Public Comment Summary Report

Project Title:

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).

Dates:

- The Call for Public Comment ran from November 9, 2015 to December 8, 2015.
- The Public Comment Summary was made on April 14, 2016.

Project Overview:

CMS has contracted with RTI International and Abt Associates to develop measures reflective of quality of care, resource use and other domains for post-acute care (PAC) settings in order to meet the mandate of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), and to support CMS quality missions. The PAC settings include SNFs, IRFs, LTCHs, and HHAs.

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 encourages the public to submit comments on the measures.

The purpose of this Call for Public Comment was to seek input on the development of discharge to community measures for PAC settings, including measure specifications such as inclusion/exclusion criteria, numerator and denominator definitions, and risk adjusters—patient/resident characteristics that are associated with the outcome.

Project Objectives:

- To develop a discharge to community measure for post-acute settings (SNFs, IRFs, LTCHs, HHAs), which includes standardized items and specifications such as the discharge to community outcome definition, inclusion and exclusion criteria, and patient characteristics for risk adjustment.
- To obtain cross-setting and setting-specific input on application and implementation of discharge to community measures for SNFs, IRFs, LTCHs, and HHAs.

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 on the CMS Public Comment website
    - Email notification to relevant stakeholders and stakeholder organizations
    - Email notification to the measure's Technical Expert Panel members

- *Volume of responses received*: CMS received 56 comment letters in total (the vast majority of letters contained more than one comment). These comment letters were submitted by a range of stakeholder types, including providers and clinicians in PAC settings, academicians and researchers with technical expertise in quality measurement, and advocacy groups representing different PAC areas.

Stakeholder Comments—General and Measure-Specific

This report provides a summary of public comments received and CMS's responses to the public comments. CMS would like to thank all commenters for sharing their comments, concerns, and suggestions. In general, CMS received considerable support for the discharge to community measure concept. We appreciate concerns shared by commenters, and have provided responses and clarifications regarding these concerns. Several commenters provided suggestions for measure modifications, which we carefully considered, making relevant measure updates where appropriate and feasible. At the end of the report, we provide a table containing the verbatim text of all public comments received.

1. Overlap with CMS's Readmissions Measures for Post-Acute Settings

Summary: Several commenters expressed concern that a PAC provider would be penalized twice for a single readmission, under the discharge to community measure and under CMS's readmissions measures for post-acute care settings. Commenters thought that the discharge to community measure is duplicative of the readmissions measures, reporting readmission rates in an inverse manner to the readmissions measures.

Response: The IMPACT Act requires the specification of a measure to address the resource use and other measures domain of discharge to community by SNFs, LTCHs, IRFs, and HHAs. The discharge to community measure has been developed to meet this requirement. This measure is intended to assess discharge to community outcomes, and the appropriatness of discharges to community from PAC settings.

CMS's goal is to develop measures that are meaningful to patients and consumers, and assist them in making informed choices when selecting post-acute providers. Given that discharge to a community setting is an important goal for a large proportion of post-acute patients, CMS believes that reporting discharge to community outcomes separately from readmission rates is important from a patient/consumer perspective.

The discharge to community measure provides information that is distinct from CMS's readmissions measures, which examine the rate of all-cause or potentially preventable readmissions in different time windows. The discharge to community measure is a broader measure - it first examines whether or not a patient was discharged to the community from the PAC setting; next, for patients discharged to the community, it examines whether they stayed alive in the community without an unplanned readmission in the 31-day post-discharge window. Including 31-day post-discharge readmission and mortality outcomes is intended to measure successful discharges to community, and avoid the potential unintended consequence of inappropriate discharges to the community.

In addition to assessing death in the post-discharge observation window, the discharge to community measure includes patients who die during the PAC stay.

2. Lack of Prior Acute Hospitalization Requirement in the Home Health Agency Measure

***Summary*:** Several commenters related that the home health discharge to community measure does not require hospital admission in last 30 days, while the other PAC settings do have this requirement for inclusion in the measure.

***Response*:** CMS carefully deliberated the target population definition for the discharge to community measure, and would like to explain the rationale for the HHA target population specification. Our analyses revealed that

the majority of HHA patients (56 percent) did not have an acute care stay within the 30 days preceding their HHA episode. Further, there was significant heterogeneity in HHA size, with many small agencies. As a result, requiring a prior acute stay for this measure would result in approximately 31.9 percent of HHAs not having the minimum number of episodes necessary to report a measure result with two years of data. If the reporting period were extended to three years, this would drop to 24.5 percent, meaning that one in four agencies would still not have reportable results. In general, CMS seeks to use measures that can speak to the experience of the maximum number of providers.

CMS adjusts for a recent prior acute care stay in the risk adjustment model for this measure, to accommodate the two distinct cohorts. For patients for whom index inpatient claims are not available, earlier inpatient claims as well as physician and other claims will be used to capture comorbidities and other covariates.

CMS has successfully developed, used and publicly-reported risk-adjusted, claims-based outcome measures that include HHA patients. For example, the Acute Care Hospitalization (NQF#0171) and Emergency Department Use without Hospitalization (NQF #0173) measures have been endorsed and publicly-reported since 2012. Prior PAC and emergency department (ED) use was found to be a significant predictor in the risk adjustment models for the Acute Care Hospitalization (NQF#0171) and Emergency Department Use without Hospitalization (NQF #0173) measures. Similar to the discharge to community measure, those measures do not require episodes to have a prior acute care stay.

3. Reliability of the Claims Discharge Status Code

Summary: Some commenters expressed concerns regarding reliability of the claims discharge status code. Commenters suggested verifying discharge destination on the PAC claim with consecutive follow-up claims to confirm admission to another provider. One commenter stated, "We recommend that, as a check, for patients determined to be discharged to the community using this variable, the measure development team identify whether there are post-discharge claims from any STCHs[1], LTCHs, SNFs, IRFs, or HHAs to ensure that discharge to community was properly coded. At a minimum, the accuracy of the discharge status code and its impact on estimated provider performance should be assessed." Other commenters recommended using assessment data rather than claims data to obtain discharge status information.

***Response*:** CMS appreciates the commenters' concerns regarding reliability of the claims discharge status code. CMS is committed to developing measures based on reliable and valid data. Because the discharge to community measure is a measure of discharge destination from the PAC setting, CMS has chosen to use the PAC-reported discharge destination (from the Medicare FFS claims) to determine whether a patient/resident was discharged to the community; these data inform us of where the PAC setting discharged the patient/resident. While some commenters suggested using PAC assessment data to obtain discharge destination, currently, the discharge destination items vary across the four PAC patient assessment instruments.

The primary use of the discharge status code for this measure is to determine whether a patient/resident was discharged to a community setting, with or without home health services. For patients discharged to a community setting, we look for any acute care or long-term care hospital (LTCH) claims in the 31-day post-discharge window, starting on the day of discharge. Thus, our measure specification will identify any acute care or LTCH claims that follow a discharge to community, and these will be considered an unfavorable outcome for the measure.

[1] STCH = Short-Term Care Hospital

CMS appreciates the suggestion to consider data validation procedures, such as verifying discharge destination with follow-up claims when the discharge is to an institutional or HHA setting, or verifying absence of any claims when the discharge is to community without any services. In the future, we could take under consideration looking for IRF and SNF admissions/claims in the 31-day post-discharge window when examining discharge to community outcomes. Nevertheless, we would like to note that an Assistant Secretary for Planning and Evaluation (ASPE) report on post-acute care relationships found that, following discharge to community settings from IRFs, LTCHs, or SNFs in a 5 percent Medicare sample, IRFs or SNFs were very infrequently reported as the next site of post-acute care.[2]

The use of the claims discharge status code to identify discharges to the community was discussed at length with the Technical Expert Panel (TEP) convened by our measure development contractor. The TEP members included researchers who have examined reliability of the claims discharge status code. During those discussions, TEP members did not express significant concerns regarding the accuracy of the claims discharge status code in coding community discharges, nor about our use of the discharge status code for defining this quality measure. TEP members suggested that CMS conduct provider education and training to improve consistency in coding the claims discharge status variable. TEP members were also of the opinion that use of the claims discharge status code in a CMS measure would help improve consistency in its coding. A summary of the TEP proceedings is available on the PAC Quality Initiatives Downloads and Videos Web page at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

CMS has assessed reliability of the claims discharge status code by examining agreement between discharge status on claims and assessment instruments in all four PAC settings, specifically examining agreement in coding of community discharges. In the IRF setting, using 2013 data, we found 98.8 percent agreement in coding of community and non-community discharges when comparing discharge status codes on claims and the Discharge to Living Setting (item 44A) codes on the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI). In the LTCH setting, using 2013 data, we found 95.6 percent agreement in coding of community and non-community discharges when comparing discharge status codes on claims and the Discharge Location (item A2100) codes on the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set v1.01. In the SNF setting, using 2013 data, we found 94.6 percent agreement in discharge to community codes when comparing discharge status codes from claims and Discharge Status (A2100) on the Minimum Data Set (MDS) 3.0 discharge assessment, when the claims and MDS assessment had the same discharge date. In the HHA setting, using 2011–2013 data, we found 96.9 percent agreement in discharge to community codes when comparing discharge status codes from claims to the Reason for Assessment (M0100) and Inpatient Facility Type (M2410) items on the Outcome and Assessment Information Set (OASIS) assessment.

For patients discharged from an inpatient PAC setting to an acute care hospital, CMS confirmed the accuracy of the PAC claim discharge status code with the presence of a follow-up acute care claim on the day of, or day after, PAC discharge. We found that 88 percent to 91 percent of IRF, LTCH, and SNF claims with acute care discharge status codes were followed by an acute care claim on the day of, or day after, PAC discharge. We believe that these data support the use of the "Patient Discharge Status Code" from the PAC claim for determining discharge to a community setting for this measure.

[2] Gage B, Morley M, Spain P, Ingber M. Examining Post Acute Care Relationships in an Integrated Hospital System Final Report. RTI International; 2009.

4. Relatedness of Post-Discharge Readmissions

***Summary*:** A few commenters were concerned that post-discharge readmissions could be unrelated to the reason for the PAC stay, and PAC providers would be held accountable for unrelated readmissions that were out of the PAC provider's control. They suggested that CMS remove the post-discharge unplanned readmissions component from the discharge to community outcome definition. One commenter asked, "While a post-acute care provider can provide services that impact the ability of a patient to be discharged back to a community setting, whether or not a patient returns to an acute care facility in the 30 days following that PAC discharge can be completely unrelated to the services furnished by the PAC provider. For instance, a patient is discharged home from a post-acute care provider but is re-admitted to acute care 10 days later for pneumonia (which is listed as a diagnosis category that cannot be considered planned). Should the post-acute care provider's discharge to community percentage be penalized if the readmission is completely unrelated to the services provided within post-acute care?"

Response: We have included 31-day post-discharge unplanned readmissions in the measure in an effort to avoid the potential unintended consequence of inappropriate discharges to the community. TEP members encouraged CMS to be cognizant of this potential unintended consequence, and were in agreement with the inclusion of both post-discharge readmissions and death in the measure. The all-cause unplanned readmissions algorithm we propose to use has been adopted from our NQF-endorsed all-cause unplanned readmissions measures for PAC settings. Because the notion of related readmissions has had a difficult defining process, the measure has used all-cause readmissions as a marker, rather than related readmissions. Most existing readmissions measures have used the all-cause version of readmissions as a marker for an undesirable result. Improved care transitions and coordination of care are expected to reduce all-cause unplanned readmissions. The measures do not benchmark an expectation of a 0 readmission rate in the measure's post-discharge observation window.

5. Readmissions to IRF or SNF in the 31-day Post-Discharge Window

Summary: Some commenters suggested that, in addition to unplanned readmissions to an acute care hospital or LTCH in the 31-day window following discharge to community, admissions or readmissions to an IRF or SNF should also be considered an unsuccessful discharge to community because the patient did not remain in the community in the post-discharge window. Commenters were concerned about potential unintended consequences that could result from not monitoring IRF or SNF (re)admissions following discharge to community. Commenters were also concerned that not counting IRF or SNF (re)admissions as an unsuccessful outcome could incentivize facilities to discharge patients to the community and then (re)admit them to an IRF or SNF in order to have a successful community discharge for the measure.

Response: By including unplanned acute care or LTCH readmissions in the measure, CMS is accounting for more serious, acute events in the post-discharge window. CMS agrees that it is important to monitor IRF or SNF admissions and readmissions in the 31-day post-discharge window to examine whether patients/residents remained in the community following discharge. In future versions of the measure, CMS will consider looking for IRF and SNF admissions and readmissions in the 31-day post-discharge window when examining discharge to community outcomes.

As previously noted, an ASPE report on post-acute care relationships found that, following discharge to community settings from IRFs, LTCHs, or SNFs in a 5 percent Medicare sample, IRFs or SNFs were very

infrequently reported as the next site of post-acute care.[3] CMS will monitor whether post-discharge (re)admissions to IRF or SNF increase once the discharge to community measure is implemented.

6. Planned Readmissions and Planned Procedures

Summary: One commenter expressed concern that transfers from a PAC facility to an acute care hospital for planned procedures would be considered an unsuccessful outcome for the discharge to community measure.

Response: CMS would like to clarify that the stays of patients/residents who have a direct planned readmission to an acute care hospital or LTCH, including readmissions for planned procedures, will be excluded from the discharge to community measure. A list of planned procedures is included in the algorithm used to determine whether a readmission was planned or unplanned. Patients who have a direct acute planned readmission at discharge from the PAC will be excluded from this measure. We would further like to clarify that readmissions that reflect interruptions in a PAC stay are not counted in the discharge to community measure.

7. Death Post-Discharge

Summary: Some commenters expressed concern about the inclusion of patients/residents who die in the 31 days after PAC discharge. Some stated that death in the 31 days after discharge did not necessarily indicate an unsuccessful discharge or an unanticipated event. They called for these patients/residents to either be excluded from the measure, or counted as a successful discharge to community if they died while on hospice care. Other commenters pointed out that PAC facilities are not responsible for events that result in death post-discharge.

***Response*:** CMS appreciates the commenters' concerns about inclusion of patients/residents who die in the 31 days after discharge to community. Including 31-day post-discharge readmission and mortality outcomes is intended to identify successful discharges to community, and to avoid the potential unintended consequence of inappropriate community discharges. We would like to highlight that death in the 31 days following discharge to community is an infrequent event, occurring in approximately 4.5 percent of LTCH community discharges, 4.0 percent of SNF community discharges, 1.5 percent of IRF community discharges, and 5.5 percent of HHA community discharges. We believe that post-discharge death is an important adverse event to monitor in order to avoid inappropriate discharges to the community.

The measure excludes patients who are at high risk of death in the post-discharge observation window by excluding patients discharged to home- or facility-based hospice care, and patients whose prior acute stay was for medical treatment of cancer. Further, we risk adjust for several case-mix variables that may be related to risk of death, such as age, diagnoses from the prior acute stay, comorbidities in the year preceding PAC admission, length of prior acute stay, and number of prior hospitalizations in the past year. In the future, CMS will consider identifying and excluding patients who start hospice care in the 31 days following discharge to community.

Finally, accidental or unrelated deaths in the post-discharge window are expected to be rare and randomly distributed. We do not expect such deaths to disproportionately affect measure performance of specific facilities.

[3] Gage B, Morley M, Spain P, Ingber M. Examining Post Acute Care Relationships in an Integrated Hospital System Final Report. RTI International; 2009.

8. Exclusion of Hospice Discharges

Summary: Some commenters suggested that discharges to hospice be included in the measure as a successful discharge to community outcome. These commenters indicated that discharge to hospice is a desirable and appropriate outcome for many patients near their end-of-life, and facilities should get credit for these hospice discharges. Commenters also suggested that CMS ignore death in the 31-day post-discharge window for patients discharged to hospice; they suggested that discharges to hospice be considered a successful discharge to community outcome irrespective of death in the 31-day post-discharge window.

Other commenters suggested that patients on comfort or palliative care, but not on hospice care, also be excluded from the measure. Commenters were concerned about patients who refused formal hospice care, but were on comfort care measures only.

Response: CMS agrees with the commenters' opinion that discharge to hospice reflects an appropriate and desirable outcome for patients near their end-of-life. CMS reached the decision to exclude hospice discharges after considerable deliberation, which included discussion with our TEP members and hospice clinical experts, comparison of post-discharge death rates for hospice and non-hospice discharges, and comparison of discharge planning and goals of care for hospice and non-hospice discharges. Based on our deliberations, we concluded that it would be conceptually confusing to include in the discharge to community outcome both patients/residents who are successfully rehabilitated to live in the community and for whom death is an undesirable outcome, and patients/residents who are terminally ill and wish to die in the comfort of their home.

Hospice selection is a complex decision involving patient/family preferences and usually requires forgoing of curative treatment by the patient/family. Further, the final decision of discharging a patient/resident to home- or facility-based hospice (Patient Discharge Status Codes 50 and 51) is made by the hospice agency, not the PAC setting and takes into consideration the availability of hospice services in the region where the patient/resident lives. Our analyses revealed that a large proportion of patients/residents discharged to hospice die in the 31-day post-discharge window. Rates of 31-day post-discharge death ranged from approximately 45.0 percent to 82.0 percent for hospice discharges from HHA, IRF, and LTCH settings. In contrast, 31-day post-discharge death rates for non-hospice discharges from these settings ranged from approximately 1.3 percent to 5.0 percent. Given the differences in discharge planning processes, goals of care, and high post-discharge mortality rates for hospice discharges, CMS, with the support of clinical experts and TEP members, reached the decision to exclude hospice discharges from the discharge to community measure.

The high death rates in the 31-day window following discharge to hospice suggest that patients/residents may benefit from being referred to and starting hospice services earlier in their course of care. We recognize the importance of monitoring outcomes of patients on hospice care, and will evaluate the need for separate discharge measures for the hospice population in future measure development. With regard to patients on comfort or palliative care, who are not on hospice, there is no way to identify these patients using claims data. These patients are not excluded from the measure.

9. Long-Stay Nursing Home Residents

Summary: Several commenters were concerned about the inclusion of baseline long-stay nursing facility residents in the measure. They stated that discharge to a nursing facility for these residents would reflect discharge to the baseline level of care because these residents lived in a nursing facility prior to their acute and post-acute stays. Some commenters believed that the inclusion of long-stay nursing facility residents is particularly problematic for SNFs, as they accept a large proportion of these residents. One commenter stated: "Many skilled nursing facilities have both a significant subacute population and custodial population living in the same facility, although in separate units or wings of the SNF. Often, the patient who needs SNF care after a hospital stay will gravitate toward a SNF that has both levels of care available. At times, this is a way for

patients and families to evaluate whether the patient might need to remain in the SNF for long term care." Some commenters recommended excluding long-stay nursing facility residents from the measure. One commenter suggested that nursing homes with data strongly suggesting that they do not specialize in SNF Part A care be excluded; they recommended doing this by examining the turnover per bed per year in a nursing home, suggesting that nursing homes with low turnover are consistent with primarily long-term care facilities.

***Response*:** CMS appreciates the commenters' concerns about inclusion of long-stay nursing facility residents in the measure. We would like to note that, currently, the IRF-PAI is the only PAC assessment that contains an item related to pre-hospital baseline living setting. Using assessment data to identify and exclude baseline long-stay nursing facility residents in all PAC settings would require addition of a pre-hospital baseline living setting item to PAC assessment instruments for SNFs, LTCHs, and HHAs. We will also consider using a linked claims-MDS longitudinal file to identify baseline nursing facility residents.

With regard to the comment suggesting exclusion of nursing homes with a low turnover rate indicating that they do not specialize in SNF Part A care, we do not exclude these nursing homes. On this note, swing bed stays in acute hospitals, IRFs, and LTCHs are also included in the measure even though they do not care for large numbers of SNF patients in a year.

10. Interrupted stays

Summary: Some commenters had questions about how interrupted stays would be treated in the discharge to community measure.

Response: Interrupted stays are defined for IRF and LTCH settings. Post-acute care episodes that include interrupted stays will be treated as a single stay for the discharge to community measure, rather than separate stays. PAC claims that have interruptions do not indicate a discharge when the patient has a period outside the facility that meets the definition of an interruption. An interrupted stay will not be considered to end a PAC stay, and return to the PAC setting following an interrupted stay will not be counted as a new PAC admission.

11. Discharges Against Medical Advice from the Prior Acute Hospitalization

Summary: A few commenters suggested that PAC patients/residents who discharged against medical advice from the prior acute hospital and ended up in a PAC provider be excluded from the measure.

Response*:* CMS appreciates the commenters' concerns regarding PAC patients who discharged against medical advice from the prior hospitalization. We examined discharge destination on the prior acute claims and found that a very small proportion of PAC patients were discharged against medical advice from the prior hospitalization. This measure does exclude discharges against medical advice from the PAC setting.

12. Discharges to the Same Level of Care

Summary: Some commenters requested clarification regarding the exclusion of stays ending in transfer to the same level of care. Commenters were unclear whether a transfer to the same level of care referred to a transfer from one type of PAC setting to another type (e.g., LTCH to SNF, or IRF to SNF), or whether it referred to a transfer between two PAC facilities of the same type (e.g., IRF to IRF, or SNF to SNF).

Response: CMS would like to clarify that a transfer to the same level of care refers to a transfer between two PAC facilities of the same type (e.g., IRF to IRF, or SNF to SNF). In PAC episodes involving transfer to the same level of care, only the final facility will be included in the measure; for example, in an IRF to IRF transfer, only the final IRF will be included in the measure. In the case of transfers between different levels of post-acute care (e.g., LTCH to IRF, or LTCH to SNF), all facility stays are candidates for inclusion in the measure, if they meet the measure inclusion criteria.

13. Discharges to Acute Care

Summary: One commenter expressed concern that patients transferred to acute care from the PAC setting were included in the measure. The commenter was concerned that such patients reflect inappropriate discharges from the acute care hospital to the PAC facility, and were thus not indicative of poor quality of care in the PAC setting. The commenter also highlighted that inclusion of these patients was different from the potentially preventable hospital readmission measure for PACs, which excludes PAC stays that end in transfer to an acute care hospital.

Response: While CMS appreciates the commenters' concerns, we would like to clarify that we expect PAC providers to assume responsibility for all admitted patients. When a PAC facility admits a patient/resident, it has shared responsibility along with the discharging facility to ensure that the patient/resident is ready for PAC admission. The discharging facility is responsible to ensure that the patient/resident is ready for discharge to the next setting, and the admitting facility is responsible to ensure that patient/resident is ready for admission to their setting. This measure is intended to improve care coordination, communication, and shared responsibility during transitions of care across facilities.

We would also like to clarify that, in developing the PAC readmissions measures, we distinguish between two readmission windows: within-stay and post-discharge. While patients transferred from a PAC setting to an acute care hospital would be excluded from a post-discharge readmission measure, they would be included in a within-stay readmission measure, and would be considered a within-stay readmission. The discharge to community measure analyzes the discharge status (considered within-stay for readmissions) and the subsequent post-discharge window.

14. Other Indicators of Successful Discharge

Summary: A few commenters suggested that, in addition to the discharge to community measure, CMS consider additional indicators of successful discharge. For example, one commenter suggested "metrics that assesses whether the patient achieved optimal level of function and independence based on his/her condition and level of community support; and/or metrics that assesses whether the patient achieved his/her care goals as developed with the clinical team". Other commenters suggested that the measure be more patient-centered by considering patient/resident satisfaction, and allowing the patient/resident to have more control over the care they receive. They stated that patients/residents have diverse cultural, religious, and personal needs and preferences, and therefore have different goals related to functioning (ADLs/IADLs) and physical activity levels. They suggested that the measure capture these preferences as they can alter the interpretation of certain discharge outcomes.

Response: CMS agrees that it is important to assess various aspects of patient outcomes that are indicative of successful discharge from PAC settings. CMS has developed functional status quality measures for IRF, SNF and LTCH settings, and is working towards developing additional standardized, cross-setting functional status quality measures for PAC settings. CMS is also committed to developing patient-reported measures for its quality reporting programs, and appreciates the commenters' suggestions. We will consider adding relevant measures to the PAC quality reporting programs in the future, as appropriate.

15. Inclusion of Assisted Living Facilities in the Definition of Community

Summary: One commenter was concerned that assisted living communities were not included in the definition of community.

Response: CMS would like to clarify that assisted living facilities are included in the definition of community, and would be coded as 01, 06, 81, or 86 on the claim Patient Discharge Status Code depending on whether the

patient was discharged with or without home health services and whether or not a readmission was planned. Further description of patient discharge status codes can be found, for example, at the following Web page: https://med.noridianmedicare.com/web/jea/topics/claim-submission/patient-status-codes.

