varicose veins of right lower extremity with both ulcer of other part of lower extremity and inflammation I83.221 Varicose veins of left lower extremity with both ulcer of thigh and inflammation I83.222 Varicose veins of left lower extremity with both ulcer of calf and inflammation I83.223 Varicose veins of left lower extremity with both ulcer of ankle and inflammation I83.224 Varicose veins of left lower extremity with both ulcer of heel and midfoot and inflammation I83.225 Varicose veins of left lower extremity with both ulcer other part of foot and inflammation I83.228 Varicose veins of left lower extremity with both ulcer of other part of lower extremity and inflammation I87.011 Postthrombotic syndrome with ulcer of right lower extremity I87.012 Postthrombotic syndrome with ulcer of left lower extremity I87.013 Postthrombotic syndrome with ulcer of bilateral lower extremity I87.031 Postthrombotic syndrome with ulcer and inflammation of right lower extremity I87.032 Postthrombotic syndrome with ulcer and inflammation of left lower extremity I87.033 Postthrombotic syndrome with ulcer and inflammation of bilateral lower extremity I87.311 Chronic venous hypertension (idiopathic) with ulcer of right lower extremity I87.312 Chronic venous hypertension (idiopathic) with ulcer of left lower extremity I87.313 Chronic venous hypertension (idiopathic) with ulcer of bilateral lower extremity I87.331 Chronic venous hypertension (idiopathic) with ulcer and inflammation of right lower extremity I87.332 Chronic venous hypertension (idiopathic) with ulcer and inflammation of left lower extremity I87.333 Chronic venous hypertension (idiopathic) with ulcer and inflammation of bilateral lower extremity I70.233 Atherosclerosis of native arteries of right leg with ulceration of ankle I70.234 Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot			

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		I70.235 Atherosclerosis of native arteries of right leg with ulceration of other part of foot I70.243 Atherosclerosis of native arteries of left leg with ulceration of ankle I70.244 Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot I70.245 Atherosclerosis of native arteries of left leg with ulceration of other part of foot I70.334 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of heel and midfoot I70.335 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of foot I70.344 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of heel and midfoot I70.345 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of foot I70.433 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of ankle I70.434 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of heel and midfoot I70.435 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of foot I70.443 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of ankle I70.444 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of heel and midfoot I70.445 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of foot I70.533 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of ankle I70.534 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of heel and midfoot I70.535 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of foot I70.543 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of ankle I70.544 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of heel and midfoot I70.545 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of foot			

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		I70.633 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of ankle I70.634 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of heel and midfoot I70.635 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of other part of foot I70.643 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of ankle I70.644 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of heel and midfoot I70.645 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of other part of foot I70.733 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of ankle I70.734 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of heel and midfoot I70.735 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of foot I70.743 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of ankle I70.744 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of heel and midfoot I70.745 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of foot L97.311 Non-pressure chronic ulcer of right ankle limited to breakdown of skin L97.312 Non-pressure chronic ulcer of right ankle with fat layer exposed L97.313 Non-pressure chronic ulcer of right ankle with necrosis of muscle L97.314 Non-pressure chronic ulcer of right ankle with necrosis of bone L97.321 Non-pressure chronic ulcer of left ankle limited to breakdown of skin L97.322 Non-pressure chronic ulcer of left ankle with fat layer exposed L97.323 Non-pressure chronic ulcer of left ankle with necrosis of muscle L97.324 Non-pressure chronic ulcer of left ankle with necrosis of bone L97.401 Non-pressure chronic ulcer of unspecified heel and midfoot limited to breakdown of skin L97.402 Non-pressure chronic ulcer of unspecified heel and midfoot with fat layer exposed L97.403 Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of muscle			

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		L97.404 Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of bone L97.409 Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity L97.411 Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin L97.412 Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle L97.414 Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone L97.419 Non-pressure chronic ulcer of right heel and midfoot with unspecified severity L97.421 Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin L97.422 Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed L97.423 Non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle L97.424 Non-pressure chronic ulcer of left heel and midfoot with necrosis of bone L97.429 Non-pressure chronic ulcer of left heel and midfoot with unspecified severity L97.501 Non-pressure chronic ulcer of other part of unspecified foot limited to breakdown of skin L97.502 Non-pressure chronic ulcer of other part of unspecified foot with fat layer exposed L97.503 Non-pressure chronic ulcer of other part of unspecified foot with necrosis of muscle L97.504 Non-pressure chronic ulcer of other part of unspecified foot with necrosis of bone L97.509 Non-pressure chronic ulcer of other part of unspecified foot with unspecified severity L97.511 Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin L97.512 Non-pressure chronic ulcer of other part of right foot with fat layer exposed L97.513 Non-pressure chronic ulcer of other part of right foot with necrosis of muscle			

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		L97.514 Non-pressure chronic ulcer of other part of right foot with necrosis of bone L97.519 Non-pressure chronic ulcer of other part of right foot with unspecified severity L97.521 Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin L97.522 Non-pressure chronic ulcer of other part of left foot with fat layer exposed L97.523 Non-pressure chronic ulcer of other part of left foot with necrosis of muscle L97.524 Non-pressure chronic ulcer of other part of left foot with necrosis of bone L97.529 Non-pressure chronic ulcer of other part of left foot with unspecified severity E08.40 Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified E08.41 Diabetes mellitus due to underlying condition with diabetic mononeuropathy E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy E08.43 Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy E08.44 Diabetes mellitus due to underlying condition with diabetic amyotrophy E08.49 Diabetes mellitus due to underlying condition with other diabetic neurological complication E08.51 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene E08.52 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene E08.59 Diabetes mellitus due to underlying condition with other circulatory complications E08.610 Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy E08.618 Diabetes mellitus due to underlying condition with other diabetic arthropathy E08.621 Diabetes mellitus due to underlying condition with foot ulcer E08.622 Diabetes mellitus due to underlying condition with other skin ulcer			

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		E08.65 Diabetes mellitus due to underlying condition with hyperglycemia E08.69 Diabetes mellitus due to underlying condition with other specified complication E09.40 Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified E09.41 Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy E09.42 Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy E09.43 Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy E09.44 Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy E09.49 Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication E09.51 Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene E09.52 Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene E09.59 Drug or chemical induced diabetes mellitus with other circulatory complications E09.610 Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy E09.618 Drug or chemical induced diabetes mellitus with other diabetic arthropathy E09.621 Drug or chemical induced diabetes mellitus with foot ulcer E09.622 Drug or chemical induced diabetes mellitus with other skin ulcer E09.628 Drug or chemical induced diabetes mellitus with other skin complications E09.65 Drug or chemical induced diabetes mellitus with hyperglycemia E09.69 Drug or chemical induced diabetes mellitus with other specified complication E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy E10.43 Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy E10.44 Type 1 diabetes mellitus with diabetic amyotrophy E10.49 Type 1 diabetes mellitus with other diabetic neurological complication			

