

November 23, 2015

Sent via E-mail to discharge to community@rti.org

RE: Draft Specifications for the Discharge to Community Quality Measure for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies

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.

<u>First</u>, 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.

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.

<u>Second</u>, 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 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.

<u>Fourth</u>, 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.

<u>Fifth</u>, 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.

<u>Sixth</u>, 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.

<u>Finally</u>, 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.

Sincerely,

Teresa L. Lee, JD, MPH

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Executive Director