16. Measure Population and Title

Summary: Some commenters questioned the inclusion of only Medicare fee-for-service (FFS) patients/residents in the measure, and asked whether the measure would be expanded to include Medicare Managed Care patients/residents in the future. Other commenters supported the exclusive focus of the measure on Medicare FFS patients/residents stating that other payers, including private insurance companies that contract with the Medicare program to manage Medicare Advantage plans, often dictate what services PAC providers could offer to their discharged patients, thereby limiting the ability of such providers to maximize their efforts to keep people healthy at home following discharge. One commenter recommended that the measure title reflect that the measure applies to Medicare FFS patients/residents only.

Response: CMS would like to clarify that the measure is based on Medicare FFS claims. CMS agrees that is it important to monitor discharge to community and other outcomes of Medicare Managed Care patients/residents as well as patients/residents of other payers. CMS will consider the appropriateness and feasibility of including Managed Care patients/residents in the measure. To keep open the possibility of future expansion of the measure population, CMS has chosen not to specify the current measure population in the measure title.

17. Risk Adjustment

17a. Socioeconomic and Sociodemographic Status, Community Supports

Summary: Several commenters requested that the discharge to community measure risk adjust for additional socioeconomic status (SES) and sociodemographic status (SDS) factors. One commenter noted that, "since these measures examine care after discharge from PAC for individuals who will be in the community, SDS characteristics could play a significant role in explaining variation in successful discharge to community between providers". Patient/resident income, living status, family/caregiver support, race, ethnicity, and median income of the county were some of the factors for which risk adjustment was suggested. Several commenters also suggested adjusting for social and community supports such availability of community resources, indicating that these factors can influence whether or not a patient/resident can get discharged to the community.

Response: CMS understands the important role that SDS factors play in the care and outcomes of patients. However, we continue to have concerns about holding providers to different standards for the outcomes of their patients of diverse sociodemographic status 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 two years, NQF will conduct a trial of temporarily allowing 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 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 SDS 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 at such time as they are available.

The discharge to community measure is a claims-based measure. We would like to add that, currently, there are no standardized data on variables such as pre-hospital living setting, living status, or family/caregiver supports across the four PAC settings.

17b. Functional Status Risk Adjustment Across All Settings

Summary: CMS received several comments requesting that functional status risk adjustment be included in all PAC settings, rather than in IRF and HHA settings only. One commenter specifically noted that, "We also believe adjusting for functional status would benefit the accuracy of the DTC measure. 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 readmission rate, and a lower DTC rate".

Response: CMS understands that functional status may be related to discharge to community outcomes in PAC settings, and agrees that it is important to test whether admission functional status is a significant predictor of patients' discharge to community outcomes. 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 the discharge to community measure.

17c. Cognitive Status

Summary: Some commenters suggested that risk adjustment should include cognitive impairments or mental health problems. These commenters indicated that patients/residents with cognitive impairments or mental health issues may not be able to be safely discharged to the community, even if the PAC facility provides high quality of care.

Response: CMS recognizes that community discharge may not be safe for certain patients with psychiatric or mental health conditions. For this reason, the measure excludes patients discharged from the PAC setting to a psychiatric hospital. Further, our models risk adjust for patients who had an acute psychiatric hospital stay prior to PAC admission. We also adjust for primary diagnosis from the prior acute stay and comorbidities based on claims from the 365 days prior to PAC admission; these primary diagnosis and comorbidity variables include various psychiatric and mental health conditions.

We will continue to evaluate measure performance and consider adding additional data sources and risk adjusters, including cognitive functional status, to future versions of the discharge to community measure.

17d. Ventilator Use in the PAC Setting

Summary: CMS received a few comments related to risk adjustment for ventilator use in the LTCH setting only. Commenters indicated that other PAC settings also admit patients on ventilator, particularly given the scarcity of LTCHs compared with other types of PAC provider. Commenters suggested that ventilator use in PAC be applied as a risk adjuster across all PAC settings.

Response: CMS understands the concerns regarding risk adjustment for ventilator use in the LTCH setting only. In response, we have added a covariate for PAC ventilator use to the SNF setting measure, and have found this to be a significant negative predictor of discharge to community outcomes. We investigated the

need for risk adjustment for ventilator use in IRFs, but found that less than 0.01 percent of the IRF population (19 patient stays in 2012, and 9 patient stays in 2013) had ventilator use in the IRF. Given the low frequency of ventilator use in IRFs, any associated estimates would not be reliable; thus, ventilator use is not included as a risk adjuster in the IRF setting measure. We will consider testing ventilator use in the risk adjustment models for the HHA setting measure.

17e. Standardization of Risk Adjustment across Settings

Summary: Several commenters suggested that risk adjustment specifications be standardized across PAC settings. These commenters questioned whether the IMPACT Act's mandate to produce standardized quality measures across PAC settings required that risk adjustment variables also be standardized across settings. Additionally, some commenters were concerned that variation in risk adjustment across settings would not allow cross-setting comparisons, or could result in unintended consequences. One commenter stated, "Including different risk adjustment variable in one setting over others, particularly for conditions that apply in all settings is unfair and will create unintended effect to discourage these types of patients in settings that do not risk adjust for them."

***Response*:** CMS applies risk adjustment as testing indicates is appropriate. We would like to clarify that the IMPACT Act provides, under Section 1899B(d)(3)(B), that resource use and other measures be risk adjusted, as determined appropriate by the Secretary. Risk adjustment should adequately adjust for patient/resident characteristics in predicting the probability of discharge to community from each PAC setting.

Adjusting for relevant case-mix characteristics in each setting improves the validity and explanatory power of risk adjustment models, and helps ensure that any differences in measure performance reflect differences in care provided rather than differences in patient case-mix. Risk adjustment models adjust for relevant setting-specific case-mix characteristics, even if this results in minor differences in cross-setting risk adjustment.

As an example, we found that ventilator use in PAC was a strong and significant predictor of discharge to community outcomes in LTCH and SNF settings; thus, we have included this covariate in the LTCH and SNF models. The IRF setting does not have a large ventilator population, with less than 0.01 percent of the IRF population (19 patient stays in 2012, and 9 patient stays in 2013) having ventilator use in the IRF. Thus, PAC ventilator use is not included as a risk adjuster in the IRF setting measure. We believe that adjusting for ventilator use in relevant settings (LTCH and SNF) is more important than harmonizing risk adjustment across the four PAC settings, so we can be confident that differences in measure performance are related to care provided.

17f. Risk Adjustment for Diagnoses for Patients without a Preceding Hospitalization

Summary: The Medicare Payment Advisory Commission (MedPAC) commented that, for PAC stays without a preceding hospitalization, CMS should gather diagnostic information from the PAC claim to increase the likelihood that a patient's condition is accurately captured.

Response: CMS would like to clarify that an acute care hospital discharge within the 30 days preceding PAC admission is required for a PAC stay to be included in the the SNF, IRF, and LTCH setting measures. For the HHA setting, a recent acute care hospitalization is not required for patient inclusion in the measure. For HHA patients without a recent acute care stay, physician and other claims will be used to capture comorbidities and other covariates. CMS did examine diagnosis codes reported on HHA claims and found V571 "Other Physical Therapy" to be the most commonly used primary diagnosis code. We concluded that HHA diagnosis codes would be uninformative, and would not help distinguish among patients for risk adjustment of this measure.

17g. Number of Hospital Stays in the Past Year

Summary: The MedPAC suggested that CMS not include the number of hospital stays in the past year in the risk adjustment model, commenting that, by controlling for beneficiaries who repeatedly cycle through hospital and PAC stays, this risk adjuster accepts this pattern of care.

Response: With regard to number of hospital stays in the past year, 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 a potential 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.[4] 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.

17h. Risk Adjustment Methodology and Facility-Level Measure Calculation

Summary: CMS received some comments related to the risk adjustment methodology. Some commenters suggested using an observed-to-expected ratio, rather than a predicted-to-expected ratio in the facility-level measure calculation. The MedPAC shared concerns regarding measure stability, suggesting that CMS pool data for providers with insufficient Medicare stays. The MedPAC also shared concerns regarding the shrinkage methodology used for measure calculation.

Response: CMS thanks the commenters for their input regarding the statistical approach for these measures. We acknowledge that the statistical approach may appear complex, but emphasize that the technical aspect of calculating the measures is needed to ensure that comparison of facilities/agencies within each setting is fair.

The modeling 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.[5] CMS has applied the methodology in several other quality measures, including the NQF-endorsed all-cause unplanned readmissions measures for post-acute care and the hospital readmissions 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.

Measure stability is an important consideration as CMS develops its measures and determines measure calculation windows. To ensure measure stability and reliability, the measure may use two years of data for calculation of the IRF, LTCH, and HHA setting measures to allow adequate samples for model estimation. Consistent with our NQF-endorsed readmissions measures, our approach for the discharge to community measure has been to use all eligible stays/episodes in measure calculations. CMS will specify the minimum public reporting sample size requirements at a later date through the appropriate processes.

17i. Other Comments Related to Risk Adjustment

Summary: The MedPAC commented that the risk adjustment models should avoid factors that measure service use in the PAC setting. CMS received other suggestions for potential risk adjusters including facility

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[4] Krumholz H.M. Post-Hospital Syndrome – An Acquired, Transient Condition of Generalized Risk. N Engl J Med 2013; 368:100-102. http://www.nejm.org/doi/full/10.1056/NEJMp1212324

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

characteristics such as geographic location and ownership status, patient compliance, pre- and post-transplant status, left ventricular assistive device (LVAD), patients on dialysis and ventilator, patients on dialysis and LVAD, patients on dialysis and with stage 3 or 4 wounds, patients with multi-system organ failure, history of substance abuse, and history of falls. Finally, several commenters requested further detail on the risk adjustment methodology including risk adjuster definitions, data sources and coding parameters, and the modeling approach.

Response: CMS appreciates the commenters' suggestions and will consider these as able in the current and future phases of the measure. CMS agrees with the MedPAC that risk adjustment models should avoid factors that measure service use in the PAC setting; our models do not include variables related to PAC service use.

Our risk adjustment models are comprehensive based on the available data, and adjust for all diagnoses and procedures listed on the prior acute claim, as well as several comorbidities based on the year preceding PAC admission. CMS will consider testing in future versions of the measure, risk adjusters that are not feasible to add to the current measure because of data restrictions.

There is no objective or standardized way to measure patient compliance. By adjusting for prior service use (i.e., number of hospital stays in the year preceding PAC admission), we may be capturing some otherwise unmeasured patient characteristics, such as access, patient compliance, or SDS/SES factors.

With regard to facility characteristics, CMS appreciates the commenters' suggestions and will consider these as able in the current and future phases of the measure. With regard to more comprehensive information on the measures, CMS will publicly post detailed measure specifications on its Web site.

18. LTCH Setting Measure

Summary: CMS received some comments specific to the LTCH setting measure. One commenter indicated that limited literature on discharge destination outcomes for LTCH patients may warrant exclusion of the LTCH setting from this measure. They further commented that an LTCH is considered to be a hospital, and thus should be identified separately from other post-acute settings. They suggested that for LTCHs specifically, discharges to the community should include discharges to SNFs as many of these patients have significant comorbidities and complexities which prevent them from being discharged to a home setting. They were further concerned about differences across LTCHs in the proportion of patients admitted who are on ventilator, are candidates for weaning from ventilator, or are on dialysis, stating that these factors can influence discharge to community outcomes. Other commenters were concerned that the Discharge to Community Measure would put LTCHs at a disadvantage, since LTCHs have a more acute patient population and are less likely to discharge patients to the community compared with the other PAC settings. 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.

Response: LTCHs are identified as one of the four post-acute providers in the IMPACT Act. The Discharge to Community Measure is being developed to satisfy one of the resource use and other measures domain the IMPACT Act.

Successful discharge to community, when appropriate, is an important goal many patients share, regardless of the provider they are receiving services from. While the body of evidence on discharge to community outcomes is smaller in the LTCH setting compared with other PAC settings, a proportion of LTCH patients are successfully discharged to community. Using CY 2012-2013 data, we estimate that approximately 25 percent of LTCH Medicare FFS patients were discharged to the community. Given that a proportion of LTCH patients return to the community, CMS believes that is it important to monitor this outcome and ensure appropriateness

and safety of these community discharges. CMS would also like to note that TEP members, including LTCH representatives, were supportive of implementing this measure in the LTCH setting.

CMS understands that patient populations and case-mix differ across the PAC settings, and that LTCHs care for higher acuity patients compared with the other PAC settings. To account for these differences in case-mix across settings, the measure is risk-adjusted. Overall, our risk adjustment models adjust for several case-mix variables, including a number of clinical variables. As suggested by the commenter, the LTCH model adjusts for ventilator use in LTCH, dialysis, and ESRD status, all of which are strong and significant, negative predictors of discharge to community outcomes.

We appreciate the commenter's suggestion that ventilator weaning status may be associated with discharge to community outcomes. The LTCH CARE Data Set, which becomes effective April 1, 2016, includes items related to ventilator weaning or non-weaning status. As these data become available, CMS will evaluate possible use of these data for our risk adjustment model. CMS will also explore other ways to risk adjust for ventilator weaning status.

CMS appreciates that, for many LTCH patients, a discharge to SNF represents a successful and valuable discharge outcome. However, a SNF is not a community setting, and a SNF discharge cannot be included in the definition of discharge to community. The measure is intended to capture discharge to community settings only, not discharges to lower levels of care.

With regard to using principal diagnosis from the prior acute claim, our approach is consistent with that of other claims-based NQF-endorsed measures of readmissions for post-acute settings. We are adjusting for the medical condition that was the precursor to the LTCH admission. We also adjust for whether the patient had surgery in the prior acute stay by adjusting for surgical category.

19. Physician Accountability for Discharge to Community in the Home Health setting

Summary: Several providers noted that physicians play a key role in helping to ensure effective discharge to community of home health patients. Physicians determine whether patients are sent to the emergency room for conditions that could otherwise be addressed by a HHA or whether a patient has been appropriately discharged to a HHA in the first place. Both commenters stressed increased physician education and accountability as key solutions to appropriately spread responsibility between the physicians and home health agencies with which they work.

Response: CMS appreciates the challenges in coordinating patient care in some post-acute care settings (e.g., HHAs, SNFs) that primarily work with external physicians or physician representatives, as well as the importance of ensuring accurate diagnostic information for discharge planning and care planning in general. The focus of the measure is on appropriate discharge from care when a licenced and qualified clinician determines that discharge is clinically appropriate according to practice guidelines, state licensure laws/practice acts, and payer coverage requirements. CMS appreciates the suggestion regarding physician training and will take this under consideration.

20. Burden from Usage of New Discharge Status Code for the Home Health setting

Summary: Several home health provider organizations noted that the discharge status code of "81" as outlined in the measure specification is not presently used by HHAs and that the introduction of this new code will create undue operational and logistical burdens for HHAs.

Response: CMS acknowledges that the introduction of new discharge to community measures for the HHA setting could require additional provider education with respect to appropriate coding of discharge status. Discharges from HHA due to a planned hospital admission are infrequent occurrences. The addition of code

"81" for planned admissions to the list of current patient status codes would result in minimal burden for home health agencies as agencies are currently required to accurately capture patient status codes on each Medicare claim. The addition of code "81" to the existing list of codes is expected to require minimal operational changes for agencies that are currently compliant with accurate data collection of the patient status code.

21. Home Health Patients Discharged due to Change in Homebound Status

Summary: Several commenters expressed concern with the definition of homebound for the home health setting and that in some scenarios a patient in need of continued care is discharged from home health service due to not meeting the definition of being "homebound". Commenters noted that this may patients at risk of adverse outcomes.

Response: CMS recognizes the complexity of providing home health services, specifically in managing the seemingly competing objectives of reimbursement and quality. The discharge to community measure assesses discharge destination based on home health fee for service claims. The Medicare Home Health Benefit is just one payer of home health services. This payment system, as any insurance system, has to be defined by "Coverage Criteria" that provides boundaries and direction to the beneficiary and to providers regarding what are payable services and under what circumstances. It is the home health agency's responsibility to be aware of these conditions and is part of the initial assessment performed at every admission. These conditions must also be continuously monitored throughout care to ensure the agency is still caring for the patient under the proper benefit/payer.

Home health agencies are required to give beneficiaries written notices when Medicare coverage criteria are in question:

- The Advance Beneficiary Notice (ABN) is issued by a home health agency to a Medicare beneficiary when the agency believes the beneficiary's status no longer meets coverage criteria (including medically reasonable and necessary care, skilled care, homebound status, or intermittent skilled nursing care). The ABN is issued by the home health agency prior to a beneficiary receiving any services not covered by Medicare. The ABN lists the items or services that Medicare isn't expected to pay for, an estimate of the costs for the items and services, and the reasons why Medicare may not pay. The ABN provides information for the beneficiary to make an informed choice about whether or not to get items or services, understanding that the patient may have to accept responsibility for payment.
- The Notice of Medicare Non Coverage (NOMNC) is issued by a home health agency to a Medicare beneficiary prior to the agency discontinuing Medicare services to the patient. This notice informs the patient that the HHA believes Medicare will no longer pay for services, and allows the patient to call the Quality Improvement Organization (QIO) to appeal the reason for discharge.

There will be times when a patient needs further services, but no longer meets the Medicare Home Health Benefit, and agencies have an investment in patient outcomes, even after discharge from home care. Home health providers are expected to include early and ongoing discharge planning efforts to prepare the patient and caregivers for a successful transition from care supervised by the HHA, to care managed by the patient, family or other community resources. Agencies can promote successful community discharge by providing all of the tools and support available to the patient prior to a safe discharge. This may include interventions as simple as providing health coaching, written materials, a medication chart/checklist, pharmacy set up of medications, a warm hand-off to outpatient therapy, and even instructions on when to call their physician with specific symptoms related to an exacerbation of their condition.

22. Burden

Summary: CMS received comments about the general burden of data collection and quality measures.

***Response*:** CMS would like to clarify that the discharge to community measure is a Medicare FFS claims-based measure. Since claims data are already submitted by PAC providers for payment purposes, there are no additional data that need to be submitted for this measure. Therefore, this measure does not impose any additional data collection burden on PAC providers.

23. ICD-9 to ICD-10 Conversion

Summary: A few commenters requested an ICD-9 to ICD-10 crosswalk for the discharge to community measure. One of these commenters expressed concern that the measure performance may be different using ICD-10 codes, compared with the current measure specifications based on ICD-9 codes.

***Response*:** CMS agrees with commenters' that it is important to assess the impact of the ICD-9 to ICD-10 transition on the discharge to community measure. We are committed to maximizing accuracy and validity of our measures. Our measure development contractors are developing a preliminary ICD-9 to ICD-10 crosswalk for the discharge to community measure, as well as other measures that use ICD codes.

24. Measure Usability

Summary: One commenter commented on the usability of this measure, voicing concern about the availability of claims data to PAC providers and their ability to reproduce the measures. This commenter stated, "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." Another commenter stated, "…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 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 readmissions of their patients post-discharge, this data will be new to many facilities."

Response: CMS appreciates the concern regarding availability of claims data and usability of the measure for internal quality initiatives.

25. Additional Measure Testing and Development

Summary: CMS received general comments indicating that the discharge to community measure needs additional work in terms of testing and input from clinical experts.

Response: CMS thanks the commenters for this comment and would like to note that we will continue testing of this discharge to community measure for PAC settings. We would like to establish that the measure development process follows a "measure lifecycle" as described in the CMS Measures Management System Blueprint. In line with the Blueprint, prior to the public comment period, we conducted three TEP meetings to solicit expert feedback on the measure development and specifications. The TEP summary report can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

26. Public Comment Time Period

Summary: CMS received comments expressing concern that the two-week public comment period was not sufficient for stakeholders to provide feedback. The MedPAC stated, "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." (Note: CMS subsequently extended the public comment period to 30 days).

Response: CMS appreciates the commenters' concerns, and notes that the public comment period was extended from two weeks to 30 days in response to concerns that the public comment period was insufficient in length. We are cognizant of the challenges that shorter public comment periods create. The initial shorter public comment periods for the IMPACT Act measures were a consequence primarily of the timelines mandated by the relevant statutes. CMS would like to thank all commenters for their thoughtful feedback on the development of this measure.

Preliminary Recommendations

CMS and the measure development contractors appreciate the comments received for the discharge to community measure for post-acute care settings. The general comments about the measures as well as specific input we received on the discharge to community definition, risk adjustment, measure exclusions, and other aspects of the measure 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 Discharge to Community-Post Acute Care Measures.

Public Comment Verbatim Report

The following table details the verbatim comments received.

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/12/2015	Re: Comments on this proposed regulation I will refrain from complaining about the massive over-regulation of home health to the point of running nurses away from this field. I do, however feel compelled to comment on the ability of home health agencies to reduce re-hospitalization rates and "preventable admissions". My thoughts are as follows: • The physician dynamic in this country has drastically changed over the past 15 years. "Home-grown" community physicians are gone; replaced with foreign doctors who do not have a personal relationship with their patients. Doctors today simply do not care about their patients like the doctors of 15, 25, etc. years ago. Today's doctors seem terrified of liability. Fallout from that fear includes refusal to give orders to home health staff in response to phone calls reporting the condition of their patients. For example, 15 years ago I could call a physician to report s/s of CHF exacerbation in my home health patient. The doctor would give immediate orders for labs, I drew the labs, and the doctor would give subsequent orders for medication adjustments, etc. and for me to return for a reassessment visit in 1, 2, or 3 days with a report called directly to him. Occasionally, the doctor would be concerned enough to have me send the patient to his office immediately, even if that meant he had to wait at his office after hours to see the patient.	Sharon Tatum, RN BSN Agency Director Community Home Care	statum@chal.org	Individual-HHA setting

(continued)

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	• Today, attempting to call a report on a patient results in being interrupted and told, "Send the patient to the ER". • Some local physicians are now refusing to even treat symptoms at their office, such as high blood sugar or high blood pressure. I have had many patients tell me their primary physician sent them to the local ER to have a non-symptomatic elevated blood sugar or blood pressure addressed. This results in angry ER physicians who feel clinic physicians are useless. And in large part, they are. Patients have no faith in their doctors because of this type of care. Some of our patients have chosen ER care before considering a call to home health or their primary physician because "they'll just tell y'all to send me to the ER anyway". • Doctors no longer provide wholistic care. They address immediate symptoms, which never resolves the underlying problem. I feel this is due to decreased reimbursement and increased regulatory burden. Doctors feel they're not paid well enough to spend the time necessary to determine the underlying etiology of a symptom or group of symptoms. They, like us in home health, are too busy nursing paperwork and meeting this regulation or that regulation and making sure all criteria are met to order this or that test to spend time providing hands on assessment and care. • Nurses can neither diagnose nor prescribe. We can only report and carry out orders. We can't intervene to prevent hospitalizations without orders to do so. Given all of these barriers, how in the world can you realistically expect any home health agency to make a significant difference in			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	"preventable admissions"? Your focus in this area needs to be on physician education. Provision of incentives to reduce these measures. Offer bonuses to patients who treat their patients in clinic and do not refer every patient who needs more than a pat on the knee to the ER. Track ER patients by primary MD and reward or penalize accordingly. You are holding home health agencies responsible for statistics that we are no longer allowed to impact in a positive and significant way. You are essentially lining agencies up in front of the firing squad because doctors keep sending their patients to the ER, and do not allow us to be their eyes, ears, hands and voices. Please put the focus of this measure where it should be: on the physicians who control re-hospitalization and preventable admission rates.			
11/12/2015	Discharge planners are been pressured to discharge the patients from the hospital and most of the time with this pressure the patients are placed incorrectly to the level of care provided. As a home health Administrator I see this picture so often. Home health agencies are called upon to help with to stabilize the patient in hope that the pt does not return to the hospital but from the beginning of the assessment, it is obvious that the pt is at a very high risk of decompensation. Also a lot of home health agencies are refusing to take on discharged patients because a lot of doctors do not want to sign the plan of care within the guidelines. Physicians need to be responsible and accountable for the continuity of the care at home but without any penalties to the doctors they will continue doing what they want unless of course they are on the home health agencies as medical directors.	Juan Carlos Dominguez	juancarlos45065@gmail.com	Individual-HHA setting

(continued)

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/12/2015	Regarding the home health discharge to community measure: I disagree with including in the metric patients with death in 31 days post discharge. Many patients desire to be in home residence at the end of life but are not ready for hospice, instead they are interested in palliative care approach in home health. Agencies providing palliative care could have lower rates in this measure for discharge to community due to providing much needed service to patients. These patients may be seeking treatments that are not combatable with hospice care, or have cultural/spiritual preferences that conflict with choosing hospice care and therefore would also reflect adversely when agencies have larger patient populations with these cultural groups.	Nina Kaiser RN, BSN PHN MBA COS-C Quality Coordinator Lakeside Home Heath Sutter Care at Home	kaisern@sutterhealth.org	Individual-HHA setting