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		E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene E10.52 Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene E10.59 Type 1 diabetes mellitus with other circulatory complications E10.610 Type 1 diabetes mellitus with diabetic neuropathic arthropathy E10.618 Type 1 diabetes mellitus with other diabetic arthropathy E10.621 Type 1 diabetes mellitus with foot ulcer E10.622 Type 1 diabetes mellitus with other skin ulcer E10.628 Type 1 diabetes mellitus with other skin complications E10.65 Type 1 diabetes mellitus with hyperglycemia E10.69 Type 1 diabetes mellitus with other specified complication E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified E11.41 Type 2 diabetes mellitus with diabetic mononeuropathy E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy E11.44 Type 2 diabetes mellitus with diabetic amyotrophy E11.49 Type 2 diabetes mellitus with other diabetic neurological complication E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene E11.59 Type 2 diabetes mellitus with other circulatory complications E11.610 Type 2 diabetes mellitus with diabetic neuropathic arthropathy E11.618 Type 2 diabetes mellitus with other diabetic arthropathy E11.621 Type 2 diabetes mellitus with foot ulcer E11.622 Type 2 diabetes mellitus with other skin ulcer E11.628 Type 2 diabetes mellitus with other skin complications E11.65 Type 2 diabetes mellitus with hyperglycemia E11.69 Type 2 diabetes mellitus with other specified complication E13.40 Other specified diabetes mellitus with diabetic neuropathy, unspecified E13.41 Other specified diabetes mellitus with diabetic mononeuropathy E13.42 Other specified diabetes mellitus with diabetic polyneuropathy E13.43 Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy			

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		E13.44 Other specified diabetes mellitus with diabetic amyotrophy E13.49 Other specified diabetes mellitus with other diabetic neurological complication E13.51 Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene E13.52 Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene E13.59 Other specified diabetes mellitus with other circulatory complications E13.610 Other specified diabetes mellitus with diabetic neuropathic arthropathy E13.618 Other specified diabetes mellitus with other diabetic arthropathy E13.621 Other specified diabetes mellitus with foot ulcer E13.622 Other specified diabetes mellitus with other skin ulcer E13.628 Other specified diabetes mellitus with other skin complications E13.65 Other specified diabetes mellitus with hyperglycemia E13.69 Other specified diabetes mellitus with other specified complication			
55	11/18/2015	On behalf of the Association of Rehabilitation Nurses (ARN)—representing more than 5,300 rehabilitation nurses and more than 13,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness—we appreciate the opportunity to comment on the Draft Specifications for the Discharge to Community Quality Measure for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs). Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. We continue to provide support and care, including patient and family education, which empowers these individuals when they return home, or to work, or school. Rehabilitation nurses often teach patients and their caregivers how to access systems and resources.	Jeremy Scott, Health Policy Associate/Cheryl Lehman, PhD RN CNS-BS RN-BC CRRN, President Association of Rehabilitation Nurses	Jeremy.Scott@dbr.com	Rehabilitation nurse association

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		Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding IRFs, hospitals, long-term subacute care facilities/SNFs, long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health, and private practices. ARN supports efforts to ensure people with physical disability and chronic illness have access to comprehensive quality care in whichever care setting is most appropriate for them. Specifically, as a part of its mission, ARN stands ready to work with policymakers at the local, state, and federal levels to advance policies and programs that promote maximum independence for people living with physical disability and/or chronic illness, particularly among the Medicare population. **Section 4.3.2: Unplanned Admissions/Readmissions in the 31-Day Post-Discharge Observation Window** ARN is supportive of CMS's proposal to develop a measure that works to identify unplanned (re)admissions; however, we have concerns with identifying unplanned (re)admissions based on the planned readmissions algorithm used in National Quality Forum (NQF) measure #2510: SNF 30-Day All-Cause Readmission Measure (SNFRM); NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs; NQF #2512: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs; and NQF #2380: Re-hospitalization During the First 30 Days of Home Health. To begin, the exclusion criteria included within NQF #2510 for SNF stays where the patient had one or more intervening post-acute care (PAC) admissions to an IRF that occurred either between the prior proximal hospital discharge and SNF admission or after the SNF discharge within the 30-day risk window fails to allow for a medically complex patient that is treated in an IRF and readmitted to the SNF within 30 days for a condition that may initially have been treated as a comorbidity. We disagree with the rationale provided for exclusion because while the measure assesses readmission rates while accounting for patient demographics, principal diagnosis in the prior hospitalization,			

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		comorbidities, and other patient factors, often, this may not be the reason for admission to a SNF. ARN believes that the measure should include the principal diagnosis during the prior proximal hospitalization, comorbidities based on the secondary medical diagnoses listed on the patient's prior proximal hospital claim and diagnoses from prior hospitalizations that occurred in the previous 365 days, length of stay during the patient's prior proximal hospitalization, length of stay in the intensive care unit (ICU), body system specific surgical indicators, end-stage renal disease (ESRD) status, whether the patient was disabled, and the number of prior hospitalizations in the previous 365 days. It also would be beneficial to understand the comorbidities being evaluated in the risk-adjustment model. ARN urges CMS to develop of a list of comorbidities, comparable to the IRF PPS list of comorbidities. As such, ARN encourages CMS to categorize an intervening admission to an IRF as a proximal hospitalization. Also, we have serious concerns with CMS's proposal to require PAC providers to utilize Medicare claims data to calculate their 30-day readmission rates. Using claims data to calculate readmission rates is difficult for health care providers, as claims data are cumbersome to use and access. Employing a 30-day readmission rate measure will not provide meaningful insight or have an impact on quality improvement efforts if the PAC settings do not have unrestricted access to the data. **Section 4.3.3: Death in the 31-Day Post-Discharge Observation Window** ARN believes that patients who have been discharged to the community and die within the post-discharge window should not be included within the quality measure, given the variation in patient characteristics across the four settings. For example, as compared to all Medicare beneficiaries, the SNF and LTCH patient population represents the most disabled, elderly, and frail beneficiaries. The Medicare Payment Advisory Commission's (MedPAC) March 2015 Report to Congress found that compared with other beneficiaries, "SNF users are older, frailer, and disproportionately female, disabled, living in an institution, and dually eligible for both Medicare and Medicaid."[1] Moreover, as compared with all Medicare beneficiaries, those admitted to LTCHs are "disproportionately disabled (under age 65), over age 85, or diagnosed with end-stage renal disease. They are also more likely to be African American."[2] ARN urges CMS to exclude patients that die within the post-discharge window after being discharged to the community from the			

