By electronic mail to: Discharge_to_Community@rti.org

November 23, 2015

Re: 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)

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.

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

1707 L Street, NW, Suite 350, Washington, DC 20036
Tel: 202-372-0107 fax: 202-835-8306 www.AAHomecare.org

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.

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 days of discharge. Should the calculation have addition measure exclusions for rehospitalizations that are completely separate from the original admission and medical conditions?

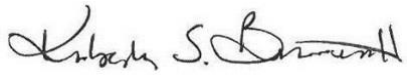
D. DMEPOS technologies are essential to managing beneficiaries with chronic conditions and reducing the number of all hospital readmissions.

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.[1] The product innovations brought about by DME manufacturers, and the care and oversight furnished by suppliers to beneficiaries in their homes allow Medicare to harness technology that ensures beneficiaries receive effective care quickly and safely without incurring expensive hospital readmissions. Again, AAHomecare believes the proposed 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.

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.

Sincerely,



Kimberley S. Brummett, MBA
VP for Regulatory Affairs

[1] 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.