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/12/2015	The issues of discharging to community from the LTC/Skilled Nursing facility are as follows: The oversight of family members who get money for taking care of these individuals is nil. From what I have seen, the family lives off the social security checks, retirement checks, etc, and we get the elderly back, usually after a hospitalization, with dehydration, malnourished, bed sores, peri area chafing, and usually not bathed. Their financial resources are depleted and the family all of a sudden cannot care for them at home. Many, many times there are multi generational family members in the home. This is a plus when the elderly is taken care of ...which is rare. APS is powerless. The rules are loose. And there isn't enough staff to cover the need. Notifying APS of the need for intervention is not even worth it anymore. CBA programs are the same – many times these people do not spend the amount of time allotted to care for the individual. These caregivers are not trained, are not overseen, and the elderly person is afraid to speak up of abuse, both mental, physical, or financial. If they have Dementia of any sort, they may not be able to tell. Ombudsman make "home by choice" decisions in a 5-10 minute meeting with individuals who cannot possibly care for themselves – Dementia reigns in nursing facilities and we have no control over who the Ombudsman decide to visit. If a person says "I want to go home" that starts the ball rolling in the nursing facility. We see these people day in and day out. We know what they can and cannot do. Assisted Living facilities want the money also – they aren't going to turn down these people. But in Assisted Living, there is no nurse on duty – most of the time, there are Med Techs, and sometime there are not even Med Aides – who administer medications... not knowing what the side effects may be or even how to look for them.	Stormy Pierce	spierce@townhallwhitney.org	Individual-SNF setting

(continued)

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/13/2015	To whom it may concern; For the most part your proposal is comprehensive to capture the numerous variables associated in determining this particular outcome measure. Below, are areas that I believe need to be addressed further prior to adopting this measure: • While you have addressed some socio-economic conditions, you have omitted race. The impact of Race has been demonstrated to have statistically significant outcomes in numerous articles, such as KJ Ottenbacher - 2008, American Hospital Association Journal. • In addition, there seems to be no consideration taken in regards to short term vs long term resident stays. SNF settings would receive unfair outcomes in comparison to IRF's & LTACH's (as evident by the MedPac study in 2013). The latter do not provide care for long stay residents. They have no capacity to do so, unlike SNF's. The patients in IRF's and LTACH's either expire, go home or to a SNF for long stay care. Please take into consideration the points made above.	Tony Farinella, NHA, MHSA Manager of Transitional Care & Physician Services Gulf Coast Health Care	tfarinella@gchc.com	Long-term care provider
11/14/2015	Hospitals needs start listening to patients just a little bit. And triage nurse should not having there comment about whats wrong the patient especially when patients just walked in the door.	Rebekka Alick	rsmollysmith@gmail.com	Individual

(continued)

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
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. 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" ie, "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	Susan Buckley Strategic Design	strategicdesign@hotmail.com	Individual

(continued)

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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. 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			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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 well being 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? Thank you for your consideration of this concept.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/15/2015	To whom it may concern, Non reimbursement of PSA screening would represent a considerable step backward in the diagnosis and treatment of prostate cancer in the United States. Please note the following: 1. While the death rate from prostate cancer has decreased somewhat since PSA screening was introduced in the late 1980's, the total population of the U.S. has increased significantly, Because of an aging population, the population at risk from prostate cancer has actually increased even more, resulting in a significant decrease in prostate cancer mortality over this time period. 2. There is no commercially available test which could at the present time replace PSA. 3. This decision would disproportionately affect older men, and would represent gender and age-related discrimination. 4. Studies that were available to U.S. Preventive Services Task Force when their recommendation for non-screening was made, contradict their estimation of over treatment. 5. Their recommendation of non screening has not been adopted by other developed countries or US-based healthcare agencies.	Gary H. Carl, MD Olean General Hospital 623 Main St. Ste 200 Olean, New York, 14760	Ghcarl2@aol.com	Hospital

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/17/2015	I am writing to voice my opposition to the proposal to develop a Quality Measure for Discharge to Community for IRF's. As you are aware, we already can be penalized if we have too many re-admission within 3- days. I believe this additional measure would put IRF's at risk for being penalized twice. Not to mention there are already so many quality measures already in place and proposed for FY 2017. Thank you for re-considering this effort.	Maggie Fogg, RN, BSN, CRRN, CCM, PPS Coordinator Novant Health Rehabilitation Center 3333 Silas Creek Parkway Winston-Salem, NC 27103	mafogg@novanthealth.org	Individual-IRF setting
11/17/2015	I have the below concerns/comments on this plan: • This measure appears to penalize facilities by reducing the discharge-to-community rate by unplanned readmissions. Given that unplanned readmissions are already being measured for quality purposes, would this cause a facility to be affected twice by each unplanned readmission? Furthermore, noting that unplanned readmissions may be outside of the PAC provider's control and may not adequately risk-adjust for sociodemographic factors, should such readmissions even be considered as a factor for a discharge-to-community measure? • The risk-adjustment factors do not appear to be finalized, and it appears that they might include site-specific factors. In light of the IMPACT Act's mandate to produce standardized quality measures across PAC sites, shouldn't risk-adjustment factors be standardized as well?	Sue Webb Rehab Director Phoebe Putney Memorial Hospital	swebb@ppmh.org	Hospital

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/17/2015	Hello, I am a PM&R physician in Northwest Montana and I am a bit concerned about the proposal of your new policy which would appear to penalize discharges to an acute setting. We are fortunate to have excellent Neurosurgery in our area despite our remote location and one of the ways in which we optimize care for rural patients is to take them inpatient rehab and then depending on the length of time they are in rehab having the bone flap replaced as a part of an interrupted stay or done at discharge. This is imperative due to the nature of many of the patients that have TBI and the decreased likelihood of close follow-up (especially given the rural nature of our state and the overall mentality of the state). When the discharge/readmission to acute for the bone flap is done this provides the best overall care. Obviously, we strive for follow-up on all our patients at discharge with PM&R and Neurosurgery, but sometimes due to geographical limitations and mentality we are limited. Done as the interrupted stay or at discharge really does provide the best overall care. Another instance in which this would affect us is as follows. We recently had a woman with stroke who was found to have asymptomatic sinus bradycardia on admit who was watched closely and then found on rehab to have a 3rd degree heart block. She was able to finish her stay with the use of life-vest, but was immediately sent for a pacer procedure upon her discharge from rehab. In this case, we would be penalized despite providing adequate care. These are 2 of the many ways in which this situation would adversely penalize institutions that are doing the correct thing. Obviously, both patients benefited from the above rehab stays. Please contact me with any additional questions or concerns.	Andrew S. Cole MD-Co director of Inpatient Rehab and Kalispell Regional Healthcare	acole@krmc.org	Individual-IRF setting

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/18/2015	Dear Acting Administrator Slavitt: 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. 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.	Cheryl Lehman, PhD RN CNS-BS RN-BC CRRN President & Jordan Wildermuth, MSW Manager, Health Policy & Advocacy Association of Rehabilitation Nurses	jwildermuth@Connect2amc.com	Rehabilitation nurse association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	rationale provided for exclusion because while the measure assesses readmission rates while accounting for patient demographics, principal diagnosis in the prior hospitalization, 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.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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."[6] 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."[7] ARN urges CMS to exclude patients that die within the post-discharge window after being discharged to the community from the 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.			

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[6] 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).

[7] 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).

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	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. If you have any questions, please contact me or have your staff contact our Health Policy Associate, Jeremy Scott (Jeremy.Scott@dbr.com or 202-230-5197). We thank you for your consideration of our concerns, recommendations, and requests.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/18/2015	Dear Mr. Slavitt: 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 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	Francis Crosson, Chairman Submitted by: Carol Carter, Ph.D. Principal analyst Medicare Payment Advisory Commission	CCarter@medpac.gov	Government

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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. Inits 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			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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 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.			

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	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. Ifthe 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 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.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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).			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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 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. 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. If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, MedPAC's Executive Director, at (202) 220-3700.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/19/15	I would like to comment on this as an individual who has worked in SNF/nursing homes for over 20 yrs in more than one state. In my experience, family members take the opportunity while their family member is a resident, to decide to leave them in facilities for long term care. A lot of times, they use a Medicare stay as gateway to have them admitted to facilities, stating intention to take them back home though once in building, refuse to take them back home or place in more appropriate setting/ALF. SNFs are then forced to keep the resident as there is little recourse(you can contact Ombudsmen, issue intent to discharge, etc.-it all comes to naught) but to keep them. Even if they are appropriate for lesser level of care-ALF, etc. responsible parties have sabotaged and refused to move residents from facilities. I have known of families who refuse to take residents home as well as not complete applications for Medicaid, etc. They leave the burden of caring for the resident then complain loudly, sue, etc. when facility tries to do what is best and in resident's desire/interest. Where is the assistance for the facilities which you continue to burden with decreased payment and increased responsibilities and regulations? I feel making this a Quality Measure further punishes already burdened facilities/ Social Service persons.	Pat Sipes, RN, RAC-CT-MDS	mds2.kinston@signaturehealthcarellc.com	Individual-SNF setting

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/19/2015	Hello, What do we do with these residents who have massive social problems and constantly use the hospital. I am driving people home, finding no food, electricity shut off, the boyfriend stealing the meds? These are the rehospitalization challenges we are facing. They are psych issues as well. There is no where for them to go, poor decision making is effecting our numbers. What do you plan to do about this? I work for a SNF.	Elizabeth A. Sarro MS, LDN, LNHA, FACHCA Administrator and President Bethany Home of Rhode Island 111 South Angell Street Providence, Rhode Island 02906	esarro@bethanyhomeofri.org	Individual-SNF setting
11/20/2015	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 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). Physical therapy is an integral service provided to Medicare beneficiaries in 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	Heather L. Smith Director, Quality Sharon L. Dunn, PT, PhD, OCS President American Physical Therapy Association	heathersmith@apta.org	Physical therapist association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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 transition of patients to the community as essential members of the health care team. Physical therapists, in conjunction with other of the health care professionals, assist in discharge planning which take 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 successful transitions to the community. <u>Comments on the Draft Measures</u> 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 continuum of care.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	APTA supports the implementation of a discharge to community measure across the care settings. We believe that successful transitions to the community following discharge from the respective post-acute care settings will decrease potentially preventable readmissions. 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 a patients ability to transition successfully back to the community. 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[8]. APTA was pleased to see "activity of daily living" scores in the home health setting included in the risk adjustment methodology for the readmissions measures, and we recently commented, encouraging the use of patient function in the risk adjustment methodology for the post-acute care setting readmissions measures. We believe that readmissions and discharge to community are closely related measures and that patient function may also be an important risk adjustment variable for discharge to community.			

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[8] Greysen SR, Cenzer IS, Auerbach AD, Covinsky KE. Functional Impairment and Hospital Readmission in Medicare Seniors. *JAMA Intern Med*. 2015;175(4):559-565.

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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 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 readmissions of their patients post-discharge, this data will be new to many facilities. 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 crosssetting comparisons as well as the evolution of better quality measures with uniform risk standardization, thus achieving the true aim of IMPACT.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Conclusion APTA thanks CMS and RTI for 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) and we look forward to working with the agency on these and other quality measures. If you have any questions regarding our comments, please contact Heather Smith, PT, MPH, Director of Quality at (703) 706-3140 or heathersmith@apta.org.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/20/2015	My name is Julie Rooney, RN and I am currently in a position to review quality for my home health agency. In the past I have been a Health Care Surveyor for both long term care, inpatient rehabilitation and hospice. I managed an inpatient rehabilitation unit in my career, as well as worked extensively as a nurse in long term care. Let me first say, your goal of improving transitions across multiple care settings is a worthy one. I would like to share some of my concerns based on my extensive experience in post-acute settings. My experience has been consistently in rural areas in Montana and Oregon. 1. The paperwork required in the OASIS and MDS are already burdensome for rural agencies and facilities who do not always have access to qualified staff. Be wary of adding more paperwork to an already overburdened system. You will get more paper, but not necessarily better outcomes. Many agencies and facilities are about to topple with the paperwork burden already present. You will not achieve better outcomes if there are no agencies/facilities for these people to be referred to. 2. As mentioned above, the goal of communicating and sharing outcomes among providers for better transitions is a worthy goal. However, in rural areas these care settings can be hundreds to thousands of miles apart. Be aware when sharing resources and information that you could be dealing with a patient who presented to a local critical access hospital,	Julie Rooney, RN Central Montana Medical Center Home Care	jrooney@cmmccares.com	Individual-HHA setting

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	referred to a major medical facility in another state, returned to an inpatient rehabilitation facility 200 miles from home and then returned to a home health agency in their locale. The logistics of coordinating care is profound without the sharing of data and resources. Think of this patient when you are setting up your plans. These patients exist and we deal with them on a daily basis in our agency. Do not base your plan on an enclosed system where the patient presents to a hospital that has all the players in their own system. It is not real here in rural Montana, nor in many rural areas in the United States. Please feel free to contact me if you would like any further information. I am deeply concerned about this subject and the potential impact the people we serve.			
11/21/2015	The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments on the CMS project – development of discharge to community quality measures for SNFs, IRFs, LTCHs, and HHAs. The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the	E. Clarke Ross, D.P.A. Public Policy Director American Association on Health and Disability 1718 Reynolds Street Crofton, MD 21114 Roberta S. Carlin, MS, JD Executive Director American Association on Health and Disability 110 N. Washington Street, Suite 328J Rockville, MD 20850	clarkeross10@comcast.net	Advocacy Group

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise. **Proposed Discharge Quality Measures** AAHD and the Lakeshore Foundation recommend that cross-setting discharge to the community quality measures be as consistent, as is technically possible, with the high priority measure gaps for persons dually eligible for Medicare and Medicaid identified in 2013, 2014, and 2015 National Quality Forum (NQF) reports to CMS. The seven High Priority Measure Gaps identified by the NQF workgroup on persons dually eligible for Medicare and Medicaid, as endorsed by the NQF Measure Applications Partnership (MAP) are: Goal-directed, person-centered care planning and implementation Shared decision-making Systems to coordinate healthcare with non-medical community resources and service providers Beneficiary sense of control/autonomy/self-determination Psychosocial needs Community integration/inclusion and participation Optimal functioning (e.g., improving when possible, maintaining, managing decline)	Amy Rauworth Director of Policy & Public Affairs Lakeshore Foundation (www.lakeshore.org) 4000 Ridgeway Drive Birmingham, Alabama 35209		

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Of these seven gaps, **AAHD and Lakeshore propose that Beneficiary Engagement – Shared Decision Making – Beneficiary Sense of Control/Autonomy/Self-Determination be the foremost quality measure** for cross-setting discharge to the community. There are existing measures for this area (for persons with intellectual and other developmental disabilities). Investment should be made to develop and pilot these measures for broader populations utilizing SNFs, IRFs, LTCHs, and HHAs. This is a priority of the mainstream of the consumer-family-advocate disability community, including many providers and state administrators. Choice and control is a quality measurement of the National Core Indicators (NASDDDS & HSRI; modified by NASUAD-NASDDDS-HSRI). Choice and self-direction are quality measures of the Personal Outcome Measures (Council of Quality and Leadership). It is the reason for being of the National Resource Center on Participant-Directed Services. The CMS HCBS settings rule declares choice and control as national Medicaid policy – a method of implementing the Olmstead Supreme Court civil rights declaration. Further, the Westchester Institute for Human Development (NY) (ACL-NIDILRR funded) has researched and adapted CAHPS (Consumer Assessment of Healthcare Providers and Systems) for persons with intellectual disability. We suggest that a CMS goal be use the health sector widely-accepted and used CAHPS, adapted for persons with disabilities and other special needs (health literacy, social determinant impacts, etc)			

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	Implementation of these current initiatives and expansion of these initiatives to broader populations will implement a focus on **Beneficiary Engagement – Shared Decision Making – Beneficiary Sense of Control/Autonomy/Self-Determination.** Thank you for the opportunity to comment on the cross setting quality measures. If you have any questions please contact Clarke Ross at clarkeross10@comcast.net.			
11/22/2015	We at Altru Rehabilitation Center have concerns regarding the development of a discharge to community quality measure for SNFs, IRFs, LTCHs, and HHAs. This measure appears to penalize facilities by reducing the discharge-to-community rate by unplanned readmissions. Given that unplanned readmissions are already being measured for quality purposes, would this cause a facility to be affected twice by each unplanned readmission? Furthermore, noting that unplanned readmissions may be outside of the PAC provider's control and may not adequately risk-adjust for sociodemographic factors, should such readmissions even be considered as a factor for a discharge-to-community measure? The risk-adjustment factors do not appear to be finalized, and it appears that they might include site-specific factors. In light of the IMPACT Act's mandate to produce standardized quality measures across PAC sites, shouldn't risk-adjustment factors be standardized as well? We urge you to reconsider the specifications for this quality measure.	Rachel Weiss Patient Care Coordinator Altru Rehabilitation Center 4500 S. Washington St. Grand Forks, ND 58201	rweiss@altru.org	Individual-Rehabilitation Center

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	Good morning— 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 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.	Janel Gleeson, Esq. Public Policy Director Pennsylvania Homecare Association 600 N. 12th Street, Suite 200 Lemoyne, PA 17043	JGleeson@pahomecare.org	Home Health Provider Association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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.			
11/23/2015	Dear Sir or Madam: 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	E. Liza Greenberg, RN, MPH Interim Vice President, Quality and Performance Improvement Visiting Nurse Associations of America 2121 Crystal Drive, Suite 750, Arlington, VA 22202	LGreenberg@vnaa.org	Home Health Association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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 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			

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	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 who did not have a short term acute stay within 30 days preceding a home health admission. 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.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Other comments are as follows: • 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. • 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.			

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	• 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 support better compliance with quality requirements during the episode, and enable them to better manage the patient			

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	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.) We appreciate the opportunity to comment and look forward to the next iteration of the measure. **VNAA's Comments conveyed to RTI (PPR@RTI.org) 11/13/15 and incorporated into VNAA's DTC comments**			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Dear Sir or Madam: 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 an crucial e role in supporting patients after facility discharge, focusing on patient education, self-management, and clinical improvement. We note, however, that home health functionally 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.			

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	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.			

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	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; • 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 <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 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;			

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	• 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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	• 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. Thank you for the opportunity to comment. We welcome the opportunity to discuss any of these issues with you further if that would be of assistance.			

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11/23/2015	I understand the concern about the smaller n, but mixing post-acute and community-admitted home health patients is mixing two different populations and will over-state an agency's predicted discharge to community rate, particularly if combined with other settings. To be consistent across the settings, the measure should look at a consistent population, post-acute patients. And if that isn't done, there should be a risk adjustment for the % of the agency's population that is post-acute, as those patients are at higher risk of readmission than patients admitted from the community. This measure relies on the calculation of unplanned readmissions, which itself is based on an untested methodology when used across settings. In 4.11.1 you make a statement that the facility/agency effects can be assumed to be randomly distributed around the average (according to a normal distribution.) While that may be true within each provider type (although, has that been analyzed and found to be true?), assumption needs to be tested when looking at discharges to community across provider types. Years of differential payment methodologies, incentives and regulatory interpretations have potentially skewed the results because of differences in the patient populations each provider admits. In 4.11.2, risk adjustment variables under consideration, there needs to be risk adjustment for the % of patients without caregivers in the home, or with cognitive deficits. These are the two most common factors affecting community discharge, either of which are amenable to provider actions. Each provider setting has a measure of this that could be used.	Catherine Gill	Catherine.Gill@nkch.org	Individual

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	To whom it may concern: AHCA is pleased to have the opportunity to comment on the proposed set of quality measure related to successful discharge to the community 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 and Abt with feedback we have received from our various committee members, we have summarized their comments into this one letter in the attached document. Thank you again for the opportunity to provide these comments. Please contact me at DGifford@ahca.org with any questions or for additional information. Sincerely David R Gifford MD MPH Senior Vice President of Quality & Regulatory Affairs AHCA Comments on "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)" RTI International CMS Contract No. HHSM-500-2013-13015I, Task Order HHSM-500-T0001 & Abt Associates CMS Contract No. HHSM-500-2013-13001I, Task Order HHSM-500-T0002 November 2015	David R. Gifford MD MPH Sr VP for Quality and Regulatory Affairs AHCA/NCAL 1201 L St NW Washington DC 20005	Dgifford@ahca.org	Provider association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	AHCA understands the statutory requirements underpinning the development of these measures, as AHCA was a strong supporter of IMPACT Act. We also have made discharge to community one of the AHCA Quality Initiative goals for all of our members. However, we believe the proposed specifications: a. Do not fully meet the statutory intent for the development and use of these measures. b. Modifications and data testing of the proposed measures is needed before these measures are ready for use under the IMPACT Act. c. There is inadequate time provided to get meaningful input on the measure as CMS and its contractors try to meet the statutory requirements for specifying these measures. Our concerns are outlined below with recommended steps to address our concerns. 1. The name of the measures should reflect the limited population to which they apply – fee-for service (FFS) Medicare beneficiaries. Since in many states, 40% or more of Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans and for SNFs over half of SNF admissions and discharges are not enrolled in FFS Medicare, this measure may not reflect the SNF's true			

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	discharge to community rate. Since the determination of discharge to the community is self-reported on the claims, we suggest the use of PAC assessment tools as the source of data on discharge to the community, which will allow the inclusion of additional Medicare Beneficiaries enrolled in MA plans. The use of the PAC assessment instruments is consistent with the intent of IMPACT act. Also, PAC care for non-Medicare beneficiaries is increasing. Measures posted on CMS Compare websites are being used by 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, data showing this needs to be provided since data on FFS vs. all payor rehospitalization measure from SNFs has shown up to 30% of SNF differ in their ranking by over 3 deciles between the two measures. AHCA is happy to provide CMS with its all payor discharge to community measure to see how rates calculated from MDS all payor measure differ or do not differ from a claims based measure.			

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	<u>AHCA Recommendations:</u> d. Change the name of the measure to reflect that they only apply to FFS and CMS should add footnote when the measure results are reported, that these measures do not reflect the discharge to community rates of patients with other insurance besides FFS Medicare. e. Expand the measure to include all payors or at least MA plan beneficiaries by using PAC assessment to collect discharge destination. 2. We disagree that the "ultimate goals of post-acute care are avoiding institutionalization and returning patients to their previous level of independence and functioning". This is true for a large number of individuals but for many it is to recover enough to return home since returning to their previous level of independence and functioning is medically impossible (e.g. patients with strokes or many neurological diseases). Also, the ultimate goal often is to complete a course of treatment or rehabilitation so that the individual may be able to return home to die. A measure of discharge to community needs to accommodate these types of individuals. Also, many individuals are admitted from the hospital with the expressed goal and desire to remain in the SNF long term but are receiving Part A covered services to complete their course of hospital treatment and/or improve their function to be as independent as possible while they reside in the SNF. This can			

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	explain the large variation in discharge to community seen in SNFs. In fact, when you look at the discharge to community rates as a relationship to the turnover of patients in Part A beds, those SNFs with low turnover that are consistent with primary long term care facilities have very low discharge to community rates while SNFs with higher turnover of beds, have higher discharge to community rates. The SNF measure needs to take into consideration and adjust for admissions to the SNF for Part A services who do not plan to return to the community. **AHCA Recommendation:** a. Take into consideration that many admissions to PAC settings may be to return people home to die by not counting death in the 30 days post discharge as unsuccessful discharge. Deaths that occur in the hospital after discharge could be considered unsuccessful discharges but without evidence that death off of hospice in the 30 days post discharge is related to poor quality of care more often than not, these individuals should be counted as successful discharge. Otherwise, deaths occurring in the hospital will increase. Consider anyone on hospice during the 30 days not just those discharged on hospice. b. Individuals admitted to SNFs with the goal for long term nursing facility care after Part A should also be excluded. This can be done using MDS data. In addition, SNFs with			

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	data strongly suggesting that they do not specialize in SNF Part A care should be excluded. This can be done by examining the turnover per bed per year in a SNF. 3. The denominator definition places SNFs at a disadvantage when comparing discharges to community for other PAC providers and the exclusions need to be modified: a. By including any admissions to SNFs, IRFs or LTCHs within 30 days post hospital discharge, more complex patients who are unlikely to be discharged home are added to SNFs, IRFs and LTCHs, but this differentially impacts SNFs since a large proportion of IRF and LTCH patients are discharged to SNFs within 30 days. b. For home health, by not requiring a hospital stay prior to HH stay, also will increase individuals in their sample who are less likely to be institutionalized after HH services, making their discharge to the community measure look better than the other PAC settings simply by the denominator definition. c. Failure to exclude individuals admitted to a SNF who were residents of a SNF prior to the hospital stay also is inappropriate since they are residents of long term care facility and would not be expected to be discharged to the community following Part A services. **AHCA recommendation:** i. The denominator should be individuals discharged from a hospital to PAC provider with 1-2 days between hospital discharge and PAC admission.			