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		quality measure, as the types of patients treated in each setting greatly varies and can lead to an inaccurate reflection of the quality of care. [1]See MedPAC March 2015 Report to Congress, p. 185. http://www.medpac.gov/documents/reports/chapter-8-skilled-nursing-facility-services-(march-2015-report).pdf?sfvrsn=0 (Last Accessed November 13, 2015). [2]MedPAC March 2015 Report to Congress, p. 271. http://www.medpac.gov/documents/reports/chapter-11-long-term-care-hospital-services-(march-2015-report).pdf?sfvrsn=0 (Last Accessed November 13, 2015). **Section 4.6: Measure Exclusions** ARN is pleased the CMS has proposed discharge measure exclusions; however, we have concerns with the proposed exclusion of post-acute stays that end in transfer to the same level of care, and specifically, CMS's proposal to include only the final post-acute provider in the discharge to community measure. CMS's proposed exclusion criteria fails to consider when a patient's "home" is a custodial nursing facility and the patient's post-acute episode involves a discharge back to his or her "home." In such circumstances, including the final post-acute provider in the discharge to community measure when a patient is discharged to the originating level of care, but in essence, is returning home, may distort the findings of the quality measure. We encourage CMS to design a quality measure that is capable of capturing the difference between a patient's return to his or her home and a patient's post-acute episode that involves transfer to the same level of care. **Conclusion** ARN very much appreciates the opportunity to provide comments to CMS regarding the Draft Specifications for the Discharge to Community Quality Measure for SNFs, IRFs, LTCHs, and HHAs. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement payment policy changes that ensure access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease.			

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56	11/18/2015	30 Days Post PAC Discharge Adult Asthma COPD CHF Diabetes short term complication Hypertension/Hypotension Influenza Bacterial pneumonia UTI/Kidney Infection C Diff Septicemia—except in labor Skin and subcutaneous Dehydration/Electrolyte imbalance Aspiration pneumonitis; food/vomitus Acute renal failure Adverse drug event Arrhythmia Intestinal impaction Pressure ulcers Within PAC Stay Adult Asthma COPD CHF Diabetes short term complication Hypertension/Hypotension Influenza Bacterial pneumonia UTI/Kidney Infection C Diff Septicemia—except in labor Skin and subcutaneous Dehydration/Electrolyte imbalance Aspiration pneumonitis; food/vomitus Anticoagulant complications	Carrie L. Condon Director, Financial Reporting Strategy & Network Development Consulate Health Care	Carrie.L.Condon@consulatehc.com	Post-acute care provider

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		Acute delirium Acute renal failure—with dehydration Adverse drug events Arrhythmia Deficiency and other anemia Intestinal impaction Pressure Ulcers Deep vein thrombosis/Pulmonary embolism Head Injury Upper extremity fracture Lower extremity fracture			
57	11/18/2015	The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the development of a discharge-to-community quality measure and the development of potentially preventable readmission measures for post-acute (PAC) care providers. We appreciate CMS's ongoing efforts to develop and test quality indicators for the Medicare program. The discharge to community and potentially preventable readmission measures are required by the Improving Post-Acute Care Transformation (IMPACT) Act of 2014 and Protecting Access to Medicare Act of 2014. The measures aim to reflect the quality of care furnished in the four PAC settings-home health agencies (HHA), skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH). MedPAC fully supports the development of outcome measures that gauge the quality of care across all four PAC settings. In its own work, MedPAC has used both measures to evaluate the quality of care in SNFs and IRFs. The goal of the cross-cutting measures is to gauge and compare the quality of care provided across PAC settings. As such, it is critical that the measures use a uniform definition, specification (such as inclusions and exclusions), and risk adjustment method. Otherwise, differences in rates could reflect differences in the way the rates were constructed rather than underlying differences in the quality of care. Further, the Commission believes that providers should be held accountable for the care furnished	Carol Carter, PhD, Principal Analyst/ Francis J. Crosson, MD, Chairman Medicare Payment Advisory Commission	ccarter@medpac.gov	Government