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	ii. Individuals who were long stay SNF residents prior to hospital admission should be excluded from LTCH, IRF and SNFs. 4. The measure for HHA does not make sense as it is essentially duplicative as the inverse of other CMS measures that look at rehospitalizations. The HH measure counts individuals who are not hospitalized which is the inverse of a rehospitalization measure for HH. The only difference would be admissions to SNF, IRF or LTCH during the 30 day window after HH discharge. It is also not clear if SNF admission following HH is a failure of HH care. This will discourage HH services for complex individuals who are likely to need SNF care in the near future. Thus accelerating placement in a SNF which is contrary to the national policy direction to expand home and community based services to keep individuals at home. **AHCA recommendation:** CMS and its contractors need to explore the patient trajectory and types of patients enrolled in HH who with comprehensive HH care will be able to remain at home to better specify a discharge to community measure for HH. 5. 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, yet the measure will be used during time periods when only ICD-10 data is available. No analysis or cross walk between ICD-9 and ICD-10 has been performed. Therefore it is unclear if this measure will perform the same using ICD-10 codes as it does for ICD-9 codes.			

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	AHCA Recommendations: ICD-10 codes for use to define discharge to community and risk adjustment variables need to be provided since when the measures are used, they will require the use of ICD-10 codes. 6. 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. **AHCA Recommendations:** a. RTI/Abt/CMS should use the actual rate as the numerator in the SRR equation rather than the predicted actual number. b. RTI/Abt/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? 7. The numerator time window for how long a PAC provider has to accomplish a discharge to the community is not specified. This needs to be specified. The implication is on the day of discharge from Part A services. However, this does not take into consideration an interruption of services during the Part A services, which most often occurs due to rehospitalization. It is not clear how these interruptions are counted in the proposed measure. It appears that they will not count as successful discharge to community and the second admission back to the PAC provider starts a new episode?			

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	<u>AHCA recommendation:</u> a. Specify the time window to achieve discharge to community as the course of Part A benefit. b. Develop a method to take into consideration interruptions in Part A stay such as those from rehospitalizations. We would recommend considering interruptions in part A PAC stay of <7-10 days to be considered the same Part A stay from which a successful discharge is to be calculated. 8. The numerator definition of alive 30 days after discharge to the community will discourage discharging individuals to their home who are dying. We appreciate that those who die in the next 30 days after discharge who are also enrolled in hospice will be exclude but believe these should not be excluded. Rather, we believe they should be counted as successful discharge to the community rather than excluded. This will encourage the use of hospice and discharging individuals home to die rather than sending them to the hospital to die. MedPAC in their more recent iteration of their discharge to community measure only exclude individuals who died within 1 day of SNF discharge.			

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	AHCA recommendation: a. Count individuals who are discharged home and die in the next 30 days but who are enrolled in hospice at any time during the next 30 days as successful discharge to the community. 9. The numerator should not count individuals who during the 30 day discharge window are admitted to a SNF just as any rehospitalizations are not counted. This is easily determined using MDS data linked to FFS claims data for the sample in the proposed measure. Individuals discharged to the community from any of the four PAC providers who is admitted to a SNF in the next 30 days is equivalent, in our opinion, to being rehospitalized. Allowing admission to SNF in the next 30 days is inconsistent with the intent of this measure. Also, failure to include SNF admission in the 30 day window, also creates an incentive to admit individuals to SNF during that 30 day window to have them appear as if they are a successful community discharge. **AHCA recommendation:** a. Admissions to SNF in the 30 day widow following PAC discharge should be counted as unsuccessful discharge to community. 10. We agree with the concept to use a planned readmission algorithm but encourage RTI/Abt to consider the revised algorithm developed by RTI for CMS in the PAC potentially preventable readmission measures.			

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	AHCA recommendation: a. Modify the Yale unplanned readmission algorithm and list to be consistent with the proposed algorithm and list developed by RTI/CMS for the PAC potentially preventable readmission measures. b. Develop cross walk with ICD-10 codes. 11. Risk adjustment is not specified other than to state "under consideration is a hierarchical logistic regression model" without any specification of the risk adjustment variables other than examples and categories. Risk adjustment needs to include and specify: 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. However, since these measures examine care after discharge from PAC for individuals who will be in the community, SDS characteristics could play a significant role in explaining variation in successful discharge to community between providers. Thus, it is hard to evaluate and comment on the proposed measures without knowing the full complement of risk adjustment variables.			

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	AHCA recommendation: PAC discharge to community measures need to evaluate the need for using SDS risk adjustment before proposing the use of these measures. b. Functional status. Functional status (ADL, mobility, self-care, and cognitive function) are some of the strongest predictors of successful discharge to the community. 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 discharge to community measures are part of the IMPACT Act which talks about using data from standardized data assessments. The risk adjustment should include functional status. Also, all the PAC instruments contain some assessment of cognitive status albeit using different assessment tools. Nonetheless, inclusion of cognitive status using different assessment tools from PAC assessment tools is likely superior to not including cognitive function in the risk assessment model.			

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	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 and cognitive status from the PAC assessment tools. c. Specifications for the risk adjustment variables The risk adjustment variables are not specifically specified with respect to data source and coding but are given as examples with just an overall descriptor. Without knowing the risk adjustment variables and how they are specified, it is hard to evaluate the proposed measures. **AHCA recommendation**. RTI/Abt should provide specifications for all risk adjustment variables including data sources and coding parameters. d. Risk adjustment variables under consideration are not consistent across all PAC settings which is understandable for some settings and patients however, since LTCHs and IRFs are not in all markets, SNFs in many parts of the country serve the same population as IRFs and LTCHs. For example			

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	i. Ventilator use is only listed for LTCH setting. SNFs also care for individuals using ventilators. ii. Activities of daily living is only listed for HHA setting but as stated above functional status should be used for all four PAC settings. iii. Case mix groups is only listed for LTCH setting but should apply to IRFs and SNFs as well. Including different risk adjustment variable in one setting over others, particularly for conditions that apply in all settings is unfair and will create unintended effect to discourage these types of patients in settings that do not risk adjust for them. Besides causing variation in measure results due to differences in risk adjustment variables, this will create access to care problems for these types of patients in areas without IRFs and LTCHS. Risk adjustment should be more consistently applied across all PAC settings to be a standardized measure consistent with the intent of uniform PAC measures specified in the IMPACT Act. **AHCA recommendation:** Add risk adjustment variables from IRF and LTCH to SNF model since SNFs in many areas of the country provide care to the same population as IRFs and LTCHS. 12. We agree with most of the exclusions but believe some put certain PACs at a disadvantage and others at an advantage on the measure and therefore these exclusions need some modifications			

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	a. We agree with the age, psychiatric hospital admission, federal hospitals or disaster alternate sites, hospital stay for cancer treatment as exclusions. b. We agree that AMA discharges from PAC provider should be excluded but so should hospital discharges that are AMA and end up in PAC provider. c. What is considered discharged to "*the same level of care*" as an exclusion? Will individuals discharged from SNF Part A to another SNF count as discharge to same level of care? Will discharge from IRF or LTCH to SNF count as same level of care? d. "*only the final post-acute provider is included in the measure*". i. As stated previously, we disagree with this since a large proportion of LTCH and IRF discharges are to SNFs. This, will inflate the IRF and LTCH discharge to community rates and will send the more difficult sick individuals who are harder to discharge to SNF who will then drag down SNF measures. ii. Having anyone with an acute hospital stay in the prior 30 days to admission to SNF, IRF and LTCH will disadvantage SNFs for the same reasons specified above that high acuity individuals discharged from LTCH and IRF but who can't go back to the community will be transferred to SNFs. A large proportion of IRF and LTCH discharges are to SNFs which enriches SNFs population of difficult to discharge to the community compared to IRF and LTCHs. This phenomena also impacts HH as well.			

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	iii. By not requiring HH admission to have a prior hospital stay in the last 30 days also results in a sample of less acuity and complex individuals making discharge back to the community or keeping out of the hospital more likely. e. Individuals who are long stay SNF residents need to also be excluded. Since the community living situation is the SNF. Thus, those individuals who are hospitalized and discharged to a SNF should n be expected to be discharged to the community. Using MDS data linked with claims of hospitalized individuals, long stay SNF residents can easily be identified and excluded. This is a considerably large number that can significantly lower a SNF's discharge to community rate, particularly among SNFs who do not specialize in sub-acute care. **AHCA recommendations:** i. Exclude individuals from IRF, LTCH and SNF measure who were a SNF resident prior to hospital stay. ii. Change the window of time between hospital discharge and PAC admission to 1-2 days rather than 30 days iii. Add AMA discharges from the hospital stay prior to PAC as an exclusion. 13. The intention to varying windows of time to be in each PAC measures makes any comparison across settings difficult and also mutes changes in improvement or decline. Also, without specifying the time widow it is hard to adequately comment on these measures.			

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	The varying time windows makes any comparison across settings difficult and also mutes changes in improvement or decline to a greater extent for PAC providers with a larger window. For example, HH are likely to have smaller sample sizes and a larger time window compared to SNFs. We understand the need to expand the time window to increase the denominator size to meet a 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 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. Larger providers would therefore have real changes unfairly muted in order to improve reliability for small volume providers. **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 available since they admitted less than 20 Medicare FFS patients per year (20 is the minimum sample size requirement for most NQF quality measures). Alternatively, for set a minimum volume based on reliability and when the PAC provider exceeds the minimum volume, their measure is updated. We think you would also need to specify volume of admissions to the PAC provider if this approach is used.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	Dear Mr. Slavitt: Thank you for the opportunity to submit comments on the draft specifications from the Centers for Medicare & Medicaid Services (CMS) contractor tasked with developing a cross-setting discharge to community quality measure for skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs). America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our 275 member hospitals provide a disproportionate share of the nation's uncompensated care and devote about half of their inpatient and outpatient care to Medicaid or uninsured patients. Through their integrated health systems, members of America's Essential Hospitals offer primary through quaternary care, including trauma care, outpatient care in ambulatory clinics, public health services, mental health and substance abuse services, and wraparound services critical to vulnerable patients. Members of America's Essential Hospitals work daily to improve care quality through a broad variety ofinitiatives-from reducing readmissions to preventing falls, blood stream infections, and other patient harm events. They have created programs to break down language barriers and engage patients and families to improve the care experience. In fact, our members participate in Project ACHIEVE, which studies care transitions among Medicare beneficiaries- work supported by a Patient-Centered Outcomes Research Institute grant to the association's research and quality arm, Essential Hospitals Institute. Through such	Maryellen E. Guinan, Esq. Policy Analyst America's Essential Hospitals Erin O'Malley, Director of Policy Beth Feldpush, DrPH, Senior Vice President of Policy and Advocacy	mguinan@essentialhospitals.org	Hospital association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	efforts, members of America's Essential Hospitals promote a whole-person care approach despite the significant cost of using integrated care models to provide needed care for these patients. As CMS develops its quality measure for discharge to community among the Medicare population, we urge the agency to consider the following recommendations for all four post-acute care settings. 1. <u>CMS should include additional risk-adjustment factors in the discharge to community quality measure.</u> The discharge to community measure seeks to describe the rate of patients who are discharged to the community and do not have an unplanned readmission to an acute care hospital or LTCH in the 31days following discharge to the community. The measure developers call attention to a performance gap that currently exists in the rates of discharge to community, across post-acute settings, and the need to examine the discrepancies in these rates as a basis for quality comparisons across such settings and facilities. The developers also cite to variation in rates often being correlated with patients' socioeconomic characteristics, facility geographic location (rural versus urban), and facility characteristics (nonprofit versus for- profit). As such, proper risk adjustment is critical for any quality measure applied across these post-acute settings to accurately report on outcomes among the patient populations they serve. America's Essential Hospitals supports the variables under consideration for risk adjustment-including sociodemographic variables, such as age group and sex-along with Medicare-Medicaid dual status and comorbidities. However, CMS should consider additional factors before making this measure final.			

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	To more precisely gauge performance on discharge to community rates, CMS should consider additional sociodemographic factors, beyond age group and sex, such as the patient's location before admission to the post-acute setting or after discharge, and the patient's primary language. A growing body of literature shows that race, homelessness, cultural and linguistic barriers, low literacy, and other socioeconomic factors can skew performance on certain quality measures, such as those for readmissions.[9] It is documented that patients who lack reliable support systems after discharge are more likely to be readmitted to a hospital or other institutional setting. These readmissions result from factors beyond the control of providers and health systems and do not reflect the quality of care provided.[10] For example, individuals with limited English proficiency require appropriate language assistance or auxiliary aids and services to fully involve them in the discharge process. These patient characteristics should be accounted for in risk adjustment of a quality measure for discharge to community to ensure patients receive accurate information about a post-acute care setting's performance.			

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[9] America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. October 21, 2015. http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/. Accessed November 2015.

[10] See, e.g., National Quality Forum Technical Report. Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. August 2014. http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx. Accessed August 2015.

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	We urge CMS to include factors related to a patient's background-such as "sociodemographic status, language, and post-discharge support structure-in its risk-adjustment methodology for the discharge to community quality measure to ensure the measure more accurately reflects quality outcomes within a facility's control. 2. CMS should take into account access to non-health care social services, which disproportionately affect care transitions among socially and medically complex patients. The importance of the transition from hospital to home is increasingly being examined-particularly regarding elderly patients with low socioeconomic status-to understand what characteristics of vulnerable populations might lead to fragmented care, adverse drug events, and readmissions. Research from the University of California, San Francisco, identified three challenges: functional limitation and difficulty with mobility, social isolation and lack of community support, and challenges from poverty and related issues of home environment. Results of this study point to the need for post-discharge interventions to address these challenges and to reduce readmissions.[11] Members of America's Essential Hospitals understand the critical contribution non-health care social services make to achieving effective care transitions and improved outcomes, including reduced readmissions. One member, in Missouri, developed a care transitions program that led to fewer hospital admissions, fewer			

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[11] Greysen SR, Hai-Cheung D, Garcia V, et al. "Missing Pieces"-Functional, Social, and Environmental Barriers to Recovery for Vulnerable Older Adults Transitioning from Hospital to Home. *Journal of the American Geriatrics SoC'iety* 62:1556-1561, 2014.

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	emergency department visits, and costs savings. This hospital identified the need to establish a multidisciplinary team, bringing together licensed clinical social workers, client-community liaisons, and advanced practice registered nurses, among other staff, so that a hospital could address not only the clinical, but the social issues impacting their patient population. The same lessons can be applied in the post-acute setting, taking into account the patient's care goals and treatment preferences while also addressing access barriers that might affect a patient's chance of being rehospitalized. Post-acute care settings providing care to vulnerable populations oflow socioeconomic status face special challenges in identifying a patient's or caregiver's capability and availability to provide necessary post-discharge care, as well as the availability of community-based services and organizations, including non-health care services, such as transportation services, meal services, and housing for homeless patients. **We urge CMS and the developers of the quality measure for discharge to community to consider factors related to the availability of and access to social services**. In doing so, the measure will more accurately reflect the quality of care in the four targeted settings and provide meaningful results that are useful to patients and account for additional factors that affect facilities' performance outcomes. * * * * * * * America's Essential Hospitals appreciates the opportunity to submit these comments. Ifyou have questions, please contact Director of Policy Erin O'Malley at eomalley@essentialhospitals.org or 202-585-0127.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	Dear Sir or Madam: The American Association for Homecare (AAHomecare) is pleased to have the opportunity to submit comments on the DRAFT Specifications for the Discharge to Community Quality Measure for Skilled Nursing Facilities (SNF), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs). The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop cross-setting discharge to community quality measure in order to meet the mandate of the Improving Post-Acute Care Transformation Act of 2014 (known as the IMPACT Act). Defining measures that are reflective of the quality of care for post-acute care settings is an important undertaking that will determine the success of the IMPACT Act. Adequate measurements will allow Medicare beneficiaries to move seamlessly into the home care setting with confidence and independence. 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 measures designed to understand factors that would allow the definition of quality care will be impactful in measuring facilities and agencies.	Mina Uehara, MPP Manager, Regulatory Affairs American Association for Homecare Kimberley S. Brummett, MBA VP for Regulatory Affairs	minau@aahomecare.org	Medical equipment supplier association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	A. To determine the effectiveness and quality of a facility or agency, Medicare must examine the entire continuum of care. Access to appropriate post discharge DMEPOS technologies and services helps to prevent 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. **B. Data sources must be broader than Medicare fee-for-service claims to determine the quality measures.** The CMS must look at the full spectrum of care a Medicare beneficiary has access to in order to determine how services provided impact the quality measure. The measure must account not only for DMEPOS services that have been or have not been provided, but also other health care related services that allow a patient to remain safely in their home. For example, many state Medicaid programs and patient families pay for personal care that is not covered under Medicare. The presence and assistance of an aide and the utilization of appropriate medical equipment in the home can be the key to the success of any discharge. Merely looking at claims data will not allow for a comprehensive measure of the quality.			

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	In addition, the timeliness of any reporting would be based not only on a yearly timely filing limit to evaluate claims data, but on the overwhelming backlog of appeals up through the ALJ level. To evaluate claims data for claims that are in the appeal process for years will limit the scope of the analysis. Additional consideration should be given the more recent 'settlement' initiatives occurring at the ALJ. Settled appeals are considered dismissed and therefore cannot be quantified in with an assessment of claims payment data. **C. Measuring facility and agency discharge to community rates is to narrow a focus to be impactful to health care community at large.** In determining an effective measure and thus score of quality for discharge has to consider the use and access to community resources, needed medical supplies, quality durable medical equipment, service and monitoring of the patient's utilization patterns. Whether a patient is being discharged from an in-patient facility or home health agencies, what occurs after this is not even considered in the measurement tools. How can a measure be accurate if only some of the analysis is complete? Since Medicare does not cover many needed modifications to patients homes, monitoring of use of prescribed oxygen or other equipment in addition to medications will lead to measure for facilities and agencies that may have no bearing. A broader analysis of all of the factors that lead to a patient being successfully maintained in their home is paramount to creating a valuable tool. Whatever ratios and risk factors are determined as part of the calculation will always be a part of the equation without including additional factors in the prevention of rehospitalizations within 31			

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	days of discharge. Should the calculation have addition measure exclusions for rehospitalizations that are completely separate from the original admission and medical conditions? **D. 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 fragile Medicare beneficiaries with the appropriate equipment and services to manage their condition post discharge 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.[12] 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 draft specifications 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 specifications as we suggested.			

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

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	Thank you again for the opportunity to submit these comments. We would be happy to meet with you to discuss these issues in more detail if you believe that would be of assistance to you.			
11/23/2015	To Whom It May Concern: On behalf of the American Medical Rehabilitation Providers Association (AMRPA), I appreciate the opportunity to submit comments on the draft measure specifications for a discharge to community measure 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). The measure, which varies slightly for HHAs, was developed through the work of a technical expert panel (TEP) convened by RTI and Abt Associates to assist CMS in developing such measures as required by the Improving Post-Acute Care Transformation (IMPACT) Act. AMRPA is the national voluntary trade association representing more than 500 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers. In 2009, AMRPA formed a Quality Committee to review and develop quality measures appropriate for IRFs and this work has included the review of discharge to community and patient satisfaction of care measures. We have been fortunate to serve on TEPs convened by CMS and the National Quality Forum (NQF) focused on the development of quality measures on more than one occasion and we appreciate the continued efforts to ensure measures applicable to IRFs are appropriately developed. Overall, we think many of the elements of the measure specifications, such as the risk-adjustment methodology, are appropriate. However, we are submitting for your consideration several recommendations to strengthen the specifications.	Sarah Warren, MA Government Relations and Policy Development Associate American Medical Rehabilitation Providers Association 1710 N Street, NW Washington, DC 20036 Bruce M. Gans, M.D. Chair, AMRPA Board of Directors Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation National Medical Director for Rehabilitation, Select Medical	swarren@amrpa.org	IRF provider association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Discharge to Community Defined – General Concerns According to the draft specifications, discharge to community will be determined based on the "Patient Discharge Status Code" from claims. In SNF, IRF, and LTCH settings, discharge to community will be defined as discharge to home with or without home health services. In the HHA setting, discharge to community will be defined as discharge to home without home health services. Table 1 of the draft specifications lists the codes that indicate a discharge to community. While AMRPA recognizes CMS' statutory mandate to implement a discharge to community measure, we have overarching concerns regarding the use of any discharge to community measure whose specifications are not sensitive enough, necessitate additional exceptions and/or better risk-adjustment to avoid a systematic bias against institutional PAC providers such as IRFs. We believe the current draft measure specifications reflect these shortcomings and offer suggestions for their improvement and refinement below. Oftentimes, the ability to discharge a patient to the community is based on facts or circumstances outside the PAC provider's control. For example, the presence/absence or desires of community or family supports may be a determinant of the patient's discharge destination which would not be a reflection of the quality of care delivered, but external factors. Also, some PAC patients are very ill or injured making return to the community unlikely or unrealistic. Accordingly, while discharge to community is often IRFs' goal, it is not always possible due to patients' clinical characteristics, socioeconomic, and/or sociodemographic factors. Any cross-setting measure assessing discharge to community rates must thoroughly account for these			

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	various factors. For example, the concerns regarding community or family caregiver supports should be addressed in the risk-adjustment methodology discussed below. Our primary concern is that a narrowly drawn definition of discharge to community will be used, and, if the measure is not carefully risk-adjusted and attentions given to factors that might preclude discharge to community, it could lead to barriers to access for certain patients that some providers consider unfit to be discharged to community. As CMS formulates the discharge to community measure, AMRPA encourages the Agency to consider including certain elements in the measure specifications which we believe are more reflective of the multitude of factors influencing discharge destinations post-PAC care. For example: • Metrics that assesses whether the patient achieved optimal level of function and independence based on his/her condition and level of community support; and/or • Metrics that assesses whether the patient achieved his/her care goals as developed with the clinical team. **Issues Regarding SNF Discharges** Additionally, we believe that the patient discharge status codes used for this measure, as shown in Table 1 of the draft measure specifications, should definitely be applicable to SNFs. SNFs have a historically low rate of discharge to community and have a tendency to discharge these patients to the residential portion of their own or another nursing home. Unfortunately, data on the overall quality of care for these patients are lacking. Therefore, we			

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	believe that patients discharged to a residential portion of a nursing home from a SNF should not be counted as a discharge to the community. **Expanding the Discharge Status Codes** At this time, discharge destination data for IRF patients is collected via the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) and the most appropriate discharge destination codes associated with discharge to community include: • 01: Home (private apartment, board/care, assisted living, group home, transitional living); • 06: Home under the care of an organized home health service organization. As currently drafted, the measure does not capture this level of information and its level of specificity is substandard to that captured by the IRF PAI. In other words, the IRF PAI definitions reflect a truer definition of discharge to community more so than the one proposed. Having the two sets of definitions could be confusing to providers. Therefore, CMS should consider modifying the patient discharge status codes applicable to IRFs, SNFs and LTCHs to reflect those in the IRF PAI. We encourage CMS, as it develops cross-setting measures, to use metrics that reflect greater specificity. This is particularly true when such specificity is already being used and captured by PAC providers, IRFs in this case. A cross-setting measure should not constitute a "step down" in the refinement of data collected.			

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	The discharge to community IRF PAI definition under "01: Home" acknowledges several aspects of the patients' status. It recognizes the presence or absence of family/caregiver supports at home; permanent or temporary barriers to access at home such as steps or the need for bathroom modifications; or that perhaps a short-term need for some assistance in activities of daily living and medication management, etc. We believe similar information can be used in the definition for LTCHs and SNFs with the understanding that discharge to the residential side of a nursing home post SNF care is not included in this definition. **AMRPA Recommendation:** 1. The discharge to community measure should account for instances when the patient's situation would preclude a safe discharge to the community, such as when they are too impaired to go home or do not have the community support for a safe discharge. 2. Patients admitted to a residential nursing home by a SNF should not be counted as a discharge to the community. 3. CMS should modify the patient discharge status codes applicable to IRF, SNFs and LTCHs to reflect the specificity and refinement of the IRF PAI definition of home (01 and 06). 4. CMS should consider developing an alternate measure of discharge outcomes such as a measure that assesses whether the patient met the goal(s) he/she established by the point of discharge as opposed to where the patient was discharged. 5. In developing this measure, CMS should pay particular attention to ways in which it can prevent providers from excluding patients that might not be discharged to community in an effort to avoid a negative quality score.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Measure Description and Design This measure describes the risk-standardized rate of Medicare fee-for-service (FFS) patients/residents/persons who are discharged to the community following a post-acute stay/episode, and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community. IRF, LTCH, and SNF patients are included in the measure if they have had an acute hospitalization within 30 days prior to admission. HHA patients are not required to have a prior acute hospitalization to be included in the measure. It is based on claims data and Medicare eligibility files. As outlined in the specifications, this measure is calculated in two steps. As noted above, this measure includes individuals who do not have an unplanned readmission to the acute care hospital or LTCH within 31 days post-discharge. The draft measure specifications propose to identify unplanned (re)admissions based on the planned readmissions algorithm used in the following PAC readmission measures, endorsed by the NQF: • NQF #2510: Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM); • NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities; • NQF #2512: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long Term Care Hospitals; and • NQF #2380: Rehospitalization During the First 30 Days of Home Health.			

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	As CMS is aware, the IMPACT Act requires the Agency to develop a readmission measure to reflect all-condition risk-adjusted potentially preventable hospital readmission rates. CMS and RTI recently solicited comments on draft measures specifications for six readmission measures for PAC providers and AMRPA responded to this comment opportunity. These six measures are based, in part, on the four measures cited in these draft measure specifications builds upon and modifies them. We are concerned that multiple different definitions of readmissions could be confusing for providers and patients, will lead to unintended differences in the data CMS receives, and will ultimately skew the data. If CMS includes the recommendations we have made with regard to the six readmission measures in prior comments,[13] it may be more appropriate to use that definition as opposed to the one included in the draft specifications for this measure. In addition, we suggest that CMS use more than just claims data to calculate this measure to ensure patient characteristics such as community support are captured. This data can be obtained through the IRF PAI and other sources.			

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[13] AMRPA comment letter submitted to CMS on November 16, 2015 in response to "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)."

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	AMRPA Recommendation: 1. Use a consistent definition of readmission across quality measures. 2. Because claims and eligibility data alone are insufficient for the calculation of this measure, CMS should also use data pertaining to community support from the IRF PAI and other sources. **Numerator and Denominator Defined** The numerator is the *risk-adjusted estimate* of the number of patients/residents/persons who are discharged to the community, and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and remain alive during the post-discharge observation window. This estimate includes risk-adjustment for patient/resident/person characteristics, and a statistical estimate of the facility/agency effect beyond case mix. The numerator estimate includes risk-adjustment for patient/resident/person characteristics, and a statistical estimate of the facility/agency effect beyond case mix. The numerator will use a model estimated on full national data specific to the post-acute setting; it will be applied to the facility's/agency's patients/residents/persons, and will include the estimated effect of that facility or agency. The denominator is the number of discharges to community that would be expected for that patient/resident/person population at the average facility/agency. The measure includes all facility/agency stays/episodes in the measurement period that are observed in national Medicare FFS data and do not fall into an excluded category. For the eligible stays/episodes at each			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	facility/agency, the measure denominator is the risk-adjusted expected number of discharges to community (without unplanned (re)admissions or death in the post-discharge observation window). This estimate includes risk-adjustment for patient/resident/person characteristics, but with the facility/agency effect removed. The "expected" number of discharges to community is the predicted number of risk-adjusted discharges to community if the patients/residents/ persons were treated at the average facility/agency. **AMRPA Recommendation:** It appears that the measure is specific to provider type meaning IRFs will be compared to IRFs. We believe this is appropriate and support this element of the draft specifications. **Exclusions** The draft specifications include the following exclusions for the measures: 1. Age under 18 years 2. No short-term acute care stay within the 30 days preceding a SNF, IRF, or LTCH admission 3. Discharges to psychiatric hospital 4. Discharges against medical advice 5. Discharges to federal hospitals or disaster alternative care sites 6. Discharges to hospice			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	7. Patients/residents/persons not continuously enrolled in Part A FFS Medicare for the 12 months prior to the post-acute admission date, and at least 31 days after post-acute discharge date 8. Patients/residents/persons whose prior short-term acute care stay was for non-surgical treatment of cancer 9. Post-acute stays that end in transfer to the same level of care 10. Post-acute stays with claims data that are problematic (e.g., anomalous records for stays that overlap wholly or in part, or are otherwise erroneous or contradictory) **AMRPA Recommendation:** At this time, we support the exclusion criteria as drafted. **Risk-adjustment** The draft specifications adjust for the following factors: 1. Sociodemographic variables a. Age group b. Sex 2. Disability as original reason for entitlement 3. Medicare-Medicaid dual status 4. Characteristics of the prior acute stay in the past 30 days (for SNF, IRF, LTCH settings, and for HHA persons whose episode is preceded by an acute care stay in the past 30 days) a. Length of stay b. Intensive care use indicator, or intensive care length of stay			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	5. Ventilator use (in the LTCH setting) 6. Clinical conditions a. Principal diagnosis from prior acute stay in the past 30 days (for SNF, IRF, LTCH settings, and for HHA persons whose episode is preceded by an acute care stay in the past 30 days) b. Comorbidities (based on prior acute stay in the past 30 days, or based on one year look back, depending on the specific comorbidity; in the HHA setting, data from the prior acute stay in the past 30 days will be used when available) c. Surgery, procedures during the prior acute stay in the past 30 days (for SNF, IRF, LTCH settings, and for HHA persons whose episode is preceded by an acute care stay in the past 30 days) d. Dialysis e. IRF Case-Mix Groups (in the IRF setting only) f. Activities of Daily Living (in the HHA setting only) 7. Prior acute care utilization in the past year a. Number of acute care discharges in the past year, not including the hospitalization in the 30 days prior to the post-acute stay, or b. Number of prior hospital days in the past year, not including the hospitalization in the 30 days prior to the post-acute stay			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	8. Prior post-acute and emergency department utilization in the past year (in the HHA setting only) a. Number of prior SNF, IRF, and LTCH discharges Number of prior emergency department visits without hospitalization **AMRPA Recommendation:** 1. In addition to the risk-adjustment factors listed above, we believe CMS should also adjust for socio-economic status including income and family/community support as well as functional status of the patient. As noted above we strongly believe that risk-adjustment must include these socioeconomic factors, such as living status, presence or absence of family/care giver/community supports, income, etc. since in the PAC arena, especially with respect to IRFs they are frequently a key determinant in choosing a discharge location. 2. We have long advocated for quality measures to include CMG as part of the risk-adjustment methodology. We support the inclusion of it in these draft specifications and thank CMS for including it. **Conclusion** Again, we would like to thank RTI, Abt Associates, and CMS for the careful consideration of the specifications for these measures. 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. If you have any questions, please contact Sarah Warren at swarren@amrpa.org or 202-223-1920.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	To Whom It May Concern: The National Association for Home Care & Hospice (NAHC) is the nation's largest trade association representing home health and hospice agencies including Visiting Nurse Associations, government-based agencies, multi-state corporate organizations, health system affiliated providers, and freestanding proprietary agencies. NAHC members serve over 3 million Medicare home health and hospice beneficiaries each year. NAHC appreciates the opportunity to provide comments 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). We wish to offer the following concerns and recommendations: **Target Population** The measure uses a different target population for facility based post–acute care (PAC) providers than for home health agencies (HHAs). The target population for SNF, IRF, and LTCH includes only those patients that have had an acute care stay within 30 days prior to admission, while home health providers include all patients admitted to the agency. Thereby, the target population for home health is a blend of post-acute and chronic care patients. It is unclear how the measure will be adequately compared across settings with divergent target populations.	Mary K. Carr V.P. for Regulatory Affairs National Association for Home Care & Hospice (NAHC)	mkc@nahc.org	Home health association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Discharge Status Codes HHAs do not typically use discharge status code "81". Patients discharged from home health to the community who later have a planned acute care hospital admission are coded as "01" (Discharged to home/self–care). According to the measure specifications a home health claim that includes a discharge status code of "01" or "81" will have the same impact on the measure. However, the concern is with those patients who are discharged from home health directly to an acute care hospital (transferred) for a planned admission. Currently there is no discharge status code that accurately captures this scenario. Discharges from home health to acute care hospitals are coded as "02"- (Discharged/ transferred to short term general hospital), regardless if the admission is planned or unplanned. If the expectation is for HHAs to use discharge status code "81" it will require operational changes that could be burdensome for agencies. NAHC recommends the measure include a method to evaluate of home health claims with a discharge status code of "02" to determine whether these admissions are planned and exclude them from the measure. **Risk Adjustment** The risk adjustment model does not include variables for socioeconomic status or caregiver support. Both of these variables are key indicators of an individual's ability to be discharged to, and remain in the community following a post-acute care stay. NAHC urges the developers to include in the risk adjustment model variables to address socioeconomic status and caregiver support.			

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	The proposed risk adjustment model will include the principle diagnosis and comorbidities listed on an acute care stay claim that has occurred within 30 days of admission to the PAC setting. If this data is not available for a home health patient because an acute care stay has not occurred within the 30 day window, these variables will not be included for risk adjustment. Data has shown that over 55% of home health patients do not have an acute care stay within 30 days prior to admission to the HHA. Therefore, a significant portion of home health patients may not have the principle diagnosis and comorbidity included in the risk adjustment model. These variables are important indicators of a patient's overall health status and the potential to remain in the community. NAHC requests if the data for the principle diagnosis and/or comorbidity is not available from an acute care stay claim, the HHA's claim be referenced to include the variables in the risk adjustment model. **ICD -10** The measure specifications are based on ICD-9 diagnoses codes; however, the measure will be implemented using claims with ICD-10 diagnoses codes. The ICD-10 code list has greater specificity and is considerably more complex NAHC recommends an ICD-10 cross-walk be provided for codes considered to be planned (and unplanned). Without this cross-walk, it is difficult to understand the scope of the measure.			

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	Measure exclusions The discharge to the community measure has a significantly different standard for facility based PAC providers than for HHAs. Facility based providers may discharge a patient with skilled nursing or rehabilitation needs to a home health agency and meet the specifications for the measure. HHAs, however, must ensure the patient no longer has any unmet skilled needs and is safe to remain in the community. Many of the patients HHAs serve are older elderly, low income, in fragile heath, and have little or no caregiver support. Long term care facilities are the most appropriate discharge disposition for these patients, not the community. NAHC recommends that patients discharged to long term care facilities paid by Medicaid, or sources other than Medicare, be excluded from the measure. **General comment** The time frame that has been permitted for public comments for the measures related to the IMPCT Act is insufficient for any real public input and raises concerns regarding the robustness of the comments. In addition, several of the measure comment periods overlap. NAHC strongly urges CMS and the measures developers to provide ample time, no less than 30 days, for stakeholders and the general public to provide thorough and thoughtful comments. Thank you for the opportunity to submit comments. Should you have any questions, please contact me at mkc@nahc.org.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	Thank you for the opportunity to submit comments on the development of a Discharge to Community quality measure for post-acute care providers. 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. 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 have particular concerns related to the definition of discharge to the community for other post-acute care providers that includes patients discharged from their setting with home health services while discharges from home health includes only those patients without home health services. Patients discharged from SNFs, IRFs, and LTCHs with home health services will have a greater chance of achieving the discharge to the community measure, not incurring an unplanned readmission, and potentially remaining alive for the 31 day period. Cross-setting comparisons of this quality measure would not be appropriate. Similarly, we believe that the inclusion of patients who did not have a hospitalization within the past 30 days only in the home health calculation and not for other post-acute care providers would create different measures that would not be comparable. We support the exclusion of patients discharged to hospice from the measure calculation. We have always disagreed with the Discharge to the Community OASIS-based quality measure's	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@homeanddhospicecare.org	Home health association

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	definition that patients transferred to a non-institutional hospice are considered an unfavorable outcome. We would recommend the addition of any patient that elects hospice during the 31-day window and not just those that are discharged directly to hospice. Patients may be hospice-eligible but choose to delay their election for a variety of reasons. This measure does not acknowledge the role that personal care/non-medical home care services can provide in keeping a patient in the community. We support the collection of this information across the PAC providers and its inclusion in the risk adjustment model. We support the inclusion of this measure in the CASPER reports as soon as possible to provide agencies with data on their performance. If we can provide any additional information to help support your measure development work, please feel free to contact me at: 803-445-7908 or heatherjones@homeandhospicecare.org.			
11/23/2015	Dear Measurement Development Team: RML Specialty Hospital (RML) is pleased to have the opportunity to present comments 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). 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	James R. Prister President & CEO RML Specialty Hospital	jprister@rmlspecialtyhospital.org	LTCH

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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. The purpose of this letter is to provide some general input, express concerns, and seek clarifications regarding several items contained in the above Draft Specifications. RML appreciates RTI and CMS' thoughtful consideration of our comments and suggestions. As a general statement, RML is supportive of utilizing 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 value, then there must be consistent comparisons, based on risk adjusted indicators, for each of the various post acute settings. RML has a strong willingness to participate in the development and assessment process. We hope that CMS recognizes that there should be an 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 specification.			

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	As described in the program narrative, this Draft Measure describes the risk standardized rate for Medicare Fee for Service patients who are discharged to the community following a post acute stay/episode and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days during discharge to community. In the description of the Measure, it is identified that a standardized risk ratio is calculated from the predicted number of patients discharged to the community divided by the expected number of patients discharged to the community from an average facility. It further goes on to note that the magnitude of the risk standardized ratio is the indicator of the facility's effect on the discharge to community rate. The definition further goes on to identify that the mean rate of discharge to community in the population is calculated separately for each post acute care setting. It is curious as to why this calculation would not be based on each facility as opposed to the setting. In markets with significant numbers of post acute providers, the averaging effect could be misleading as it could be skewed to lower acuity providers. Conversely, it should be noted that in markets with few post acute providers, using this calculation by "setting" could also be biased if an actual facility's rate is not used. In the Measure justification section, it is noted that MedPac used discharge to community as one of the three indicators of quality of care in ERF and SNF settings. It should be specifically identified that this same statement was not utilized in the LTCH setting. An LTCH is considered to be a hospital and thus should be identified separately from the other post acute settings.			

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	There is also a statement made that studies have reported variations in discharge to community rates based on patient's socioeconomic characteristics, facility geographic location, and facility characteristics with or without adjustment for case mix. This is an important factor and should be recognized and adjusted in this Draft specification Measure. There is a citation to a study that was conducted in the LTCH setting based on one multicenter study of 23 LTCHs reporting that 28.8% of patients who are ventilator dependent upon admission were discharged to home or an assisted living facility. Of specific concern regarding this study, is the fact that RML was the largest participant in the study accounting for over 20% of all the ventilator patients in the study. There were a couple of other sites with volumes over 100, but most LTCHs had very small numbers of ventilator discharges. The study's 28.8% discharge to home rate is misleading and should not be used as a benchmark because many of the participating LTCHs in that study only admitted patients that were identified as being candidates for weaning. As RML's patient population included patients on dialysis and other difficult to wean patients, RML's discharge to home percentage (<15%) was much different than the remaining facilities in the study. As a matter of fact, RML continues to provide care to the largest number of ventilator dependent patients across any LTCH in the country. High ventilator patient populations, which includes both dialysis and non-dialysis patients, must be factored into this new Measure. By not recognizing specific facility characteristics, it would put RML (as a regional referral center) at a significant disadvantage when this Measure is calculated. It is difficult to grasp how this Measure will be fully utilized as there are many			

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	LTCHs who admit very small numbers of vent dialysis patients around the country. In our last fiscal year, approximately 20% of our entire LTCH population received dialysis services. This is a significant impediment to discharge and cannot be adjusted by utilizing a mean rate of discharge to the community for each post acute setting. It is also of interest to note that the LTCH patient population is the smallest sector of all of the post acute providers. We suggest that for LTCHs specifically, that discharges to the community should include discharges to SNFs. The discharge to community statistic for LTCHs should include discharges to SNFs as many of these patients have significant comorbidities and complexities which prevent them from being admitted into a home setting. In addition, some of these patients start their care process in a SNF setting before their acute stay admission. For LTCHs, SNFs should thus be identified as part of an acceptable and valuable discharge location. The current proposed Measure specification identifies that the numerator is the risk adjusted estimate of the number of patients who are discharged to the community, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31 day post discharge observation window. Why are admissions to acute rehab also not included in this distinction as they are considered to be a "hospital"? There is a statement made that death in the 31 day post discharge window should be identified as an unfavorable outcome. We would suggest that this blanket statement is not appropriate in that			

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	these patient's complexities are such that it is not necessarily an unanticipated event to have a death occur post LTCH discharge. One of the exclusions is to exclude individuals under age 18 and the statement is made that there is limited literature on discharge destination outcomes in this age group. If this is being used as a base assumption, then this same statement could be utilized for those patients discharged from an LTCH. In addition to the risk adjustment variables that are being considered, we suggest that patients who are pre- and post-transplant, patients on LVAD, patients on dialysis and vent, patients on dialysis and LVAD, patients on dialysis and with stage 3 or 4 wounds, and multi-system organ failure patients should also be identified as clinical conditions for risk adjustment. 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. If there is any additional information we can provide, please do not hesitate to call upon us. We can be reached at 630-286-4120.			
11/23/2015	To Whom It May Concern: LeadingAge welcomes the opportunity to comment on the development of a cross-setting discharge to community quality measure in order to meet the mandate of the Improving Post-Acute Care Transformation Act of 2014 (IMPACT Act). The members of LeadingAge and affiliates touch the lives of 4 million individuals, families, employees and volunteers every day. The LeadingAge community (www.LeadingAge.org) includes	Peter Notarstefano Director, Home & Community-Based Services LeadingAge Cheryl Phillips, MD Senior VP Public Policy and Advocacy Leading Age	ssullivan@LeadingAge.org	Advocacy group

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	6,000 not-for-profit organizations in the United States, 39 state partners, hundreds of businesses, research partners, consumer organizations, foundations and a broad global network of aging services organizations that reach over 30 countries. The work of LeadingAge is focused on advocacy, education, and applied research. We promote home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, continuing care communities, 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. We believe the draft specifications for the Discharge to Community Quality Measure for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Hospitals and Home Health Agencies developed by the CMS, RTI International, Abt Associates and the Technical Expert panel are consistent with the three aims and six priorities of the National Quality Strategy. There are a few recommendations that we believe would improve the Discharge to Community Quality Measure for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Hospitals and Home Health Agencies, so it is more reflective of quality of care for post acute settings that are the goals of the IMPACT Act.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Recommendations We recommend the draft specifications for the Discharge to Community Quality Measure for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Hospitals and Home Health Agencies include the availability of a caregiver. Nearly 34 million family caregivers care for frail elders.[14] This "informal" care of individuals with chronic illnesses or conditions that prevent them from handling daily activities such as bathing, managing medications or preparing meals on their own is a major determinant of achieving the aim of Better Care within the National Quality Strategy. A caregiver also decreases the chance of social isolation that can occur, as well as providing a safe environment for the individual with chronic illnesses or conditions. Inclusion of the availability of a caregiver to the draft specifications for the Discharge to Community Quality Measure for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Hospitals and Home Health Agencies aligns with the priorities of the National Quality Strategy. The following priorities align closely with the availability of a caregiver: - *Ensuring that each person and family is engaged as partners in their care* - *Promoting effective communication and coordination of care*			

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[14] National Alliance for Caregiving *Caregiving in the U.S. 2015 at* http://www.caregiving.org/caregiving2015/

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	• We recommend the draft specifications for the Discharge to Community Quality Measure for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Hospitals and Home Health Agencies include consideration of patient satisfaction that is tied into the individual's personal goals. One 85 year old individual may have a goal of continuing to play golf every weekend, while another 85 year old individual with the same post acute condition may have a goal to continue to prepare their own meals. The aim of Better Care within the National Quality Strategy recognizes that each patient is different and may have different needs and preferences. There are multiple cultural, religious and personal needs and wants that may alter the interpretation of the outcomes from a Discharge to Community Quality Measure for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Hospitals and Home Health Agencies. Please do not hesitate to contact us if you have any questions or would like further discussion. We look forward to our continued work with you on this and related issues.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	Dear Technical Expert Panel, The New Jersey Hospital Association (NJHA) appreciates the opportunity to comment on the Draft Specifications for the Discharge to Community Quality Measure 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. Overall, we concur with the way in which these measures are being developed, but we have some concerns and suggestions to share as detailed below: • Discharges to assisted living communities do not appear to be captured by the patient discharge status codes proposed to be used to determine discharge to community. This is a significant concern since assisted living communities are concerned part of the fabric of home and community-based care for seniors. One possible remedy is to instruct providers that discharges to assisted living should be coded as "01." However, this would not be completely accurate since individuals who reside in assisted living communities receive services as part of their housing.	Theresa Edelstein, MPH, LNHA Vice President Post-Acute Care Policy New Jersey Hospital Association	TEDELSTEIN@NJHA.com	Hospital association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	• Often there are underlying mental health conditions that have an impact on the ability of an individual person to successfully remain in the community post-discharge from a SNF, IRF, LTCH or HHA. These go beyond mild dementia and include depression and other serious mental health diagnoses. We recommend that RTI review this issue to determine if there is a reliable way to adjust for this since it is an increasing challenge. • Many skilled nursing facilities have both a significant subacute population and custodial population living in the same facility, although in separate units or wings of the SNF. Often, the patient who needs SNF care after a hospital stay will gravitate toward a SNF that has both levels of care available. At times, this is a way for patients and families to evaluate whether the patient might need to remain in the SNF for long term care. Therefore, for facilities that have both levels of care, their discharge to community rate could be affected by this phenomenon. • The risk-adjustment factors do not appear to be finalized, and it appears that they might include site-specific factors. For example, IRF Case-Mix Groups, prior post-acute and ER use in the past year and ADLs in home health are listed. In light of the IMPACT Act's mandate to produce standardized quality measures across PAC sites, shouldn't risk-adjustment factors be standardized as well? Thank you for the opportunity to participate in the comment period for this draft. Please feel free to reach out to me at 609-275-4102 or via email (tedelstein@njha.com) if you need additional information or have questions about our comments.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	Re: Section 4.3 – "A favorable outcome….and without death in the 31 days following discharge to community" • Does this mean IRFs (and SNFs/LTCHs) would be penalized for accepting patients who may have a terminal illness? Section 4.3.1., table 1 – • Are the discharge status codes 81 and 86 already in place? These are not options on the IRF PAI form. • If they are not yet in place, how are planned versus unplanned admissions tracked? • As re-admissions are tracked via claims data, would it not be easier and as effective to simply add theses 2 discharge disposition options to the IRF PAI and the rehab claim. Re: Section 4.3.2 – • Define "readmission"? Is an ED visit or observation stay considered an admission, or does that only apply to patients who spend at least one midnight in an acute hospital bed? • Where can one find the specific list of codes that result in an admission being classified as "planned"? • This appears to penalize IRFs by reducing the discharge to community ratio by unplanned readmissions, as these are already being measured for quality purposes. Re: Section 4.6 – "No short-term acute stay within the 30 days preceding a SNF, IRF, or LTCH admission" – • Will IRFs be penalized for accepting direct-admission patients or those who have most recently been in an ECF?	Holly J. Mills, PT, UDSMR IRF PPS Certified Carle Foundation Hospital Inpatient Rehabilitation Unit Urbana, IL 61801	Holly.Mills@carle.com	Individual-IRF setting

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	Re: Section 4.8.1 – • What constitutes a desired sample size? • What is the maximum amount of time it would take to calculate the facility-level discharge to community measure? Re: Section 4.11.1 – • For what will the risk-standardized discharge to community rate be utilized? Re: Section 4.11.2 – • 8.a. – Will IRFs be penalized for repeated admissions of the same patient, despite the reason for the admission? Example – Patient X is admitted in April for a stroke, then again in July for a femur fracture? • As this lists "Risk Adjustment Variables Under Consideration", it doesn't appear that these have been finalized. Is there a plan to standardize these factors to best comply with the IMPACT Act's mandate to produce standardized quality measures across sites? Re: Section 4.14 – Why is this even necessary, as opposed to simply comparing facility level discharge to community rates to a national benchmark (adjusted for CMI/CMG as needed)? It seems redundant.			