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		during "their watch" and for safe transitions to the next setting or home. To that end, the Commission's comments focus on additional measures needed to assess both aspects of care and ways to standardize the measures so that the rates reflect actual differences in the care furnished, not in the measure specification. The Commission's comments in response to this specific solicitation are organized into three sections: the proposed discharge to community measure, the proposed readmission measures, and issues relevant to both measure sets. **Discharge to community measure** The discharge to community measure is a risk-adjusted rate of FFS beneficiaries who are discharged to the community following a PAC stay and do not have an unplanned hospital readmission (to an acute care hospital or LTCH) during the 31 days following discharge to the community. This measure relies on the discharge status codes on claims to determine community discharge. Our work has indicated that this field is not as reliable as matching claims from one provider with admissions to another to confirm the discharge destination. In its final specification of these rates, CMS and its contractor (RTI International) should consider an approach that verifies discharge destination by matching consecutive claims for the same beneficiary. **Potentially preventable hospital readmission measures** CMS's contractor proposes six measures of potentially preventable readmissions. Four are setting-specific rates of readmissions during the 30 days after discharge from the PAC setting. These measures gauge how well the PAC provider prepares beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting or home. A fifth measure calculates the readmission rate during the first 30 days after discharge from an acute care hospital and admission to a SNF. The last measure gauges the rate of readmissions during IRF stays. The key problem with these measures is that they do not gauge the rate of readmissions during the stay in HHAs and LTCHs. This is a substantial omission. All PAC providers should be held accountable for readmissions that occur while they are caring for beneficiaries, not just for the period after beneficiaries are discharged from their care. CMS should move as expeditiously as possible to develop measures of readmission rates during stays in HHAs and LTCHs. In addition, HHAs should be held accountable for			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		hospital admission rates for stays that do not have prior hospitalization, which comprise the majority of HHA stays. We urge CMS to develop a measure of hospital admissions that occur during HHA stays. In addition, there are two problems with the proposed SNF stay measure. First, it gauges readmissions during the first 30 days after discharge from an acute care hospital even though one-third of SNF stays are longer than this period. This could encourage SNFs to delay readmissions for beneficiaries who require rehospitalization until after the post-period ends. Second, the measure can include a mix of days while the beneficiary is in the SNF and days after discharge from the SNF. The factors (such as diagnoses and comorbidities) that influence the risk of readmission and their importance of the factors may differ for the two periods (during the stay and the post-period). Therefore, separate measures are required and should use separate risk adjustment. Separate measures have the added advantage of giving SNFs more actionable information since the processes and actors differ for the two periods. CMS plans to test the inclusion of dual eligibility, race, and possibly other measures of socio- demographic status (SES) into the risk adjustment based on work it is conducting on the all- cause readmission rate measures. The Commission has stated that the best way to examine differences in outcomes across providers with varying shares of low-income beneficiaries is to calculate rates without SES adjustment and then compare the rates across providers with similar shares of these patients. This way, the actual readmission rates remain intact. If the rates themselves are adjusted, the reported rates will "adjust away" any differences in outcomes, hide actual disparities in care, and could reduce the pressure on providers to improve care for the poor. We appreciate that the IMPACT Act requires the Secretary to study the effect of SES on quality and resource use measures. We urge CMS to calculate the rates without SES adjustment, divide providers into peer groups (with similar shares of low-income beneficiaries), and compare each provider to its peer group. **Issues relevant to both measures** Accurate risk adjustment requires clinical information about beneficiaries-their diagnoses and comorbidities. A patient's comorbidities can be gathered looking at the prior year's claims (and are captured in the hierarchical condition categories). However, PAC users without a preceding hospitalization will not have clinical information from an			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		immediately preceding hospitalization. For HHA, LTCH, and IRF stays without a preceding hospitalization, CMS should gather diagnostic information from the PAC claim. This will increase the likelihood that a patient's condition is accurately captured. CMS and its contractor note that the measures for some settings may require pooling data over two years to increase the sample of stays and stability of the measures. It also discusses adjusting rates towards the average for providers with low counts, sometimes referred to as a "shrinkage" methodology because it shrinks the difference between the observed rate and the average. Small counts are not limited to particular PAC settings. Therefore, for each measure, the contractor should establish the minimum number of stays for stable measures and pool data for any provider with insufficient Medicare stays during one year. This will increase the stability of the measures for small providers in any setting. CMS should avoid using shrinkage because it hides the actual rates, thereby undercutting the ability to assess the quality of individual providers. Consistent with the goal that cross-setting quality measures should be easily compared across settings, the risk adjustment methods for both measures should include the same factors for the four settings. This way, the rates across settings can be compared. If different factors are used in each setting's models, the rates will not be directly comparable because they will have been adjusted for some factors in one setting but a different set of factors in another. Therefore, the Commission urges CMS and its contractor to avoid setting-specific risk adjustment factors (such as prior PAC and emergency department use in the risk adjustment model for HHAs) and factors that cannot be included for each setting's methodology (such as the severity score of the activities of daily living). The risk adjustment models should also avoid factors that measure service use in the PAC setting because providers can control whether and how much service to furnish. Including measures of particularly discretionary service use could influence the care beneficiaries receive. Finally, the proposed risk-adjustment methods include a factor for the number of hospital stays during the past year. By controlling for beneficiaries who repeatedly cycle through hospital and PAC stays, the risk adjuster effectively accepts this pattern of care. A PAC provider could have a high rate of potentially avoidable readmissions in the prior year and yet this would improve a provider's readmission rate because the risk			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		adjustment would control for these prior hospitalizations. Including this factor in the risk adjustment model undercuts our ability to assess the quality of care furnished by a provider, and we urge CMS to drop this factor from its risk adjustment model. MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the CMS and its contractors. The Commission also values the ongoing cooperation and collaboration between MedPAC and CMS staff on technical policy issues. We look forward to continuing this productive relationship. To that end, we feel compelled to make a general comment on the timelines for submitting comments in recent solicitations. We are concerned that we are observing a trend towards shorter and shorter comment periods in CMS's recent solicitations for comments and requests for information (RFI). The comment period for this notice is two weeks; the comment period for CMS' s recent RFI on the advanced payment models (APM) mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 was 30 days (subsequently extended by two additional weeks). While we understand CMS' s desire to move as expeditiously as possible in its policy development process, we do not believe that the process is well-served by these short deadlines. CMS is requesting information and comments on issues that are both technically complex and that have broad implications for the Medicare program. Stakeholders need sufficient time to digest the issues on which CMS is seeking comment, to develop an appropriate technical response, and to clear their technical responses through any applicable administrative structures within their organizations. Based on our extensive track record in responding to CMS notices of proposed rulemaking (which we are required to do by law), a 14-day, or even 30-day comment period may be insufficient time to produce well-considered, and optimally useful comments. We will, of course, make every effort to meet CMS's deadlines for comments or information in response to agency solicitations. However, in cases where the set comment periods are extremely short, we reserve the prerogative of submitting our comments, consistent with our legal mandate, on the best timeline that we are able. We urge CMS, in the interest of engaging the various stakeholders in the policy development process, to grant a full 60-day comment period on major initiatives, whether done through the regulatory process or otherwise, whenever possible.			

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58	11/23/2015	Thank you for the opportunity to comment on the proposed measure, Discharge to Community (for Home Health). VNAA is a national trade association that supports, promotes and advocates for mission-driven providers of home health, hospice and palliative care. VNAA's 130 members are nonprofit home healthcare and hospice agencies from all regions of the country from rural to urban. Our members serve communities in over 33 states, through 600 branches. First of all, we would like to note that the Discharge to Community (DTC) Measure appears to conceptually incorporate another CMS measure under development, Potentially Preventable Hospital Readmissions for Home Health (PPR). We have two concerns about this: 1) the measure appears to include the same logic model, e.g., that home health can prevent readmissions to higher levels of care (by stating the flip side, that home health care keep patients in the community), but the measure itself is not the same. We urge CMS to develop a single set of specifications and risk adjustors to capture this concept and to use it in both measures. And 2) home health agencies reporting this measure could potentially be penalized twice for the same level of performance: once under the PPR measure and once under the DTC measure. For your reference we include VNAA's comments on the PPR measure at the end of this email, and ask that they be incorporated into our comments on DTC. Second, while we support the notion of standardized measurement across PAC providers, we are concerned in this instance that a standardized measure comparing home health agencies to other PAC providers—SNF, LTCH, and IRF—introduces 'apples to oranges' comparisons. • Home health agencies are the 'safety net' and transitional source of care accepting discharges from both acute and other PAC providers. Patients with unresolved clinical or rehabilitation needs can be discharged from other PAC settings to home health. Home health does not have a safety net. While we understand that under the proposed measure some (re) admissions are expected, we believe that the common	E. Liza Greenberg, RN MPH, Interim Vice President, Quality and Performance Improvement Visiting Nurse Associations of America	LGreenberg@vnaa.org	Home health association