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11/23/2015	To whom it may concern: The Alliance for Home Health Quality and Innovation (the "Alliance") appreciates 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). 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 this measure on discharge to community. First, the specifications appear to still be in development as 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 Alliance recommends that there be an additional opportunity for comment once the specifications are in a form that is closer to final.	Teresa L. Lee, JD, MPH Executive Director Alliance for Home Health Quality and Innovation	tlee@ahhqi.org	Home health provider association

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	Furthermore, the Alliance is concerned that providing only two weeks for public comments is not sufficient time to permit thoughtful and comprehensive comments. Compounding this issue is the fact that more than one set of measure specifications were released for public comments simultaneously. The Alliance recommends that CMS and its contractors welcome public comments for at least 30 days, and that such comment periods occur sequentially, rather than overlapping. Second, the Alliance supports the limitation of the measure to traditional Medicare fee-forservice 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 discharge to community measure is structured as a single measure, but the target populations are not standardized among the various settings. Specifically, the target population for the home health setting is all Medicare fee-for-service persons admitted to home health care. An acute care discharge in the 30 days preceding the start of the home health episode is not required; by contrast, for the SNF, IRF and LTCH settings, the target population is only those who were admitted within 30 days of discharge from an acute care hospital. As a result, for home health settings, the discharge to community measure is not solely a post-acute care measure. Further, as drafted in the specifications, the measure as applied to home health care would be a unique home health measure that is inconsistent with the intent of the IMPACT Act to standardize patient assessment data in post-acute care. If the intent of the IMPACT Act is to be able to compare			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	patient outcomes and characteristics across post-acute care settings, the unique target population for home health care will confound the ability to achieve the goals of the IMPACT Act. The Alliance recommends that the target population for home health match that of the other settings, so that only those admitted to home health within 30 days of discharge from an acute care hospital are included in the target population. Fourth, it is unclear from the measure specifications whether discharge to a long-stay nursing home (not within the Medicare skilled nursing facility benefit) would be considered a discharge to community. There are patients who need caregiving support in the community, but who do not have an able and willing caregiver to support their care at home. Some of these patients also do not have private long-term care insurance and do not qualify for Medicaid. In these cases, some patients are discharged to long-term nursing homes, for which Medicare does not pay. The Alliance requests clarification on how discharges to long-stay nursing homes will be treated for purposes of this measure. Fifth, home health agencies do not currently use discharge status code 81. The Alliance is concerned that use of this code presents operational issues and associated administrative burden. Sixth, the measure specifications are based on 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 planned (and unplanned). Without this cross-walk, it is difficult to understand and predict the scope of the measure.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Finally, the risk adjustment factors for the measure are under consideration and the Alliance supports the use of sociodemographic variables (age and sex) and dual eligibility status for use in adjustment. The clinical conditions, ventilator use, and characteristics of prior acute stays and utilization of acute care and post-acute care will also serve as appropriate risk adjustment factors. The Alliance recommends that income also be included in the context of risk adjustment for sociodemographic factors. 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. Thank you for the opportunity to comment. Should you have any questions or comments, please contact me at tlee@ahhqi.org or 202-239-3671.			
11/23/2015	Kindred is pleased to have the opportunity to comment on the proposed set of quality measures related to discharge to community 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 skilled nursing and rehabilitation centers, 18 inpatient rehabilitation hospitals, 101 hospital-based acute rehabilitation units, 626 Kindred at Home home health, hospice	Kathleen Smith Kindred Healthcare Manager, Public Policy Dr. Marc Rothman Chief Medical Officer	kathleen.smith4@kindred.com	PAC provider association

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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 make it possible for individuals to safely and efficiently return to the comfort of their home or community. 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 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 discharge to community measures for post-acute care laid out within the IMPACT Act.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Concern that Home Health Measure Is Not Solely a Post-Acute Care Measure. The discharge to community measure is structured as a single measure, but the target populations are not standardized among the various settings. Specifically, the target population for the home health setting is all Medicare fee-for-service persons admitted to home health care, regardless of whether they are truly 'post-acute' or not. An acute care discharge in the 30 days preceding the start of the home health episode is not required; by contrast, for the SNF, IRF and LTACH settings, the target population is only those who were admitted within 30 days of discharge from an acute care hospital. These are distinctly different populations. As a result, for home health settings, the discharge to community measure is not solely a post-acute care measure. Further, as drafted in the specifications, the measure as applied to home health care would be a unique home health measure that is inconsistent with the intent of the IMPACT Act to standardize patient assessment data in post-acute care. If the intent of the IMPACT Act is to be able to compare patient outcomes and characteristics across post-acute care settings, the unique target population for home health care will confound the ability to achieve the goals of the IMPACT Act. Kindred Healthcare recommends that the target population for home health match that of the other settings so that only those admitted to home health within 30 days of discharge from an acute care hospital are included in the target population. **Unclear How Long-Term Nursing Facilities Patient Will Be Treated**. It is unclear from the measure specifications whether discharge to a long-stay nursing home (not within the Medicare skilled nursing facility benefit) would be considered a discharge to			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	community. There are patients who need caregiving support in the community, but who do not have an able and willing caregiver to support their care at home. Some of these patients also do not have private long-term care insurance and do not qualify for Medicaid. In these cases, some patients are discharged to long-term nursing homes, which Medicare does not pay for. Kindred Healthcare requests clarification on how discharges to long-stay nursing homes will be treated for purposes of this measure. **Insufficient Risk Adjustment**. The risk adjustment factors for the measure are under consideration and Kindred Healthcare supports the use of sociodemographic variables (age and sex) and dual eligibility status for use in adjustment. The clinical conditions, ventilator use, and characteristics of prior acute stays and utilization of acute care and post-acute care also will serve as appropriate risk adjustment factors. Kindred Healthcare recommends that income also be included in the context of risk adjustment for sociodemographic factors. Thank you for the opportunity to provide these comments. If you have any questions about these recommendations or would like to set up a meeting, please contact me at (502) 596-7607 or marc.rothman@kindred.com.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	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 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). Before proceeding with details, we would like to provide you a brief summary highlighting our concerns and recommendations: **Concerns:** 1. The inclusion of unplanned readmissions in the discharge to community measure development and calculation. 2. Potential for site-specific risk adjustment for a "cross-setting" measure. **Recommendations:** 1. Remove unplanned readmissions from the measure. 2. Make risk adjustment factors "cross-setting", such that all post-acute care providers are subject to standardized and interoperable measurement of quality domains.	Troy Hillman Director of PAC Strategy & Analysis Uniform Data System for Medical Rehabilitation	thillman@udsmr.org	Functional assessment specialists

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	The following sections detail each of the concerns noted previously and provide context to each of the recommendations. **1. The inclusion of unplanned readmissions in the discharge to community measure development and calculation.** Our concerns related to the inclusion of unplanned readmissions in the discharge to community measure development and calculation can be defined as follows: a. <u>Duplication/commingling of quality metrics</u> With the inclusion of unplanned readmissions in the discharge to community measure development and calculation, there is the potential for there to be a strong correlation between the performances of the two measures. In other words, those PAC providers that perform poorly with the unplanned readmission measure are more likely to perform poorly on this measure, while those PAC providers that perform well with the unplanned readmission measure have a better opportunity to perform well on this measure. Take for instance the scenario of two facilities with similar patient populations (age, sex, etc.), where provider A discharges 75% to a community setting with a 5% readmission rate while provider B discharges 72% to a community setting with a 2% readmission rate. Which facility performs better at discharging patients to a community setting? Is the discharge to community measure truly representative of the ability of the post-acute care provider to provide services that get the patient back to a community setting, or is too much emphasis being placed upon the ability of the patient to stay in a community setting?			

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	b. Inclusion of a factor that is outside of post-acute care provider control While a post-acute care provider can provide services that impact the ability of a patient to be discharged back to a community setting, whether or not a patient returns to an acute care facility in the 30 days following that PAC discharge can be completely unrelated to the services furnished by the PAC provider. For instance, a patient is discharged home from a post-acute care provider but is re-admitted to acute care 10 days later for pneumonia (which is listed as a diagnosis category that cannot be considered planned). Should the post-acute care provider's discharge to community percentage be penalized if the readmission is completely unrelated to the services provided within post-acute care? With the concerns noted above, we would recommend that the measure developers remove the unplanned readmission component from the discharge to community measurement, and provide side-by-side comparison of these two separate and unique quality measures. **2. Potential for site-specific risk adjustment for a "cross-setting" measure.** While we note that the risk adjustment variables are "under consideration", we are very concerned that the variables noted in the draft specification designate certain variables as being applicable to unique or specific post-acute care providers. The			

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	IMPACT Act requires the specification of quality measures and resource use metrics that are standardized and interoperable across PAC settings. In creating a measure where consideration is being given to risk adjustment variables that differ by post-acute care setting, is CMS truly meeting the definition of "standardized and interoperable"? As an example, "Activities of Daily Living" (ADLs) are noted as one of the Clinical conditions variables, yet is noted for "the HHA setting only". If the measure developer can show that ADLs can be used to differentiate the performance within the HHA population, couldn't ADLs also be used to differentiate the performance of all post-acute care settings and produce a measurement value that is "standardized and interoperable"? **We urge CMS and the measure developers to introduce risk-adjustment variables that are "standardized and interoperable" in order to meet the IMPACT Act requirements.** We appreciate the opportunity to comment and CMS's careful consideration of the concerns and issues raised in this letter. We welcome the opportunity to work with CMS to provide ongoing research regarding the selection and implementation of standardized and interoperable quality indicators. If you have any questions about these comments or require additional information, please contact us at 716-817-7800.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	Dear RTI: 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 a Discharge to Community ("DTC") measure for the different post-acute care ("PAC") settings. We believe that the PAC industry should embrace measures, such as DTC, that place an emphasis on the ability for patients to return and stay at home – a central tenant of post-acute care. 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 DTC measure development for IRFs. **I. THE DISCHARGE TO COMMUNITY MEASURE SHOULD BE DISTINGUISHED FROM THE 31-DAY POST-DISCHARGE READMISSIONS MEASURES** The measure specification document states that this DTC measure tracks "patients/residents/persons who are discharged to the community, and do not have an unplanned (re)admission to an acute care hospital or LTCH on the day of discharge or in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community." Based on this description, this DTC measure, although not called a "readmissions" measure, functions as a readmission measure, similar to those post-acute readmissions measures already in place	Andrew C. Baird HEALTHSOUTH Director, Government Relations Mary Ellen Debardeleben Associate Director, Quality HealthSouth	Andrew.Baird@healthsouth.com Mary.Debardeleben@healthsouth.com	IRF and home health provider association

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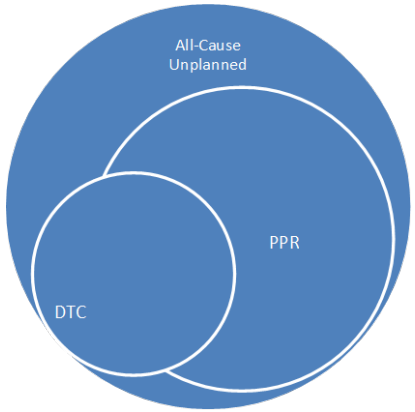
Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	and being developed under the IMPACT Act (All-cause Unplanned Readmissions (NQF #2502), and the Potentially Preventable Readmissions ("PPR") measures under development), but instead focused on a subset of a provider's patient population – Medicare patients that are discharged to community. If those existing (and soon-to-be implemented) readmission measures already track the number of people who are readmitted to a hospital within 30 days after being discharged from the PAC setting either under an all-cause basis or a potentially preventable basis, and this DTC measure tracks those patients that are discharged to community and do not have a "(re)admission to an acute care hospital or LTCH" within the 31 day timespan, then all of the patients who have an "unfavorable outcome" under the DTC measure will also and already be captured in at least one, if not both, of these existing readmissions measures. See Figure 1: **FIGURE 1**: DTC Rate Overlap with All-Cause Unplanned Readmission Rate and PPR Readmission Rate  			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	Instead of using the DTC measure to track and eventually publicly report on such readmissions, which are already tracked by the other readmission measures soon to be in place, it would be more meaningful to track the number of patients who go directly to the community (numerator) vs. the number of patients expected to go directly to the community (denominator), regardless of subsequent readmissions. The proposed DTC measure design is already built around comparing the actual number of successful discharges to community vs. expected successful discharges, but our comment here is directed at the definition of what it means to be "discharged to community." In other words, if "discharged to community" means "31 days at home without a readmission," then this measure effectively becomes a readmission measure that selectively focuses on those patients who are discharged home – a population that is already covered both by the All-cause Unplanned Readmissions measure (NQF #2502) and the proposed 30-day Post-discharge Potentially Preventable Readmission measure (under development at RTI). If, on the other hand, "discharged to community" means "patients who are discharged home without an intervening facility stay" (regardless of a subsequent readmission), that definition does not unnecessarily overlap with other readmission measures, thus giving providers			

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	II. MEASURE SHOULD REMAIN LIMITED TO MEDICARE FEE-FOR-SERVICE POPULATION According to the measure description (specifically Measure Exclusion 7), this measure is only applicable to Medicare fee-for-service ("FFS") populations, and not other payer populations, including Medicare Advantage ("MA"). We support this exclusive focus on FFS because other payers, including private insurance companies that contract with the Medicare program to manage MA plans, often dictate what services IRFs and other PAC providers can offer to their discharged patients, thereby limiting the ability of such providers to maximize their efforts to keep people healthy at home following discharge. This has the potential to negatively impact the ability to optimize performance on this DTC measure (and other readmission measures). We note that, while CMS and RTI have made the laudable decision to focus only on Medicare FFS for this DTC measure, we think this approach should extend to other measures developed under the IMPACT Act as well. If some IMPACT Act measures focus solely on Medicare FFS while others cover all patients and all payers, a significant disconnect in the underlying data will arise. Despite the logic behind this approach, CMS' response to the Drug Regimen Review measure public comments, released last week, indicated support for the opposite view. In response to comments on that Drug Regimen Review measure recommending that all PAC settings assess the same populations with the IMPACT measures and that the denominators be limited to Medicare fee-for-service enrollees only (since this is the			

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	population that is subject to changes in payment policy under the IMPACT Act), CMS replied saying that it felt that quality improvements are an appropriate goal for all patients, "regardless of payer source."[15] While no one would disagree with this broad statement of quality improvement across payer populations, this view does not account for the specific fact that, if a CMS quality measure that is ultimately tied to Medicare reimbursement measures non-Medicare populations for which PAC providers are limited (by non-Medicare payers) in post-discharge service offerings, such a scenario potentially thwarts a providers ability to control and improve performance on that measure, and could have significant payment or regulatory implications. **III. RISK ADJUSTMENT FOR SOCIODEMOGRAPHIC AND FUNCTIONAL STATUS** The draft specifications indicate that the DTC measure will be risk-adjusted for multiple variables, including age, sex, dialysis status, and prior acute care utilization in the past year. We generally support this broad range of risk adjustment, but also believe that CMS and RTI should consider including risk adjustment for additional sociodemographic factors and functional status as well, such as geographic area (urban/rural) or percentage of low income patients.			

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[15] *See* CMS, Public Comment Summary Report Including Verbatim Comments for IMPACT Act of 2014 Cross-Setting Quality Measure: Drug Regimen Review at 6 (posted Nov. 18, 2015) , *available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Drug-Regimen-Review-Comment-Summary.pdf.

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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.[16] Since this DTC measure, as currently proposed and as argued above, is (in its current form) effectively a readmissions measure focused on the population of patients discharged directly to community, we feel that this evidence is also applicable to this measure, not just the formal readmission measures. 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. 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. We also believe adjusting for functional status would benefit the accuracy of the DTC measure. 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 readmission rate, and a lower DTC rate. Accordingly, we			

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[16] *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.

Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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 scheduled to have the PPR measure publicly reported beginning next year, not to mention "within stay" readmissions measures. 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 and various QRP provisions, the eventual public reporting of all of these 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 readmissions measures and the DTC measure are all publicly reported without thorough explanations, PAC providers will have one all-cause unplanned readmission rate, a separate PPR rate, a separate PPR "within stay" rate, and a DTC percentage that is measured in the opposite direction (looking at how many patients stayed home instead of how many patients were readmitted). As a side comment, we note that it may be more administratively simple if CMS instead measured DTC as a readmissions measure for patients discharged to home. That would harmonize this version of a readmissions rate with the other measures. Nevertheless, we question whether the crucial distinctions between these different, but related,			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	readmissions indicators 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 indicators. IRF providers already receive annual PEPPER reports and also report on the All-cause measure (NQF #2502). With the addition of a "within stay" readmissions measure, a post-discharge PPR measure, and this DTC measure, we think it would be highly valuable if CMS were to take deliberate steps to clearly communicate the intended use of and distinctions between each of these readmission tools, making sure to note 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. Lastly, in order to standardize readmission measures and avoid unnecessary confusion, we ask that CMS and RTI standardize the language and definitions used in conjunction with establishing observation windows for all readmissions measures. For example, the IRF All-Cause Unplanned Readmissions measure (NQF #2502) is measured beginning two days after the day of discharge for 30 days; this DTC measure begins one day after the day of discharge for 31 days. These two measures both end on the same day, but it could help to avoid confusion if these discharge and observation window definitions and timeframes were standardized.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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), 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 has given stakeholders only 8 business days to develop input for this DTC measure – the initial CMS comment request email was sent on Nov. 12 and comments are due Nov. 23. This measure and other IMPACT Act 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.**			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	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.			
11/23/2015	On behalf of Johns Hopkins Medicine, Johns Hopkins Home Health Services and Potomac Home Health Inc. are pleased to offer comments on the Draft Specifications for the Discharge to Community Quality Measure for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LCTHs) and Home Health Agencies (HHAs). Johns Hopkins Home Health Services and Potomac Home Health Inc. provide a wide range of comprehensive home health services to a diverse group of Medicare Beneficiaries in the Baltimore Washington Area (see below table).	David Parker, RN, MHS Director, Federal Affairs Johns Hopkins Office of Government and Community Affairs	dparker@jhu.edu	Home health provider

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<tr><td></td><td>
<table>
<tr><th></th><th>Johns Hopkins Home Health Services (FY 15)</th><th>Potomac Home Health (FY 14)</th></tr>
<tr><td>Geographic Area Served</td><td>Baltimore Metro</td><td>Washington DC Metro</td></tr>
<tr><td>Total Admissions</td><td>5493 (74% Medicare)</td><td>3945 (75% Medicare)</td></tr>
<tr><td>Total Visits</td><td>83,908</td><td>47,069</td></tr>
<tr><td>Avg. Visits per Admission</td><td>15.28</td><td>11.93</td></tr>
<tr><td>Referral Sources</td><td>Hospital – 81.3%
Physician – 5.5%
SNF – 13.3%
Other – 0.1%</td><td>Hospital – 60%
Physician – 15%
SNF – 15%
Other - 10%</td></tr>
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Johns Hopkins Home Health Services & Potomac Home Health

Comments to Discharge to Community Quality Measure

<u>Overview</u>

The comments below reflect our uniqueness as a home health provider who is affiliated with an Academic Medical Center. We provide services to a sicker population with the majority of our admissions being post-acute and we accept virtually all referrals to</td><td></td><td></td><td></td></tr>
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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	our home health agencies without regard to a patient's admitting condition or their co-morbidities. Due to these facts, we have some specific comments below but also have a concern that if some of the below issues are not resolved, there may be home health agencies who will begin to refuse admitting patients who should, but refuse to accept a higher level of care. <u>Comments</u> • Patients who refuse the appropriate discharge plan should be excluded from this measure. For example, if a patient needs 24X7 care and the discharge team recommends SNF placement but the patient chooses a less them optimal alternative such as home health, readmission would not be surprising as 24 hour care is required. • For home health agencies, this measure is not requiring a prior hospital stay within 30 days. It is indicated that 50% of all home health agency admissions are not proceeded by a hospitalization. However, the majority of our patients are post-acute and these patients are most likely more compromised/sicker than those coming from the community. For this reason, comparing us against the national average would potentially yield negative results directly related to our admission source being almost entirely post-acute. • Death in the 30 day post-discharge window will be considered an unfavorable outcome. This is a concern because many chronically end stage patients are eligible for hospice but refuse it and instead accept home health services. The home health agency will incur an unfavorable event even though the patient's death was expected. In this instance, the death should not be considered an unfavorable outcome or unexpected.			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	• Risk adjustments to this measure should include: – Availability of willing and able caregiver, – Caregiver status (none, new, ill), – H/O substance abuse, – PCP visits, – History of falls, – Patient engagement and literacy, and – Oxygen use. • Home Health Agency admissions do not require an acute care discharge, so there should be a differentiation between those who are community patients versus those discharged from a post-acute setting. • If a patient signs out of a hospital "Against Medical Advice" (AMA), there should be a provision to risk adjust/categorize this patient since they are more likely to be readmitted within the 30 days window. • <u>We seek clarification on the following points:</u> – If a patient is readmitted within 30 days of SNF Discharge (which was immediately proceeded by acute care discharge), would both the SNF and HHA have an unfavorable outcome? – Will any data be collected on Medicare Advantage Beneficiaries who are receiving home health services?			

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
11/23/2015	To whom it may concern, RE: 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) I am writing on behalf of the University of Pittsburgh Medical Center (UPMC) Community Providers Services (CPS) to submit feedback on the draft measure specifications for discharge to community (DTC) 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	Nicole Fedeli-Turiano UPMC Community Provider Services Public Policy and Government Relations, Dir.	fedeliturianon@upmc.edu	Home health provider

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Date Posted	Verbatim Comments	Name, Credentials, and Organization of Commenter	Email Address	Type of Organization
	affiliate, Home Nursing Agency is a Visiting Nurse Association providing a full range of nursing, social services, and rehabilitation therapies. • We believe HHAs act as 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**. Therefore, home health may be a step-down after other providers but those providers serve as a step-up when needed. Is CMS promoting measure specs that say that NO step ups are allowable? Under the DTC measurement model, the only acceptable discharge from home health is to the community. 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. • 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			

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	as the non-excluded population, we urge CMS to use the same populations for reporting across all PAC providers because as written, it is partial. • **Would community referrals under DTC have be charged a home health co-pay if implemented by CMS in the future?** Some policymakers have suggested adding copayments for Medicare home health as a means of both reducing the deficit and preventing overutilization. The Administration and MedPAC have recommended co-pays ($100-$300) on home health episodes **not** preceded by a hospital or nursing home stay. Our position is that a copayment would deter chronically ill Medicare beneficiaries from accessing home health care and instead create an incentive for more expensive institutional care. Numerous studies have concluded that a copayment would discourage the use of necessary and beneficial care, resulting in the deterioration of a patient's condition and ultimately leading to higher costs for the Medicare program through acute care interventions in higher cost settings. **Clarification and concerns are as follows:** • 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.			

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	• In general, we are concerned about the adoption of measures holding home health accountable for events after discharge while at the same time adopting administrative / payment 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 audit contractors 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 contractors on these allowable services such that home health agencies may 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). Thank you extending the comment period to 30 days as we have expressed concern similar to our national associations that the highly complex and detailed IMPACT Act draft measures are			

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	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 release measures sequentially instead of concurrently, and offer some technical assistance as part of SODFs that would enable more informed input from the provider community**. **Comments conveyed to RTI (PPR@RTI.org) 11/16/15 and incorporated into DTC comments** November 16, 2015 To whom it may concern, RE: 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) 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			

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	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. **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**			

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	Independence at Home demonstration and Bundled Payment for Care Improvement models. **Other recommendations include:** • 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 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 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			

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	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, 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			

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	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: **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*			

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	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**			

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	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 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.**			

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	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 . **Recommended Revision to Exclusion List** 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. **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			

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	the average agency will be selected. One assumption is that the average will be calculated based on the previous three years of claims data. **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?			
11/23/2015	Dear Sir or Madam, 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 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)*. We offer comments on the following provisions:	John Travis Vice President and Compliance Strategist Cerner Corporation Cheri Whalen, CHTS-IM, CHC Regulatory Strategy	Cheri.Whalen@Cerner.com	Electronic health record supplier

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	Section 4.3.1 – Discharge to Community This section of the proposal references Patient Discharge Status Codes Used to Determine Discharge to Community. We question the inclusion of the following codes: 81 = Discharged to home or self-care with a planned acute care hospital readmission 86= discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission. We do not believe these discharge status codes are currently used in claim submissions and would request RTI and CMS re-evaluate the use of these codes for the look-back and data collection periods. We understand the CMS billing guides indicate any NUBC approved code is valid in the Patient Status Code of the claim https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf; however the codes 81-95 were requested by the provider community and CMS indicated in the IPPS 2014 Final Rule these new discharge status codes were not related to the Hospital Readmission Reduction Program and not be taken into account for that program. http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf https://newsletters.ahima.org/newsletters/Code_Write/2014/February/CodeWrite_DischargeCodes.html			

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	Upon further inspection of the use of discharge status codes on claims, we found CMS provided additional "Clarification of Patient Discharge Status Codes and Hospital Transfer Policies" in an MLN Matters Article SE1411 revised November 17, 2015 (notably, one week after this Request for Public Comment opened). This new version of the article now includes the expanded code set https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1411.pdf. The previous version which was in place up to November 17, 2015, SE0801 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf did NOT include this expanded code set and listed 71-99 as Reserved for National Assignment. We feel we can reasonably conclude 81 and 86 Patient Status Codes were not commonly used in historical claim submissions. We request CMS and RTI provide additional communication and education to the provider community on the usage of correct Patient Status Codes on claim submissions before using these codes as a part of a quality measurement approach. Sections 4.3.3 and 4.8.3 – Death in 31-Day Post-Discharge Observation Window / Post-Discharge Observation Window for Unplanned Admissions/Readmissions and Death			

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	The proposal references in 4.3.3 and 4.8.3 "that death within the 31-day post discharge window of a post-acute stay is considered an unfavorable outcome for the measure". This section of the proposed rule indicates an exclusion from this unfavorable outcome for the measure when the patient is discharged to an inpatient or outpatient hospice. We believe there are other scenario's in which a patient my expire within the 31-day post-discharge window and not be related to the post-acute stay. We request CMS also consider the following exclusions for expired patients who: • are "comfort care only" and refused Hospice • commit suicide • Expire from a non-related hospital diagnosis (sudden AMI) • Expire from an accident • Expire by a stroke which was a not related to a post-acute diagnosis • Section 4.3.2 Unplanned Admission/Readmissions in the 31-day Post-Discharge Observation Window This section indicates the unplanned readmissions will be identified based on the planned readmissions algorithm used in post-acute care readmissions measures including: NQF #2380: Re-hospitalization during the First 30 Days of Home Health.			