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		interpretation will be that all admissions or readmissions to a higher level of care (acute or PAC), are to be avoided. We believe that the DTC measurement model will be interpreted such that the only acceptable discharge from home health is to the community. This may be to the clinical detriment of the patient. Under current payment rules there is no 'step down' strategy from home health unless the patient has the means to pay for additional private pay services. Clinically, this does not align with the needs of many patients, who remain fragile even after an episode of therapeutic and rehabilitative services. For these patients, another PAC stay or an acute stay followed by PAC or HH may be the most appropriate clinical care. • Lack of standardization is also introduced to the home health version of the measure by incorporating a population that is excluded from other PAC provider versions of the measure: patients <u>who did not have a short term acute stay within 30 days preceding a home health admission.</u> It is a fairly fundamental concept of standardization that all reporting entities should use the same numerator and denominator specifications. Unless CMS or the contractor can provide statistical evidence that the population excluded from other providers has an identical demographic and utilization profile as the non-excluded population, we urge CMS to use the same populations for reporting across all PAC providers. <u>Other comments are as follows:</u> • We recommend that patients admitted to hospice any time during the 31 day window after discharge from home health be excluded, as should be any patient with a hospital (re)admission who is subsequently discharged from acute care to hospice. Any admission to hospice is an indicator of a very sick and fragile patient for whom a long term community stay would not be expected. Alternatively, redefine 'discharge to community' to include a 'discharge to community hospice' any time during the PAC window, regardless of other admissions to acute or PAC settings. Either strategy may promote more appropriate referral to hospice, while other approaches may have the unintended impact of discouraging hospice referral.			

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		• Please confirm that readmission to home health after a home health discharge (e.g., readmission to the same level of care) will not be counted as a readmission. Multiple episodes of home health services may be an appropriate strategy to enable a member to remain in the community. • Consider how to use available information on use of personal care services after discharge from home health, OASIS item M2420-Discharge Disposition. CMS would need to review data to see whether the information can be used as a risk adjustor. • Please provide final inclusions and exclusions to the risk adjustment model for each PAC provider, and allow a public comment on the model. A noted, the same risk adjustment model should be applied to all IMPACT measures to promote consistency in the measure specifications and interpretation of results. • In general, VNAA is concerned about the adoption of measures holding home health accountable for events after discharge while at the same time adopting payment and audit policies that make it challenging to provide skilled services to coordinate care and stabilize the patient based on a patient care plan. Through the CY 2016 HH PPS regulations on Clinical and Functional Thresholds, CMS increased the functional and clinical acuity thresholds for purposes of determining reimbursement. The net result is that home health agencies will receive less reimbursement for high acuity/high need patients and therefore have fewer resources to invest in the care management or other services necessary to monitor a patient post-discharge. Simultaneously, many MACs appear unaware that home health agencies may be reimbursed for management and evaluation of the patient care plan and for skilled services to maintain function or slow deterioration within Medicare coverage benefit standards. As the IMPACT measures are implemented, we strongly encourage CMS to educate both MACs and RACs on these allowable services. Allowing home health agencies to manage cases to the full extent of Medicare coverage will			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		support better compliance with quality requirements during the episode, and enable them to better manage the patient with anticipatory care planning to avoid preventable relapses after the episode (as measured in the PPR and DTC measures). • In general, VNAA is concerned that the highly complex and detailed IMPACT Act draft measures are being released for public comment with an extremely limited time window for comment. The short time window for comment and the challenges accessing the statistical expertise needed to fully understand the measures means that CMS may not be fully benefiting from the comments and perspective of the provider community. We encourage CMS and its contractors to allow more time for public comment, release measures sequentially instead of concurrently, and offer some technical assistance that would enable more informed input from the provider community. (For example, CMS or a contractor could record a webinar explaining the measure calculations or risk adjustment models for a non-expert audience.)			
59	11/23/2015	I am writing on behalf of the Pennsylvania Homecare Association's home health member agencies to submit feedback and questions on the draft measure specifications for discharge to community (DTC) being developed by RTI International and Abt Associates (hereinafter "the contractors"). My comments today echo the same concerns and feedback our members had when considering the potentially preventable readmissions (PPR) measure, as the two measures share many characteristics and calculations. <u>Community Population Measured</u> In the PPR measure, the contractors excluded from the calculation any home health patients admitted directly following an acute care stay. In the DTC measure, these populations are excluded when calculating the measure for all PAC providers but home health agencies without any rationale provided for the difference. The IMPACT Act measures are meant to provide standardized across all PAC settings, and yet the populations measured here could produce results that are not statistically comparable. Patients admitted from the community rather than an	Janel Gleeson, Esq., Public Policy Director Pennsylvania Homecare Association	JGleeson@pahomecare.org	Home health association

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		inpatient acute setting are more likely to have unmanaged chronic conditions and healthcare needs that are complicated by other economic or social factors. PHA asks the contractors to provide their rationale for including community patients for HHAs but no other settings. We urge you to bring the HHA measure into alignment with the others and exclude community admissions from all PAC calculations. Questions for Clarification As with the PPR draft, the contractors a key question unanswered in the DTC draft. 1. **What information will be used to determine the readmissions at the "average" home health agency?** The measure is calculated using as the denominator the patient's expected care path in the average HHA, but the draft does not offer details on how the average agency will be selected. PHA asks the contractors to please clarify. Thank you for the opportunity to provide comment on the DTC draft measure specifications. We hope that any future public comment period will allow more time for analysis and more notice of the release of these drafts. We look forward to continued dialogue with CMS and the contractors as the IMPACT Act provisions are carried out.			
60	11/23/2015	Once again, another regulation placed on our healthcare system that is already over taxed with regulations, red tape, reduced funds, etc. etc. I do not agree with this proposal. It does not ensure better patient care. What we are seeing in the healthcare field is patients being shuffled from one place to another or totally denied service because of all the regs. When you continue to cut funding, add more regulations, and place a bigger burden on healthcare workers, you end up getting poorer care because everyone is doing more paperwork and less patient care. Our government is so out of touch with reality when it comes to truly caring for people and what they need. I've been a registered nurse for 32 years and I'm appalled at what has become of our healthcare system. I use to love taking care of people. Now I don't. The paperwork burden has become so great and the regulations have become so burdensome that I am seeing more and more nurses and physicians wanting out. Then who is going to care for all the politicians that have made these rules??? I say let them care for themselves.	Kim Crockett, RN	comfortcare@windstream.net	Individual provider

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61	12/1/2015	Considering that discharges to hospice is one of the suggested measure exclusions, I would encourage consideration to additionally exclude anyone with a condition or chronic condition with physician documentation for those with a life expectancy of less than 6 months. This would allow for the exclusion of anticipated deaths when the patient may elect to decline hospice services.	Mindy Hathaway-Nelson, Clinical Reimbursement Resource Nurse Presbyterian Homes and Services	mhathawaynelson@preshomes.org	Home health agency
62	12/1/2015	When a resident is admitted to a skilled facility often time with in 24 to 48 hours the labs that were pending up on discharge from the hospital to the skilled facility become available and based on the lab and diagnosis the PCP may send them back to the hospital for further/follow up treatment as it often relates to the skilled stay or the skilled facility may not even be made aware labs are pending this creates another scenario and repeat of labs within sometimes one day.	Linda Batch	lbatch@nikkeiconcerns.org	Individual
63	12/1/2015	One of the most concerning issues with transitions of care and preventing hospital readmissions is the home health agency being able to secure physician frequency orders in a timely manner to continue seeing patients when they discharge home.	Marie Guthrie, RN BSN PHN, Director of Patient Care Medical Home Care Professionals, Inc.	mguthrie@medicalhomecarepros.com	Home health agency
64	12/1/2015	On behalf of Uniform Data System for Medical Rehabilitation (UDSMR) and the nearly 900 post-acute care facilities (IRF, SNF, LTCH) that we serve, we appreciate the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS) Call for Public Comment related to the Development of Potentially Preventable Readmission Measures for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs). We would like to note the following concerns regarding the development of these measures: 1. **Measure development for the IMPACT Act appears to create 4 separate measures that are site specific with their own set of criteria and risk adjustment factors.** The IMPACT Act aims to create quality measurement within Post-Acute Care (PAC) that is "standardized and interoperable." By developing measures which differ in their calculation, such as site-specific inclusion/exclusion criteria or risk-adjustment factors, PAC	Troy Hillman, Director of PAC Strategy and Analysis Uniform Data System for Medical Rehabilitation	thillman@udsmr.org	Not-for-profit organization

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		sites will be subjected to comparisons of quality that do not differ based upon the quality of care provided, but rather the differences inherent in the measure calculations. We strongly recommend that CMS and the measure developers produce a measure that is calculated in a "standardized and interoperable" manner with inclusion/exclusion criteria and risk-adjustment factors the are applied consistently across all PAC sites. **The measures developed for the IMPACT Act hold PAC providers responsible for circumstances that occur outside of their control.** While PAC providers are responsible for providing care that allows patients safe transitions to their next setting or home, holding these providers accountable fora time period in which they are not furnishing care should not differentiate the quality of care they actually provided. In Appendix A, Table A1 lists various conditions that define potentially preventable hospital readmission for 30-days post-PAC discharge. In this list, conditions such as Asthma, Congestive Heart Failure, and Dehydration are listed as a reason for a potentially preventable readmission. So if the patient fails to care for themselves post-discharge (against the advice and discharge instructions provided by a PAC provider) and requires readmission to Acute Care for one of these conditions, the PAC provider is penalized even though the patient is no longer being cared for by the PAC provider. We strongly recommend that CMS and the measure developers produce a measure that represents the quality of care provided by PAC providers while the patient is in their care.			
65	12/1/2015	On behalf of Golden Living, a long term and post-acute care provider comprised of Medicare and Medicaid certified skilled nursing facilities and assisted living facilities; Aegis Therapies, a provider of Medicare and Medicaid occupational therapy, physical therapy, and speech language pathology services; and AseraCare Hospice, (hereinafter referred to collectively as "Golden Living"), we are pleased to offer comments on the draft measures for Potentially Preventable Hospital Readmission Measures for Post-Acute Care. Initially, our general concern regarding the measures is the detailed diagnostic categories which would be lumped into potentially preventable readmissions (PPRs). Specifically, two which are most problematic are Arrhythmias (specifically atrial fibrillation), since most SNFs have limited ability to predict a new or worsening arrhythmia. Electrocardiography is not routinely performed in skilled nursing facilities and telemetry studies	Candace Bartlett, National Senior Director Regulatory Affairs Golden Living	Robin.Bartlett@goldenliving.com	Long-term care provider

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		are also uncommon in that setting. Acute Delirium can be caused by an unlimited number of factors, some preventable and some not. Further, cause is not always explored or investigated thoroughly in the inpatient setting, with some clinicians reaching for a preliminary explanation such as UTI when something more serious such as a brain tumor could be causing the delirium. It also appears from these measures that the only acceptable reason for readmission to the hospital (other than the excluded categories) is for surgical procedures. While we understand that this proposal is intended to prevent rehospitalizations from any post-acute space, it seems to set an expectation that individuals should not expect to be hospitalized for many of the conditions that currently fill American hospitals and that do not include surgical procedures. At p. 5, the proposal indicates, "Proper care and management of patient conditions (in the facility or by primary care following discharge) along with appropriate, clearly explained and implemented discharge instructions and referrals, can often prevent a patient's readmission to the hospital." This statement makes several assumptions about the quality and quantity of care available in communities. While proper and effective discharge planning upon leaving a SNF stay is essential, many of our patients do not have reliable, ready access to primary care providers in the community who have the capacity to see patients in a timely way after discharge from a post-acute care facility, or even possess enough understanding about these patients' current medical problems to manage them in one or even two visits and thereby prevent subsequent rehospitalization. The proposal goes on to state, "Some conditions such as pressure ulcers…the literature strongly recommends that readmissions for these conditions can be prevented with close monitoring from healthcare providers and under appropriate ambulatory care." Few community health care providers are prepared to care for any but the lowest stages of pressure ulcers. This also assumes that a patient has a caregiver available at home who has the knowledge and willingness to care for those pressure ulcers and the other comorbidities that tend to accompany pressure ulcers. So if a patient is cared for in a SNF for a stage III or IV pressure ulcer and is discharged when the skilled benefit exhausts but before the ulcer heals, they would presumably be discharged to home if they could not afford to continue their stay at a SNF. This type of patient would be at high risk for the pressure ulcer to worsen and need to return			