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	Is there consideration for patient populations who were discharged from acute care but unable to stabilize in the home environment? We would request CMS consider a specific grouping of ICD-10 codes which could be excluded from this patient population such as, but not limited to: • Patients who receive comfort care only and are not admitted to Hospice, • Pain management patients who cannot be stabilized at home, • Patients with IV complications which may require a central line, • Patients who fall at home We also acknowledge this measure is being developed with ICD-9 procedure and diagnosis codes which will be revised using an ICD-9 to ICD-10 crosswalk and encourage CMS to prioritize this task as quickly as possible. 4.11.2 Risk Adjustment Variables under Consideration We request further clarification on data collection for Home Health patients who do not have a 30-day prior acute stay. The proposed rule accurately indicates there would be a large subset of home health population lost if a 30-day previous acute stay is required to apply this quality measure; however, in using a one-year look back period of claims review, how would the impact related to Activities of Daily Living (ADL's) be evaluated as a risk adjustment, as noted in 4.11.2 risk adjustment variable #6.f.?			

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	Cerner Corporation hopes these comments will be of value to CMS and RTI in considering possible update in the development of the Discharge to Community Quality measure. We are happy to help clarify any of the comments should CMS or RTI wish to pursue any such conversations with us during the period of public comment review.			
11/23/2015	I am submitting the following on behalf of Golden Living, a provider of long term care services in multiple states. These comments are addressed to discharge to community measures for SNFs. We would suggest that residents receiving palliative care or those determined to have a terminal diagnosis be excluded. Thank you for your attention to the concerns of Golden Living.	Candace Bartlett National Senior Director Regulatory Affairs Golden Living	Robin.Bartlett@goldenliving.com	Long-term care provider
11/23/2015	Dear Mr. Slavitt: The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Many occupational therapy practitioners serve Medicare beneficiaries in post-acute care (PAC) settings, including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs). Occupational therapy practitioners are actively engaged	Jennifer Bogenrief Manager, Regulatory Affairs American Occupational Therapy Association	jbogenrief@aota.org	Ocupational therapist association

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	in the Department of Health and Human Services' Triple Aim objectives of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the growth of rates of health care costs. Occupational therapy is a critical component of achieving improved status to maximize health and function and to prepare for discharge from PAC and should be recognized as a contributing quality factor. The Centers for Medicare and Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop a cross-setting discharge to community quality measure in order to meet the mandate of the Improving Post-Acute Care Transformation Act of 2014 (IMPACT Act). We appreciate the opportunity to comment on the draft specifications for SNFs, IRFs, LTCHs, and HHAs, posted at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html. The IMPACT Act requires the development and submission of standardized data from PAC settings with the intent for cross-setting quality comparison to promote patientcenteredness. The IMPACT Act also requires the development and reporting of measures pertaining to resource use, hospitalization, and discharge to the community. CMS has stated that the intent of the measures and standardized data required by the IMPACT Act is to use an individual's assessment data, goals and preferences in real time, as well as longitudinally, to facilitate coordinated care and improved outcomes. A discharge to community measure would allow quality comparisons across PAC settings and facilities to help identify facilities that may, and facilities that may not, adequately prepare patients for discharge.			

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	We appreciate CMS's need to move forward with development of quality measures and policy required by the IMPACT Act as quickly as possible. However, we request that CMS allow longer comment periods so that stakeholders have adequate opportunity to review these complex measures and policies and offer relevant, comprehensive, and detailed feedback. I. Section 4.6 Measure Exclusions The draft specifications for the discharge to community quality measure do not include an exclusion for long stay nursing home residents. We are concerned that long stay nursing home residents are included in the measure. These are residents that have had a medical event, gone to the hospital, then to PAC, and back to the nursing home. They would not be expected to be discharged to the community. These types of residents have a very different discharge process back to the nursing home as a long stay resident compared to patients returning to a traditional community setting. Patients returning to a community setting require more planning and coordination for discharge, which we believe is what this measure intends to capture. Residents returning to the nursing home for long-term stay should be excluded from this measure and CMS should instead look at other measures for these patients, such as whether they return to prior function, improve function, or stabilize, develop pressure ulcers, are a falls risk, etc., in order to determine whether the resident is receiving the appropriate standard of care they need in a long-term nursing home stay. CMS is already considering transitions of care and quality requirements for these facilities through proposed rulemaking for reform of requirements for long-term care facilities (published at 80 Federal Register 42168 on July 16, 2015).			

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	AOTA recommends that long stay nursing home residents be excluded from this measure. II. Section 4.11.2 Risk Adjustment Variables under Considerations; Clinical conditions The draft measure uses the IRF case-mix group for IRF and ADLs for HHA, but there is no similar measure for SNF or LTCH. If this data is coming from the PAC assessment tools (MDS, IRF-PAI, LTCH CARE, OASIS) consistent with the IMPACT Act, then we believe that it should be collected in SNF from the MDS on the long stay residents in order to exclude them. In addition, function and case-mix data should also be collected from the MDS. III. Future Revisions of the Measure: Functional Cognition We believe that the measure should include function across settings, as well as cognition. AOTA was pleased that Congress recognized the importance of collecting data on cognitive status in the IMPACT Act because cognitive impairments have a significant relationship to Medicare resource use, length of stay, and patients' long term outcomes. Occupational therapy has a critical role in assessing functional cognition and ensuring that Medicare beneficiaries in post-acute care settings receive quality care in the most appropriate setting, using only the necessary Medicare resources. We believe that functional cognition is an area that must be looked at more closely and that, as the Medicare population continues to live to older ages, providers in all post-acute care settings will need more training in assessing cognitive and functional status for patients with cognitive impairments. Occupational therapists are experts in the measurement of and interventions for functional cognition issues, which encompasses			

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	assessment of everyday task performance (e.g., self-care, personal hygiene behaviors and dressing, household management, cooking, medication management and adherence to drug regimens, and patient safety). Occupational therapists specialize in the identification of performance-related or functional cognitive impairments, which range from subtle to obvious and which affect overall treatment, successful discharge placement, long-term outcomes, and, of course, resource utilization. Occupational therapy practitioners treat cognitive impairments because they have the potential to compromise the safety and long-term well-being of patients, especially more frail elderly patients. Early identification of performance-related or functional cognitive impairments allows for the timely implementation of an occupational therapy care plan. The plan can include implementing the supports necessary to prevent harmful events which commonly happen during routine everyday activities for patients with cognitive impairments, for example, falls due to problematic sequencing during bathing or dressing activities. The occupational therapy care plan can also promote optimal recovery, stabilization, and success in post-acute care and discharge settings. This is an important aspect for the IMPACT Act to consider because traditional neuropsychological evaluative measures were developed to localize individual cognitive abilities such as selective attention, verbal memory, inhibition, and processing. In contrast, performance-based tasks report how a person interacts with the environment to accomplish an activity, and whether these tasks can be accomplished quickly and efficiently. AOTA has engaged CMS officials in face-to-face meetings to discuss the collection of data on functional cognition, and will continue to provide research studies and related materials to CMS to advocate			

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	that assessment of functional cognition be incorporated into the IMPACT Act requirements. The purpose of occupational therapy is to enable compensatory activities and to improve function where possible. For Medicare beneficiaries, early detection of performance based cognitive impairments by occupational therapists also facilitates the selection of the most appropriate levels of care, the appropriate resources to support and train caregivers and reduce caregiver burden, and client-centered discharge options, and contributes to reduced hospital readmissions and increased safety at discharge. Cognition refers to information-processing functions carried out by the brain that include attention, memory, executive functions (i.e., planning, problem solving, self-monitoring, self-awareness), comprehension and formation of speech, calculation ability, visual perception, and praxis skills.[17] Cognitive functions, such as memory, attention, goal directed behaviors, abstract thinking, and decision making, are critical to occupational performance. An individual who has cognitive impairment may be slow to respond, may lack initiative or perseverate, or may be likely to slide down the continuum from independence to dependence, especially for complex occupations. The AOTA Cognition, Cognitive Rehabilitation, and Occupational Performance Statement describes occupational therapy's role in addressing cognition as follows:			

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[17] American Occupational Therapy Association. (2013). Cognition, Cognitive Rehabilitation, and Occupational Performance. *American Journal of Occupational Therapy*, *67*(6 Suppl.), S9-S31. http://dx.doi.org/10.5014/ajot.2013.67S9.

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	Occupational therapy practitioners facilitate individuals' cognitive functioning to enhance occupational performance, self-efficacy, participation, and perceived quality of life through the use of occupations and activities. Cognition is integral to effective performance across the broad range of daily occupations such as work, educational pursuits, home management, and play and leisure… Occupational therapy practitioners administer assessments and interventions that focus on cognition as it relates to participation and occupational performance. Furthermore, occupational therapy practitioners believe that cognitive functioning can only be understood and facilitated fully within the context of occupational performance. This understanding of the relationship among the client, his or her roles, daily occupations, and context make occupational therapy a profession that is uniquely qualified to address cognitive deficits that negatively affect the daily life experience of the individual.[18] Moreover, cognitive impairments have a significant relationship to Medicare resource use, length of stay, and patients' long-term outcomes. Therefore, we believe cognition is a critical area that must be identified and addressed in PAC settings. * * * * * Thank you for the opportunity to comment on the draft discharge to community measure. AOTA looks forward to a continuing			

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[18] *Id*.

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	dialogue with CMS on coverage and payment policies that affect the ability of occupational therapists to provide quality occupational therapy to Medicare beneficiaries. If you have any questions, please contact me at jbogenrief@aota.org or (301) 652-6611 ext. 2017.			
11/24/2015	To Whom It May Concern: Thank you for allowing providers to review the proposed measures for Discharge to the Community for SNF, LTCH and HHAs. The comments I offer are taken from the perspective of a non-profit home health agency and largely address the measures as they apply to home health agencies and the beneficiaries to whom they provide care. We concur that it is prudent to measure unplanned readmission to an acute care facility using standardized metrics in order to align providers in the continuum of care. We note, however, that home care has several highly unique features that confound measurement, and our comments are based on those unique qualities. First, we pose a question about the data included in the numerator: will *all cause* unplanned readmission be considered eligible for inclusion in the numerator even if the cause is ***unrelated*** to the diagnoses/plan of care for which the agency is seeing the patient? For example, if a home health agency is providing service to a patient for aftercare of joint replacement and the patient develops a pulmonary embolus, it is imperative that the patient be readmitted to the hospital. While the pulmonary embolus is clearly an undesired outcome, it is a known risk of joint replacement – even in the face of anticoagulant therapy. Indeed, readmission is life-saving and there is little the agency	Margaret Franckhauser MS MPH RN Chief Executive Officer	mf@centralvna.org	HHA

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	could do to avoid the condition. If the rule moves forward as proposed, the agency would be held responsible for the readmission, yet the agency has little power to alter the outcome. In another example, would the readmission be counted in the numerator if a patient receiving skilled care for an indwelling urinary catheter developed a myocardial infarction within 31 days? The two diagnoses are unrelated, yet failure to admit the patient would result in avoidable morbidity or mortality. One element that makes home health care unique is that the care is delivered in the patient's own home. If a patient elects not to continue receiving care – for whatever reason – after he/she has been admitted to homecare, this is the home health equivalent of "discharged against medical advice", yet no such category exists in homecare. The patient may continue to qualify for care. Indeed, the patient may benefit from care, but he/she is still free to decline continued services. If a patient declines care and is readmitted to acute care, a negative quality score would be assigned to the agency, but the agency had no control over the patient's decision. While your rules have made provisions for discharged against medical advice in facilities, you have made no allowance for analogous situations in home care. Further, you have made no allowance for patients who relocate out of the homecare agencies service area during the POC period. How would you propose to address these situations? We believe there should be an allowance for discharged due to the patient's choice that removes these patients from the numerator and denominator. The homecare rules are also unique in that the patient no longer qualifies for home healthcare once he or she is no longer			

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	homebound. We have noted many instances in which the goals of care were not met, yet we are unable to continue to provide homebased care because the patient was no longer confined to the home. In those instances, we believe it is wrong to hold the agency responsible for the outcomes of care when the agency was unable to continue care because the patient no longer qualified for service under Medicare. We believe that patients who are discharged because they are no longer homebound should be removed from both the numerator and the denominator. We thank you for considering these questions and are happy to provide more information upon request.			
11/24/2015	Thank you for the opportunity to comment. The approach is very thorough and sound. Our only comment is below: 1. The explanation is the text says that the IMAPCT measure is readmission following discharge from a SNF and the PAMA measure is following a hospital discharge to a SNF setting, but as written this is not clear and the two measures appear to be measuring the same thing. IMPACT 1) Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facilities (IMPACT) PAMA 5) Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) (PAMA)	Eliza Navarro Bangit Director, Office of Integrated Care Innovations Administration for Community Living U.S. Department of Health and Human Services	Eliza.Bangit@acl.hhs.gov	Government agency

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12/1/2015	Aging population and limited resources, force patients to be readmitted to hospital even after best plans have been made by discharge teams. Current policy of mandatory 3 midnights as inpatients perpetuate this problem in large urban cities across the country. Many times aging patients do not meet criteria for inpatient, but however cannot take care of themselves and are sent home with family member who either can't or won't meet their care needs and are returned to the hospital within days with the same condition they were discharged with. There need to be exceptions that will allow or take into consideration age and social conditions that will allow patients to be discharged from acute care facilities in observation status to long term care facilities. Case in point had a 97 year old female with only two living relatives. Patient presented with broken ® wrist from fall a week ago. Patient treated as observation, wrist placed in cast, discharged home with 75 year old daughter. Patient attempted to get up during night to go to bathroom, fell tore (L) rotator cuff. Patient now unable to perform ADL's or toilet herself. Under UR review patient doesn't meet IP criteria is therefore placed in observation status. Second daughter is 64, widow, who has to work to maintain health insurance until she is old enough for Medicare. I share all of this because of my compassion for this patient, and to make you aware that our current system is broken. Hospitals are designed to care for the ill and will continue to do so. As a case manager our jobs are to provide the best and safest discharge plan as possible. I really hope that consideration is given to these situations.	Gwendolyn Webb, RN, MS, CCM Case Management Dept. Director Methodist Germantown Hospital 7691 Poplar Ave. Germantown, TN 38138 901	Gwendolyn.Ellis-Webb@mlh.org	Individual-case manager

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12/1/2015	Currently Medicare patients must have a three night inpatient hospital stay prior to discharging to a SNF (skilled nursing facility) for the rehab stay to be covered. Please consider eliminating this rule to assist in the Medicare goal of reducing hospital readmissions.	Kathryn Lund-Reed, MSW, LISW/Licensed Independent Social Worker	Lund-ReedK@centracare.com	Individual-social worker
12/2/2015	1. Patients are discharged to the community without complete information on what they are actually able to have provided to them at home through family or outside services, whether the lack of information comes from inaccurate info from the patient and family or not enough research into what their capabilities are from the discharging facility, there needs to be a way to monitor what is expected and acceptable for care at home. 2. Patients are discharged too soon to community services and the expectations the patient and family have from those services is care and cost prohibitive. 3. Transportation is the biggest issues for community services, patients that are able to have transportation services may have to wait hours at their appointment site due to the transportation company trying to cover as many appointments as possible before coming back and picking patients up to take home, this is detrimental as most of the time the patients have no way to access food or water during these visits either due to lack of money or to prideful to ask for a drink. We are talking about pts with diabetes, CKD, wounds, etc. that can not tolerate this type of inconsistency in their care.	Glenda Huff, RN Clinical Administrative Director SWRHH	glenda.huff@swrmed.org	Individual-Registered nurse

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	4. There truly are patients that cannot keep their medications straight due to the fact that the generics may change every couple of months in color, shape or size and when they cannot read the label well enough they depend on there ability to distinguish their meds by color, shape and size, this leads to complications and hospitalizations that may never be figured out because there is no one to monitor this as a problem for the patient. Plus there are other patients that just don't know how to take their meds correctly without help. 5. There are patients with family that do not and will not help even though they say they will and there needs to be a way make sure patients do have the help they need when they need it.			
12/6/2015	Individual comments. I am a HHA Case Mgr for an inner city agency with 98% low income, high risk patients. I can only speak from a Home Health perspective which is different than more controlled environments. 1. A patient does what they want to in their own home. They are not under the direct supervision by a home health agency, like they are in a hospital or SNF. If they want to smoke 50 cigarettes in one day, they can light right up in their chair without having to leave the comfort of their room. If they want to stay up all night and eat an entire dozen donuts, they can and sometimes do. Many drink 2 litre bottles of pop as if they can't live without it. How do you hold patients responsible for some of their own re admit rates for their own lifestyles? They need to take their meds when they are supposed to, or question why	Mary Jo Newport RN Case Manager	rncasemgrmj@gmail.com	Individual-HHA case manager

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	they are taking 50 meds, instead of accepting all meds from every doctor they ever go to. The HHA doesn't have an MD that prescribe the meds and they cannot force a patient or their assorted healthcare providers to change their medications. We can encourage and request, but in the end, we can't force it. So, why would an HHA be held accountable for outcomes of a patient who we believe should quit smoking or we believe a doctor has prescribed an anti-diabetic medication with severe side effects possible, because the patient doesn't want insulin? And Patients don't get 24/7 care within the home, most times it is only 1-2 hr a day. So we are graded for the other 22-23 hours a day x31 days for which we have no influence or authority whatsoever. Home Health Care is a completely different animal than in-patient facilities. Grouping HHA's into the same Oasis requirements as a nursing home is often non-sensible. It would be so nice if CMS Oasis would stop trying to put the square peg into the oval shaped hole! 2. In 4.82, an HHA patient will be counted no matter when, or if, they were discharged from an acute care facility. Won't this fact ALONE skew the results for HHA's, let alone what I mention in 1 above. 3. Is there going to be a code for non-compliance to interventions recommended for better outcomes? What if there are no known interventions that can help a chronically ill patient or the standard ones don't work for that patient?			

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12/7/2015	Dear Mr. Slavitt: The Centers for Medicare and Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop a cross-setting discharge to community quality measure in order to meet the mandate of the Improving Post-Acute Care Transformation Act of 2014 (IMPACT Act). As an occupational therapist with more than ten years of clinical experience in post-acute care (PAC), health services researcher, and member of the community discharge TEP, I appreciate the opportunity to comment on the draft specifications for SNFs, IRFs, LTCHs, and HHAs, posted at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html. The IMPACT Act requires the development and submission of standardized data from PAC settings with the intent for cross-setting quality comparison to promote patient-centeredness. CMS has stated that the intent of the measures and standardized data required by the IMPACT Act is to use an individual's assessment data, goals and preferences in real time, as well as longitudinally, to facilitate coordinated care and improved outcomes. A discharge to community measure would allow quality comparisons across PAC settings and facilities to help identify facilities that may, and facilities that may not, adequately prepare patients for discharge. Furthermore, since community discharge is a key goal of rehabilitation consumers, this measure can equip patients and consumers with key data to make healthcare decisions about where to receive postacute care.	Natalie E. Leland, PhD, OTR/L, BCG, FAOTA USC Mrs. T.H. Chan Division of Occupational Science and Occupational Therapy	nleland@chan.usc.edu	Individual-health services researcher

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	I. Defining the denominator The draft specifications for the discharge to community quality measure do not include an exclusion for long-term nursing home residents. I am concerned that long stay nursing home residents are included in the measure. These are long-term/custodial nursing home residents who have had a medical event, gone to the hospital, are then discharged to PAC, and then return to the nursing home for continued custodial or maintenance care. They would not be expected to be discharged to a community-based living environment. These types of residents have a very different discharge process back to the nursing home as a long stay resident compared to patients returning to a traditional community setting. Patients returning to a community setting require more planning and coordination for discharge, which I believe is what this measure intends to capture. Residents returning to the nursing home for long-term stay should be excluded from this measure and CMS should instead look at other measures for these patients, such as whether they return to prior function, improve function or stabilize, develop pressure ulcers, are a falls risk, etc., in order to determine whether the resident is receiving the appropriate standard of care they need in a long-term nursing home stay. This can be done using MDS data or can be used by excluding SNFs with data strongly suggesting they do not specialize in SNF Part A care. CMS is already considering transitions of care and quality requirements for these facilities through proposed rulemaking for reform of requirements for long-term care facilities (published at 80 *Federal Register* 42168 on July 16, 2015).			

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	I recommend that long stay nursing home residents be excluded from this measure. **II. Numerator** The intent of this measure is to capture PAC patients returning to the community "to stay." As the measure is currently specified, a patient that is discharged from PAC to the community but is then admitted to a SNF during that 30-days would still count as a "successful community transition". An individual discharged to the community from any of the four PAC providers who is admitted to a SNF in the next 30 days is equivalent to a failed community transition.[19] Allowing admission to SNF in the next 31 days is inconsistent with the intent of this measure. Furthermore, failure to include SNF admission in the 31-day window, also creates an incentive to admit individuals to SNF during that 31 day window to have them appear as if they are a successful community discharge. *I recommend that the numerator should not include individuals who were admitted to a SNF after PAC community discharge during the 30-day measure window.* **III. Section 4.11.2 Risk Adjustment Variables under Considerations; Clinical Conditions** The draft measure uses the IRF case-mix group for IRF, ADLs for HHA, and ventilators for LTCH but there are no similar measures for the other respective settings. If this data is coming from the			

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[19] Leland N, Gozalo P, Christian TJ, Mor V, Wetle TF, Teno JM. (2015). An examination of the first 30 days after patients are discharged from postacute care. Medical Care, 53(10):879-87.

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	PAC assessment tools (MDS, IRF-PAI, LTCH CARE, OASIS) consistent with the IMPACT Act, then I believe these variables should be collected across settings. If items are going to be drawn from the legacy assessment tools, an indicator of long-stay residency status can be extrapolated from the MDS to identify the long stay residents in order to exclude them from the measure. Additionally, further detail is needed on the hierarchical logistic regression models and variables that will be used for risk adjustment. *Recommend providing more details on modeling, variables, and including case--mix and ADL status as risk adjustments across settings, not just HHA and IRF.* **IV. Exclusions** I agree with most of the exclusions, such as AMA discharges. However, I am unclear on what is meant by the same level of care, given that this measure is only holding the last PAC setting accountable for the community discharge and research has demonstrated the use of multiple PACs within an episode. SNFs will be at a disadvantage for this measure. IRFs and LTCHs often discharge patients to SNFs for continued care before community discharge, thus the SNF will be the one held accountable and may be at a disadvantage. Additionally, as stated previously, long stay nursing home residents should be excluded from this measure. **V. Future Revisions of the Measure** The measure should include function across settings, as well as cognition as risk adjustment variables.			

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	Cognitive status is associated with resource use, length of stay, and patients' long-term outcomes. Occupational therapy has a critical role in assessing functional cognition and ensuring that Medicare beneficiaries in post-acute care settings receive quality care in the most appropriate setting, using only the necessary Medicare resources. Functional cognition is an area that must be looked at more closely and that, as the Medicare population continues to live to older ages, providers in all post-acute care settings will need more training in assessing cognitive and functional status for patients with cognitive impairments. Occupational therapists are experts in the measurement of and interventions for functional cognition issues, which encompasses assessment of everyday task performance (e.g., self-care, personal hygiene behaviors and dressing, household management, cooking, medication management and adherence to drug regimens, and patient safety). Occupational therapists specialize in the identification of performance-related or functional cognitive impairments, which range from subtle to obvious and which affect overall treatment, successful discharge placement, long-term outcomes, and, of course, resource utilization. Occupational therapy practitioners treat cognitive impairments because they have the potential to compromise the safety and long-term well being of patients, especially more frail elderly patients. Early identification of performance-related or functional cognitive impairments allows for the timely implementation of an occupational therapy care plan. The plan can include implementing the supports necessary to prevent harmful events			

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	which commonly happen during routine everyday activities for patients with cognitive impairments, for example, falls due to problematic sequencing during bathing or dressing activities. The occupational therapy care plan can also promote optimal recovery, stabilization, and success in post-acute care and discharge settings This is an important aspect for the IMPACT Act to consider because traditional neuropsychological evaluative measures were developed to localize individual cognitive abilities such as selective attention, verbal memory, inhibition, and processing. In contrast, performance-based tasks report how a person interacts with the environment to accomplish an activity, and whether these tasks can be accomplished quickly and efficiently. The American Occupational Therapy Association (AOTA) has engaged CMS officials in face-to-face meetings to discuss the collection of data on functional cognition, and will continue to provide research studies and related materials to CMS to advocate that assessment of functional cognition be incorporated into the IMPACT Act requirements. The purpose of occupational therapy is to enable compensatory activities and to improve function where possible. For Medicare beneficiaries, early detection of performance-based cognitive impairments by occupational therapists also facilitates the selection of the most appropriate levels of care, the appropriate resources to support and train caregivers and reduce caregiver burden, and client-centered discharge options, and contributes to reduced hospital readmissions and increased safety at discharge.			