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ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	E-Mail Address	Type of Organization
		somewhere other than home. We are concerned that patients won't get the appropriate care for these conditions that they need in a community setting. While CMS has the previous 12, 24 or 36 months of claims data in order to calculate the patient's risk of unusual deterioration based on comorbidities and previous hospitalizations, the post-acute care provider would not have access to this type of data when making decisions about potential SNF admissions. SNF providers however, would be blindly accepting the risk of deterioration of these patients during their rehab care. Alternatively, patients with certain "high risk" diagnoses such as HIV don't appear to have exclusions under this proposal. HIV patients would be at higher risk for many medical problems including infections that are considered treatment failures, i.e., "inadequate management of chronic conditions," "inadequate management of infection," "inadequate management of unplanned events." These patients would be much more likely to have poor outcomes than non-HIV patients. Many of our residents are frail and elderly, and do not respond to "standard" medical care as effectively or efficiently as younger people. The list of potentially preventable readmission diagnoses includes exacerbations of most chronic medical conditions and infections. A certain percentage of older patients will not respond adequately even given the best medical care and could deteriorate and require rehospitalization. This would not be a measure of quality of medical or nursing care in a SNF, but simply an expected unfortunate event in a certain percentage of patients. These proposed changes are likely to have many unintended consequences for patients and their families, as well as for post-acute providers. While we support the goal of preventing unnecessary, expensive rehospitalizations, we are concerned that patients and their families will have fewer choices about the type of care that they may be able to receive. For example, it may seem obvious to some health care providers that a patient has end-stage medical problems, is clearly on a trajectory toward death, and would be appropriate for palliative/hospice care. However some families do not, even with exhaustive explanation from medical teams, want to accept that avenue of care. Patient and family choice in these instances would be restricted by the hospital and/or post-acute care system, who would be penalized for continuing aggressive medical care and futile rehospitalizations.			

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		Further, we would want to review the Demographic factor (SDS) before the QMs are developed. The SDS will exclude all Medicare Advantage programs, causing variability based upon demographics and location. Finally, the measures are all based on ICD-9 Codes. Will these be re-evaluated based upon new ICD-10 coding practices?			
66	12/1/2015	1) Page 7, Paragraph starting with "In order for a readmission…"—My comment is that the PAC provider is completely subject to the accuracy of the hospital provider on their coding of the claim. Ideally there would be an opportunity for the PAC provider on the claim or patient assessment to identify the patient returning for a planned procedure. 2) Page 8, Paragraph starting with "The post-PAC discharge…"—I understand the IRF measure is constructed similarly with respect to the count being "discharge day plus 2." What I question is how the readmission measure is constructed for the hospital readmission measure, is it also defined as "discharge day plus 2?" My recommendation is that the 30 day readmission measure if defined consistently across all provider types, and if all, including the hospital, are "discharge day plus 2," then that is acceptable. 3) Page 12, item #6) on the top of the page—I agree with the recommendation to exclude patients who are discharged against medical advice, a concern that I have is whether or not providers are consistent in applying the definition of "against medical advice," as I believe there is latitude in the SNF/PAC provider application of the AMA status code. Is it possible that there is a resulting increase of the application of the AMA status code by providers? 4) Page 13-14, general comment regarding "risk adjustment"—I agree that for PAC providers, a risk adjustment taking into account the multiple items identified is necessary. I'd recommend consideration of two additional factors should be considered for risk adjustment of potential re-hospitalizations: patient functional status and cognition. Patients who access PAC services that are immobile or generally totally dependent upon a caregiver for mobility are likely at a greater risk of re-hospitalization. This possibly could be accounted for in the patient assessments, such as FIM score for IRF or ADL index in SNF. Additionally, patients who have profound cognitive impairment are less able to participate effectively in their care or follow recommended treatment plans by providers. This likely leads to an increase risk of re-	Craig Miller	ctmiller0322@att.net	Individual

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		hospitalization that should be adjusted for. There is an acknowledgement of the significance of cognition with the addition of acute delirium in Appendix B, however the patient who accesses PAC services with chronic cognitive deficit is also likely at higher risk. Consider for example two patients who suffer a stroke, one has chronic dementia, and is bed bound requiring SNF care VS a stroke patient who has no pre-existing cognitive deficit and has some functional return enough that allows him/her to participate in a IRF stay…clinically it would seem the differences in their cognition and mobility may lead to an increased re-hospitalization risk for the SNF patient, and this should be adjusted for. Patients who are both immobile and have profound cognitive impairments concurrently are likely at greater risk, that should be adjusted for.			
67	12/1/2015	CVS Health appreciates the opportunity to comment on the proposed set of quality measures that are part of the project titled, "*Development of Potentially Preventable Readmission Measures for Post-Acute Care.*" CVS Health is a pharmacy innovation company helping people on their path to better health. Through its more than 7,900 retail drugstores, more than 1,000 walk-in medical clinics, a leading pharmacy benefits manager with more than 70 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, and expanding specialty pharmacy services, the Company enables people, businesses and communities to manage health in more affordable, effective ways. This unique integrated model increases access to quality care, delivers better health outcomes and lowers overall health care costs. Our long-term care (LTC) pharmacy subsidiary, Omnicare, is the market leader in professional pharmacy and consulting and data management services for skilled nursing, assisted living, and other chronic care settings. Omnicare serves over one million residents in LTC facilities/ communities each year. Omnicare leverages its unparalleled clinical insights into the geriatric market, along with some of the industry's most innovative technological capabilities, to benefit its LTC residents. We believe that the integration of Omnicare into CVS Health will help facilitate improved transitions of care for patients being discharged to the community from acute and post-acute care settings.	Elizabeth Terry, Director, Government Affairs & Policy Omnicare, Inc./CVS Health	libby.terry@omnicare.com	Pharmaceutical company

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		General Comments CVS Health strongly supports the development of programs and initiatives aimed at improving health outcomes and value in transitions of care. We believe quality measures help serve to evaluate the success of those programs and initiatives. We also believe that the development of quality measures would benefit from precise definitions, data-driven analyses, review by expert panel(s), pilot-testing as needed, and refinements following pilot-testing as warranted, before such quality measures are broadly implemented. **Specific Feedback on Draft Measures** CVS Health supports the goal of the draft potentially preventable readmissions (PPRs) measures for post-acute care (PAC). We also understand the underlying statutory requirements that direct their development. However, we caution that making a direct correlation between a SNF's instructions and referrals provided to a discharged resident, and potentially preventable hospital readmissions during the 30-day period following a SNF discharge, reflects an assumption that a SNF has control of both post-discharge care and compliance with such instructions. To explain in more specific terms, following a resident's discharge, the SNF may be only one of numerous providers with a direct role in any the following: 1) the discharged resident's actions/inactions, behaviors, choices, and adherence; 2) the discharged resident's exposure(s) to health risks; and 3) the quality and frequency of health care provided by the discharged resident's primary care provider or other outpatient provider(s). In other words, while the SNF's discharge instructions are specifically designed to influence and guide post-discharge care and decisions, they are not the only instructions that the patient may be receiving. Despite this, under the proposed measures, the SNF would be the (only) provider held accountable during the 30-day post-discharge period. Further, we draw attention to the fact that adverse events identified (in Appendix A of the draft measure) as potentially preventable and unplanned, for which the SNF would be held accountable, may be unrelated to the medical reason(s) why the patient had a recent SNF stay. We are providing three examples to help illustrate the points mentioned above:			

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		Example 1: Dehydration A resident is discharged from a SNF to home after a hip replacement. The social worker confirms that a follow-up visit to their primary care provider is scheduled in one week. Ten days after the SNF discharge, the grandchildren come to visit the discharged resident, and one of the children had a gastrointestinal virus. The discharged resident becomes dehydrated three days after the visitors (13 days after the SNF discharge) due to severe nausea, vomiting, and diarrhea, and, despite taking antiemetic and antidiarrheal medications prescribed by their primary care provider, is hospitalized for dehydration. This readmission was not due to "inadequate management of infection" in the SNF, as the discharged resident was infected after discharge. We are concerned that the SNF would be held accountable for the readmission illustrated in this example, under the current draft of the PPR measure. Example 2: Acute Renal Failure/ Adverse Drug Event A resident is discharged from a SNF to home after recovering from pneumonia. Two weeks later, the discharged resident strains a back muscle getting out of bed. For the next three days, the discharged resident takes high doses of OTC ibuprofen, which he/she bought at the store after the SNF discharge. He/she suddenly is not urinating, has swelling, and experiences nausea/vomiting. He/she is admitted to the hospital 17 days after the SNF discharge, with acute renal failure. Again, this readmission was not due to "inadequate management of other unplanned events" by the SNF, yet the SNF would be held accountable based on the current draft of the PPR measure. Example 3: Cellulitis A resident is discharged from a SNF to home. Five days later, while being driven to a follow-up appointment with the primary care provider, he/she is in a car accident and suffers several deep lacerations to his/her left arm. Ten days later, his/her arm becomes red, hot, and swollen, and the patient develops a fever. The patient visits the emergency department (15 days after the SNF discharge), and is admitted to the hospital for IV antibiotics for diagnosed cellulitis. Again, this is not "inadequate management of infection" by the SNF, a both the cause of the infection and the infection itself happened after, and was unrelated to, the SNF stay. We believe similar examples could be provided for virtually every condition listed in Appendix A of the draft measure.			

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		Recommendations CVS Health respectfully makes the following four recommendations for your consideration: • We believe the draft SNF PPR post-discharge measure should be redesigned to focus on any readmissions within the 30 day period for the patient's original condition for hospital and nursing home admission (index admission primary diagnosis), and/or complications associated with that condition. We believe this reflects a more appropriate approach as part holding a SNF accountable for the quality of care provided in that facility, and the facility's discharge instructions and follow up care referrals. • We recommend that a narrowed post-discharge SNF PPR measure be pilot-tested, and be refined as warranted, before its widespread implementation. • We draw attention to the fact that ICD-9 codes listed in the draft measures for an adverse drug event may not be specific enough. We understand that ICD-9 codes were likely used given only recently was ICD-10 coding implemented. We believe use of ICD-10 codes in the next versions of the draft measures will help provide the needed additional specificity. • With regard to the SNF measure being developed for the 30-day period following a hospital discharge to a SNF setting—a "within stay" measure—we believe the conditions listed in Appendix B, considered to be potentially preventable, are appropriate and reasonable.			
68	12/1/2015	On behalf of our nearly 400 member hospitals and health systems, including approximately 75 inpatient rehabilitation (IRFs), 20 long term acute care hospitals (LTCHs), 100 hospital based skilled nursing facilities (SNFs), and 110 hospital/health system home health agencies (HHAs), the California Hospital Association (CHA) welcomes the opportunity to provide comments on the potentially preventable readmission measures for post-acute care (PAC). CHA recognizes and appreciates the recent extension of the comment period to December 1st from the original date of November 19th. While the additional time was helpful, the total duration of the comment period remained insufficient, which limited our ability to engage providers, review the measures and provide meaningful input. We ask that CMS	Alyssa Keefe, Vice President Federal Regulatory Affairs/ California Hospital Association	akeefe@calhospital.org	Provider association

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		consider a minimum of 60 days for all comment periods regarding quality measures. These are technical specifications that require careful review by those with various levels of expertise. In addition, this specific comment period was particularly challenging, due to the publication date's close proximity to other recently released regulations (discharge planning, home health prospective payment system final rule) as well as the timing of the recent CMS training for LTCH data collection. At this time we offer the following general comments, and will continue to provide feedback as the measure development process continues. In the interim, we ask that CMS require RTI International and Abt Associates to move quickly to provide more meaningful information on the measure testing results and solicit additional input from clinical experts to further inform this process. <u>Conditions and selected codes</u> We understand that the lists of codes and conditions were developed in consultation with a technical expert panel (TEP) and based on specific clinical rationales. Unfortunately, the measure specifications document does not provide enough detail to understand that rational for augmenting the existing algorithms for the PAC setting. CHA urges CMS to provide some examples to further illustrate the clinical justification for augmentation of the current algorithms. This may be done by way of example to help the reader understand the opportunities and challenges of the inclusion or exclusion of a particular condition or code. In addition, we believe additional documentation would allow for greater transparency of the methodology and that moving forward, CMS should make the TEP meetings open to the public. Moreover, the technical specifications should be supported by robust testing data that demonstrates the clinical rational for inclusion or exclusion. This information should be made available for further discussion by clinical experts. CHA is particularly concerned about the use of ICD-9 codes for measure development, versus the use of ICD-10 codes. We urge CMS to pursue testing using ICD-10 in order to identify any possible impact on measurement of performance associated with the transition from ICD-9 to ICD-10. The findings of this testing should also be made available for review.			

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		Risk adjustment Our request for additional testing is informed by our understanding of factors associated with readmissions. Recent research has identified an individual's functional status and ability to perform activities of daily living (ADLs) as significant factors in in predicting and managing hospital readmissions 1 2 In that context, we are concerned that the current proposal for risk adjustment is based exclusively on diagnosis and comorbidity codes. We urge CMS to conduct additional study directed toward the evaluation and incorporation of measures of functional status measures in risk adjustment for readmissions. The inclusion of functional status measures will be particular important to assess the need and efficacy of rehabilitation care provided at all levels of care PAC care continuum. Sociodemographic adjustment CHA appreciates the inclusion of adjustments to measure the effect of sociodemographic factors on readmissions, and we have frequently advocated for their inclusion in quality measures. For the PAC potentially preventable readmission measure, RTI/Abt proposes to use race and dual-eligibility for Medicare and Medicaid as risk adjusters. We join our colleagues at the American Hospital Association in urging CMS and RTI/Abt to examine a broader set of proxies. We agree with their November 19 comments, in which they observed that dual-eligible status and race are not the most appropriate or effective proxies for sociodemographic status, and recommend that Census-derived data on income and educational status may be more direct proxy.			