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	Cognition refers to information-processing functions carried out by the brain that include attention, memory, executive functions (i.e., planning, problem solving, self-monitoring, self-awareness), comprehension and formation of speech, calculation ability, visual perception, and praxis skills.[20] Cognitive functions, such as memory, attention, goal-directed behaviors, abstract thinking, and decision-making, are critical to occupational performance. An individual who has cognitive impairment may be slow to respond, may lack initiative or perseverate, or may be likely to slide down the continuum from independence to dependence, especially for complex occupations. The AOTA Cognition, Cognitive Rehabilitation, and Occupational Performance Statement describes occupational therapy's role in addressing cognition as follows: Occupational therapy practitioners facilitate individuals' cognitive functioning to enhance occupational performance, self-efficacy, participation, and perceived quality of life through the use of occupations and activities. Cognition is integral to effective performance across the broad range of daily occupations such as work, educational pursuits, home management, and play and leisure… Occupational therapy practitioners administer assessments and interventions that focus on cognition as it relates to participation and			

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[20] American Occupational Therapy Association. (2013). Cognition, Cognitive Rehabilitation, and Occupational Performance. *American Journal of Occupational Therapy*, *67*(6 Suppl.), S9-S31. http://dx.doi.org/10.5014/ajot.2013.67S9.

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	occupational performance. Furthermore, occupational therapy pracitioners believe that cognitive functioning can only be understood and facilitated fully within the context of occupational performance. This understanding of the relationship among the client, his or her roles, daily occupations, and context make occupational therapy a profession that is uniquely qualified to address cognitive deficits that negatively affect the daily life experience of the individual.[21] Moreover, cognitive impairments have a significant relationship to Medicare resource use, length of stay, and patients' long-term outcomes. Therefore, cognition is a critical area that must be identified and addressed in PAC settings in order to ensure appropriate discharge planning and care transitions. Thank you for the opportunity to comment on the draft discharge to community measure. If you have any questions, please contact me at nleland@usc.edu or (323)442-1307.			
12/8/2015	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.	Scott Amrhein President Continuing Care Leadership Coalition	Amrhein@cclcny.org	Long term care provider association

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[21] *Id*.

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	CCLC supports CMS's focus on improving care coordination between health care settings, and has been dedicated to improving care coordination in member long term care healthcare settings, including skilled nursing facilities (SNFs) and home health agencies (HHAs) 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 proposed CMS specifications related to the Discharge to Community Quality Measure for post-acute health 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 specifications 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.			

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	Based on experience under the NYS Nursing Home Quality Improvement Program, which is a value-based payment model that includes a measure for discharge to the community, we note that the proposed CMS specifications do not fully account for certain circumstances out of the facility's control. Specifically, we note that: • The specifications 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 specifications do not risk adjust for factors that are unique to certain specific provider types, such as providers offering dedicated services to specialty residents (e.g., those with HIV/AIDS) who may have triggering conditions that would present greater challenges with moving into the community, such as needs for affordable and safe housing, mental health and substance abuse counseling, and medication management and supports. • The specifications do not fully account for the presence of caregiver support, which is expected to have a significant impact on the success of discharge to the community. While factoring in caregiver support, it will be important to also determine a caregiver's availability, willingness, and ability to support the person in the community.			

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	• The specifications do not explicitly factor in goals of the patient as the individual moves to the community. Although the specifications seem to factor in the fee-for-service Medicare hospice benefit, they do not sufficiently account for other individuals seeking end-of-life care in the community. • The specifications do not account for regional differences in community-based needs and supports, including those within a given state, that result from factors such as geographic variance in availability of affordable housing, in appropriate services, in cultural influences, or in medical practice. Finally, as the development of these specifications 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 Discharge to Community Quality Measure 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 impacting the finances of post-acute care providers based on factors beyond their control. CONCLUSION On behalf of CCLC and its members, I want to reiterate my appreciation for the opportunity to comment on these proposed measure specifications. Should you need further information, or if you have questions about these comments, please contact me at CCLC.			

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12/8/2015	Comments: • For home health, we applaud the developers' clear statement that the population involved is solely those individuals who are Medicare FFS enrollees for the designated time period, and NOT the entire patient population subject to OASIS data set reporting. • We also applaud the value of a discharge to community measure for home health which is calculated whether or not the patient experienced a preceding inpatient stay. The scope of this measure will bring important information to the home health industry and to the assessment of quality for patients receiving post acute care. • We would recommend a definition of the reference to an "average facility/agency". What does that mean? The documentation of the 'average' agency would be valuable. • In Step Two of Section 2.4, could an effort be made to use the phrase facility/agency throughout? For home care providers this is an ongoing struggle, as it appears that measures may too quickly be repeated across settings without attention to those items that are unique. • As a general comment, the descriptions of the numerator and denominators involve several references to "estimates". These are new measures, therefore the length of time involved in collecting and understanding data prior to tying results to payment needs to be appropriate. We would encourage transparency as to the evolution of these measures from estimates to knowing when the data can be relied upon. The use of the word 'estimates' would indicate such an evolution.	Barbara A McCann Chief Industry Officer Interim HealthCare Inc.	BarbaraMcCann@InterimHealthCare.com	Healthcare franchise

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	• Our own quality measurement studies have indicated some variation in both resource use and cost directly related to secondary or tertiary active diagnoses. For example, discharge to community following a LEJR can be different when accounting for whether the surgery was elective or post trauma, such as a fall indicated in diagnoses for head injuries, other fractures. With this example in mind, we encourage use of more diagnoses than solely the principal diagnosis. The principal diagnosis in home care is the reason why the patient is receiving home care, such as after care for LEJR. Without additional diagnoses the fact that for example our care is related to a major fall with injury would not be known. In other words, the delivery of home care can be so "far down the continuum" that coding practices may not provide enough information to understand variations in outcome. • Section 4.3.1, Table 1 for SNF, IRF, LTACH: Reason 6 ="under an organized home health service" we would recommend clarification and standardized definition. A variety of organizations provide home health services in the community - does this include only Medicare certified agencies, does this definition include Medicaid LTSS which involves only aide level and/or homemaker services? Does this include private pay services from an entity, which may be licensed depending on the state, and is being paid out of pocket by the beneficiary. We respectfully offer that this variation is critical to understanding and "estimating" the results.			

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	o Under Reason 86, we find the wording confusing. Is this selection made to report that the patient went to a HHA and was admitted while under the HHA's care, or they had an planned admission while in the SNF and are now going to the HHA. o The same confusion exists for the HHA Reason 81, the sequencing of the admission and who is making that decision is not clear. • Please clarify if the Discharge to Community measure essentially is also adding mortality for PAC settings. Death within 31 days of discharge from the perspective of a home care provider can be particularly problematic. Home health is the last setting available to many frail elderly with end-stage chronic disease and who do not wish to elect hospice care. There is currently no recognition of palliative care, and the option to pursue curative treatment and palliative care exists only in the Medicare Choices Model in which we participate. As people enter the final stages of a disease and wish to remain at home, they may no longer meet the definition of receiving "skilled care" as required by the Medicare home health benefit. We have no choice except to end home health services, fully knowing that these people may die soon and unless they decide to enroll in hospice they often have no alternative. Is there a way to identify this population or take them into account in the risk adjustment? Our discharge of these patients to the community is often not because the patient does not need our care, but because they do not meet the strictly interpreted definition of skilled home health to be eligible for the benefit, even under the monitoring and evaluation provision. We would also anticipate that many of			

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	these patients may be admitted to short term SNF stays and subsequently die quickly. We appreciate the opportunity to make these comments and the extension generously made during this season of the year.			
12/8/2015	We are a non-medical home care agency, wondering what impact this may have on us, versus a Home Health Agency that receives payment through Medicare and Medicaid. We presently have a program in place, Readmission Rescue program, which safeguards against patient health and helps ensure hospital compliance with the Affordable Care Act with non-medical home care services.	Rebecca Rushing, BSN, RN FirstLight HomeCare	rrushing@firstlighthomecare.com	Home care agency
12/9/2015	Dear Ms Pratt and Members of the Technical Expert Panel: 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 provides comments on the recently developed discharge to community quality measure for post-acute care (PAC). CHA recognizes and appreciates the recent extension of the comment period to December 8th. While the additional time was helpful, the total duration of the comment period remained insufficient, which limited our ability to engage providers provide more meaningful input. We request that CMS provide a minimum	Alyssa Keefe Vice President Federal Regulatory Affairs California Hospital Association	akeefe@calhospital.org	Hospital association

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	of 60 days for all comment periods on 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. 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 move quickly to provide more meaningful information on the measure testing results and solicit additional input from clinical experts to further inform this process. CHA appreciates the important measurement gap that this measure seeks to address, but we believe additional work is needed and we look forward to participating in the measure's further development. **Patient Discharge Codes** CHA is concerned that CMS has not presented any information on the current reliability and validity of the coding by PAC providers on discharge status. In the short-term acute care hospital setting, data has shown that the discharge status codes are unreliable due to a number of factors. Hospitals spend tremendous resources by going back to claims to identify overpayments and underpayments due to inaccurate coding of discharge status. This continues to be a known data challenge in the acute setting and we anticipate that CMS may share similar challenges in the PAC setting. Despite changes in 2013 to CMS discharge code definitions, we believe additional changes and further clarifications are needed to ensure accurate coding. Further, CHA urges CMS to provide additional evidence on the reliability of the coding of discharge status to help inform the dialogue regarding this measure.			

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	Measure exclusions CHA is concerned about the patients included in this measure originating from a custodial nursing home setting. Individuals residing in a skilled nursing facility on a long-term basis may require admission to post-acute care following hospitalization for acute medical need or decline in functional status. In such cases, the appropriate outcome goal will be to support the individual's recovery so they can return to their residence, which may be a SNF. Under current practice, patients returning to a SNF for residential care may be coded as being discharged to their home, in part because the codes do not make a distinction between transition to a SNF for continued post-acute care vs. transition for residential care. This lack of distinction will limit the ability to compare and contrast outcomes across and between post-acute care providers. We urge CMS to consider adding a discharge code that reflects an individual's return to residential care in a nursing facility, and to provide clear guidance and definitions regarding the use of all discharge codes, in particular the discharge status codes reflecting discharge to home. **Risk adjustment** Our request for additional risk adjustment is informed by our understanding of factors associated with a patients' ability to successfully transition to a community setting. As we have noted in previous communications, recent research has identified that an individual's functional status and ability to perform activities of daily living (ADLs) are significant factors in a patient's outcome,			

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	in particular with regards to readmissions.[22,23] This relationship speaks to the role functional status plays in the hospital's transition planning, and in identifying the most appropriate setting for post-hospital care. Hospitals and other health care providers must balance the goal of returning to the greatest level of independence with the need to access continued medical care in a safe environment. We appreciate that CMS has incorporated the use of the IRF Case Mix Groups (CMG) and ADLs in HHAs in this measure, and we urge CMS to include functional status in the risk adjustment for SNF and LTCH also. The inclusion of functional status measures in the risk adjustment for all settings will be particularly important to assess the need and efficacy of rehabilitation care provided at all levels of the PAC care continuum. **Sociodemographic adjustment** CHA is concerned that the identified sociodemographic adjustment factors of age group, sex and dual status are too limited. An individual's ability to return to independent living is strongly influenced by many factors, including the availability of resources and facilities in a given region, reimbursement policies, economic status, etc. For example, an individual may be medically and functionally capable of transitioning to independent living or assisted living, but may not have access to these alternative			

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[22] Shih, et al. "Functional Status Outperforms Comorbidities in Predicting Acute Care Readmission in Medically Complex Patients." Journal of Geriatric Internal Medicine May 9, 2015.

[23] DePalma, et al. "Hospital Readmission among Older Adults Who Return Home With Unmet Need for ADL Disability." The Gerontologist, 2012; 53(3): 454-461.

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	settings in their area, or may have insurance coverage that will cover their continued medical treatment only in an inpatient setting such as a SNF. We urge CMS to consider additional research regarding the impact and influence of a broader range of sociodemographic factors. Thank you again for the opportunity to provide input. If you have any questions, please contact Pat Blaisdell, vice president, continuum of care, at pblaisdell@calhospital.org or (916) 552-7553, or Alyssa Keefe, vice president, federal regulatory affairs, at akeefe@calhospital.org or (202) 488-4688.			
12/8/2015	Thank you for the opportunity to provide public comment on the Draft Specifications for the Discharge to Community Quality Measure. Partners Continuing Care has a depth of experience in providing safe and effective discharges of patients from our post-acute care network which includes Inpatient Rehabilitation Facilities (IRF), a Long Term Acute Care Hospital (LTCH), Skilled Nursing Facilities (SNF) and a Home Health Agency (HH). We offer these comments in the spirit of constructive feedback. We appreciate the opportunity to contribute to the development of this cross-setting discharge to community quality measure in order to meet the mandate of the Improving Post-Acute Care Transformation Act of 2014 (IMPACT Act). We have several concerns regarding the Risk Adjustments which are under consideration: This measure appears to penalize facilities by reducing the discharge to community rate by unplanned readmissions. Given that unplanned readmissions are already being measured for	Karen S. Nelson, MPA, RN Vice President, Quality, Compliance & Regulatory Affairs Partners Continuing Care	KNELSON@PARTNERS.ORG	Health care provider system

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	quality and performance purposes, would this cause a facility to be adversely impacted twice by each unplanned readmission? It seems that aspects of the IMPACT Act are not coordinated with the Quality Reporting Programs and Value Based Purchasing Programs. The risk adjustment factors appropriately include sociodemographic variables such as age group and sex, and Medicare-Medicaid dual status. As noted in section 3.2, Performance Gap, variation in discharge to community rates has been observed, based on patients' socioeconomic characteristics (e.g., race and ethnicity), facility geographic location (e.g., regional location, urban vs. rural location), and facility characteristics (e.g., for-profit vs. nonprofit, freestanding vs. hospital-based), with or without adjustment for case-mix. We would recommend that these additional socioeconomic variables be included in the risk adjustment, to more fully inform the measure. We know that a discharge to community measure shares characteristics of a readmission measure, in that both reflect patient socioeconomic status coupled with the community's resources as much as they reflect the ability of facilities or HHAs to provide safe and effective discharges. Therefore, we believe it's important to capture as many socioeconomic variables as possible, to fully inform the measure. Section 3.3, Actionability, notes that improvement in discharge to community rates among post-acute patients/residents/persons is			

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	possible through modified provider-led processes and interventions. We are strong believers that our care makes such a difference. We also believe that the addition of socioeconomic variables can contribute to identification of additional community based processes and interventions that can support safe and effective discharges to the community. Section 4.11.2, Risk Adjustment Variables under Consideration, item 6 , includes Ventilator use in the LTCH setting only. Is there a reason limit this risk adjustment variable? Why not include this variable for IRFs and HH? Those IRFs and HHAs which provide care to such complex patients, whether inpatient or in the home, should be acknowledged as well. Specific to Home Health: We are concerned that the conflicting pressures on Home Health Agencies (HHA) will lead to adverse consequences for patients or for HHAs. CMS has continually narrowed the definition of "homebound" and has applied inconsistencies and excessively stringent evaluation of that definition on pre- and post-payment review. HHAs must promptly discharge patients who are no longer homebound, else risk denial of claims. Yet, some of these patients may remain in need of services and supports, not clinically ready for discharge and remaining in need of closer observation than could be obtained from ambulatory visits to their primary care provider. Such patients have an increased risk of unplanned readmission should they be discharged from HHA before they are ready. The addition of a discharge to community			

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	measure will create a disincentive, in the other direction, for HHAs to retain patients on service beyond the emergence from homebound status in order to avoid readmission penalties but at the same time violate the regulations and risk denial of claims or worse penalties. They will need to choose between patient care quality and organizational compliance. As noted in our comments on risk adjustment, HHAs are also subject to double jeopardy with readmissions. This discharge to community measure will create further pressure on HHAs, with the potential to adversely impact unplanned readmissions, and may not fairly reflect HHAs ability to return patients to their 'independent' state. This, too, can be compounded by socioeconomic status and the availability of community resources to influence an effective discharge. In general, we are concerned with the lack of harmonization among the CMS regulations and the measures offered by the proposed IMPACT Act, and remain concerned about the additional burden on post acute care systems to collect and submit quality measures using non-standardized metrics and reporting systems. Thank you for the opportunity to provide public comment on the IMPACT Act of 2014 Cross-Setting Quality Measure: Discharge to Community.			

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12/8/2015	I am submitting a suggestion on behalf of the Home Care Association of America (HCAOA) which represents franchise and independent home care providers across the nation. Our simple comment is that Medicare should ensure that discharge of a beneficiary to the community based provider should acknowledge the importance and availability of a range of home care providers (including those who do not operate a Medicare certified home health agency). The references to home care in the November 2015 document appears to only reference home care provided by home health agencies. I would be happy to speak with you more about the home care industry if that would be of assistance. Thank you for your time. www.hcaoa.org	Patrick Cooney President Home Care Association of America (HCAOA)	patrick@federalgrp.com	Home care association
12/8/2016	Dear Measure Development Team, The National Association of Long Term Hospitals (NALTH) is pleased to submit comments on the discharge to community quality 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 who 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.	Cherri Burzynski, MSN, RN, NE-BC President National Association of Long Term Hospitals Lane Koenig, PhD NALTH Director of Research and Quality National Association of Long Term Hospitals	lane.koenig@knghealth.com	LTCH provider association

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	We have carefully reviewed the draft specifications for the *Discharge to Community Quality Measures for Post-Acute Care* and believe that the measure for LTCHs is flawed as a cross-setting PAC measure of quality. We discuss this and other concerns below. <u>Discharge to community, as currently specified, is a flawed measure of care quality for LTCHs</u> LTCHs are highly specialized acute care facilities that treat complex and often critically ill patients who require hospital-level care for an extended period of time.[24] As such, an LTCH must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay of more than 25 days. Like short-term care hospitals (STCHs), LTCHs treat patients requiring critical, acute, or sub-acute levels of care1 and discharge patients that no longer require such high levels of care. As acute care hospitals, an LTCH's goal is to discharge patients to the appropriate care setting when they no longer need treatment at the acute care level; the goal is not to keep the patient until they are ready to be discharged to the community. As a result, the discharge to community measure as currently constructed is not an appropriate measure of quality for the LTCH setting. After successful LTCH and STCH care, some patients are discharged to lower levels of care such as SNFs. The discharge to community measure would wrongly treat discharges to lower, non-acute care settings as unfavorable outcomes although these			

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[24] Kathleen Dalton, Amy Kandilov, David Kennell, and Alton Wright, "Determining Medical Necessity and Appropriateness of Care for Medicare Long-Term Care Hospitals (LTCHs): Final Report" (prepared for William Buczko, Centers for Medicare and Medicaid Services, July, 2012).

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	discharges are favorable outcomes from the perspective of patients and LTCHs. Just as the discharge to community measure is not used as an indicator of care quality for STCHs, it should not be used as a quality measure for LTCHs. While we understand the IMPACT Act requires the development of a discharge to community measure, we urge the Centers for Medicare & Medicaid Service and the measure development team to consider the role of LTCHs as acute care hospitals and take a broader perspective that includes discharges to lower acuity settings and/or discharges to home after a period of time in the definition of discharged to the "community". We believe that more time is needed to develop and test an appropriate measure that does not produce incentives to send patients to the community before it is medically appropriate to do so. <u>Limitations in the measures hinder cross-setting quality comparisons</u> a. CMS seeks to develop a cross-setting discharge to community quality measure to meet the mandate of the IMPACT Act. However, the draft discharge to community measures are calculated by multiplying a risk standardized rate by the mean rate of discharge in the specific PAC setting's population (section 2.4, step two on pg. 2). The mean rates of discharge used in the calculation are not adjusted for patient clinical differences between PAC settings. As a result, the differences in the rate of discharge to community between PAC settings (e.g., LTCH, SNF, IRF, and HHA) may reflect patient clinical differences rather than differences in care quality.			

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	There exist significant differences in patient severity and acuity across PAC provider settings. 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.[25] 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.[26] These differences in patient acuity may lead to vastly different mean rates of discharge to community for LTCHs compared to other PAC settings. As reported in the draft specifications, rates of discharge to community range from 28.8% for LTCHs as reported in a multi-center study of 23 LTCHs to a high of 80% for IRFs (page 3). These large differences in rates of discharge cannot be plausibly attributed to only care quality. b. The measures of discharge to community require a short-term acute-care stay within 30 days prior to a PAC admission (section 4.1.1 on pg. 5). This requirement would mostly exclude patients discharged from LTCHs to less intensive care			

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[25] 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.

[26] 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.

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	settings in calculating the discharge rates of those less intensive care settings. For example, if a patient is discharged from a short term acute care (STCH) to an 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 discharge to community rates for that SNF. Patients who transition from more intensive care settings (such as LTCHs) to less intensive care settings (such as SNFs) 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 discharge to community rates 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 by 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 discharge to			

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	community 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. The measures include PAC stays that end in transfer to STCHs. For patients inappropriately discharged from a STCH to a PAC facility and then transferred back to a STCH, the measure would incorrectly count the transfer as an unfavorable outcome for the PAC facility even though the transfer did not reflect the quality of PAC care. In contrast, the draft potentially preventable hospital readmission measure for PACs exclude PAC stays that end in transfer to a STCH from being considered an index PAC admission. d. The measures consider patients who experience an unplanned readmission to a STCH or LTCH within 31 days of discharge to the community as an unfavorable outcome and are excluded from the numerator (section 4.3.2 on pg. 6). This requirement does not treat readmissions from different PAC settings in anequivalent way and thus raises concerns about the cross-setting comparability of the measure. Specifically, this requirement indicates that for the LTCH setting, readmissions back to an LTCH counts as unfavorable outcomes whereas for the IRF/SNF/HHA settings, readmissions back to an IRF/SNF/HHA settings are not treated as unfavorable. We recommend that unplanned readmissions to the same or higher levels of care for all PAC settings, not just LTCHs, be included as an unfavorable outcome. For example, SNF patients discharged to the community but who are then readmitted to a SNF or higher care setting within 31 days of discharge should not be counted as a successful discharge to the community.			

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	<u>The validity of patient discharge status code in Medicare claims data should be verified</u> The measures determine whether a patient has been discharged to the community by using a patient's discharge status code in Medicare claims data (section 4.3.1 on pg. 6). We are concerned about the reliability of this variable in determining patients' discharge status. We recommend that, as a check, for patients determined to be discharged to the community using this variable, the measure development team identify whether there are post-discharge claims from any STCHs, LTCHs, SNFs, IRFs, or HHA to ensure that discharge to community was properly coded. At a minimum, the accuracy of the discharge status code and its impact on estimated provider performance should be assessed. <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 that may lead to different likelihoods of being discharged to the community. Without sufficient risk adjustment, differences in discharge to community 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 (pg. 12, #6a). 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			

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	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 discharge to community measure include the principal diagnosis associated with the LTCH stay. b. We are pleased to see the inclusion of intensive care length of stay during the prior acute stay as a risk adjustor (pg. 12 #4b). 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 intensive care unit/cardiac care unit (ICU/CCU).[27] The same study also showed that LTCH care is 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. In the set of risk adjustors for the draft potentially preventable hospital readmission measure for LTCHs, the length of stay and length of stay in the ICU/CCU in the prior short-term hospital stay were included as categorical variables to account for nonlinearity. In the set of risk adjustors for this discharge to community measure, these two variables are not similarly specified as categorical (pg. 12 #4a and 4b). We recommend giving consideration to using length of stay variables as categorical variables to account for nonlinearity.			

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[27] 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 welcome the inclusion of Medicare-Medicaid dual status as a risk adjustor (pg. 12 #3). However, we recommend that the discharge to community measures be adjusted for other sociodemographic factors such as race. For example, a prior study showed differences by race/ethnicity in the likelihood of community discharge from IRFs for patients with stroke.[28] In addition, in its 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 35% of patients who are non-white was 24.8%, 1.3% higher than the median rate among facilities with less than 12% of patients who are non-white. This difference is equivalent to the difference in rates between a facility at the 25th percentile and a facility at the median. 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 discharge to community measure calculations, once available, needs to be established and followed.			

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[28] Timothy Reistetter, Amol Karmarkar, James Graham, Karl Eschbach, Yong-Fang Kuo, Carl Granger, Jean Freeman, and Kenneth Ottenbacher, "Regional Variation in Stroke Rehabilitation Outcomes," *Archives of Physical Medicine and Rehabilitation* 95 (2014): 35.

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1/2/2016	Discharge to Community is summarized in a Discharge Planning tool with input and approval from all care planning disciplines, including attending physician and nursing supervisor. Safe Discharge must include: 1. Evaluation of individual's capacity to comply with medication administration or care compliance by a psychiatrist and attending physician. 2. Nursing evaluation of the individual's capacity for self-care in all activities of daily living. 3. Social worker's assessment of the individual's willingness to receive community support services and self-care. 4. Risk management issues must be identified and addressed.	Rica Pura Josafat	hagis0202@yahoo.com	Individual