



By electronic mail to: PPR@rti.org

November 16, 2015

Re: **DRAFT Measure Specifications: Potentially Preventable Hospital Readmission Measures for Post-Acute Care**

Dear Sir or Madam:

The American Association for Homecare (AAHomecare) is pleased to have the opportunity to submit comments on the proposed measure specifications for potentially preventable hospital readmissions for post-acute-care. The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop the measures, in alignment with the Improving Post-Acute Care Transformation Act of 2014 (known as the IMPACT Act) and the Protecting Access to Medicare Act of 2014 (PAMA). Identifying and implementing measures such as these is an important undertaking that will assure the Medicare program transitions seamlessly to providing modern, comprehensive and quality post post-acute care for the next generation of Medicare beneficiaries.

AAHomecare is the national association representing the interests of suppliers, manufacturers and distributors of durable medical equipment (DME), prosthetics, orthotics and supplies (collectively, DMEPOS). Our members manufacture and furnish technologies that allow Medicare beneficiaries to safely move from institutional care to their homes. Any set of measure designed to understand factors that might result in, or potentially prevent, hospital readmissions under any circumstance is incomplete unless they also examine the availability and proper utilization of home medical technologies.

- A. To prevent post-acute hospital readmissions, Medicare must examine the entire continuum of care. Access to appropriate post discharge DMEPOS technologies and services helps to reduce unnecessary hospital readmissions.**

Beneficiaries with chronic conditions receive their care under separate benefit buckets that make it difficult to see when care is excessive, inadequate or merely substandard. Recent Medicare “innovation” initiatives, including this project, are an attempt to overcome these hurdles. But as far as we can see, not one of these initiatives examines the entire continuum of care and whether a beneficiary’s ability to consistently access timely, comprehensive, quality DMEPOS technologies post-discharge reduces or prevents post-acute hospital readmissions.

We suggest that it is not possible to “manage” a chronic condition, especially one like COPD, which is among those identified in the report, after an individual has been discharged from an acute or post-acute stay. Post-acute facilities have limited ability to manage or influence the care that beneficiaries

with chronic conditions receive post-discharge. Those who have the most ability to impact utilization are the patient and chronic care providers and suppliers, overseen by the beneficiary's physician.

It makes no sense to penalize the post-acute provider without first making a concerted effort to understand the role that DMEPOS technologies have in reducing or preventing hospital readmissions. In addition to understanding how access to DMEPOS technologies reduce hospital readmissions post-acute-care, an effective strategy would be to focus on engaging beneficiaries and providing them with the proper chronic care infrastructure, including access to appropriate DMEPOS and physician services.

B. The availability of DMEPOS technologies and services post-discharge is an important marker for potentially preventing hospital readmissions for beneficiaries with chronic conditions.

For the most part, the diagnoses included in the tool are too broad to serve as meaningful measures, and we recommend you consider refining them. But in keeping with our comments above, we offer some pertinent observations. Beneficiaries who receive DMEPOS post-discharge often have a home assessment at the time the supplier delivers the DMEPOS. Measures that examine post discharge injury prevention are not useful on their own, because as we have noted, the post-acute provider cannot manage a chronic condition after the beneficiary's discharge. A comprehensive analysis of the sort we described above would identify fall hazards in the home as potentially preventable hospital readmission measures and consider whether a beneficiary has access to a home assessment post-discharge.

Approximately 50% of Medicare beneficiaries are discharged to home health agencies and therefore receive a home assessment. The remaining 50% have no resources can be evaluated under this model. DMEPOS suppliers are often in the beneficiary's home even when home health is not prescribed and could offer an opportunity for additional oversight on issues within the home.

Other potentially preventable fall measures include the availability of, and training on the use of, walking aids, for example. Effective fall prevention tools like grab bars for bathrooms are not covered by Medicare, but may be covered by state Medicaid programs or should be considered for coverage under Medicare. Including greater specificity in your measurements to capture the beneficiary's access to chronic care support like DMEPOS and physician services provides a true picture of what drives hospital utilization post discharge from post-acute-care.

The diagnosis codes listed for COPD and CHF are, again, too broad to be truly useful as stand-alone measures. But home medical technologies for these chronic conditions are very important in reducing hospital readmissions for beneficiaries with these conditions. Accessibility to these technologies post discharge would serve as a potentially preventable hospital readmission measure. Appropriate access includes the involvement of the patient's physician, the appropriate diagnostic tests, and assessments and follow-up by the homecare provider. All of this requires coordination or resources while the beneficiary is in the post-acute facility and by his or her chronic care team, the physician and DMEPOS supplier, post discharge.

Any tool measuring drivers for unnecessary hospital readmissions should examine the difficulty in qualifying beneficiaries for DMEPOS technology based on confusing and nebulous coverage policies. Meeting these requirements makes it very difficult for discharge planners to obtain medically necessary DMEPOS for their patients and for DMEPOS suppliers to actually furnish the equipment patients need. Access is impeded by overly complex qualification criteria.

Whether appropriate access is available necessarily includes an assessment of whether individuals fail to qualify because of burdensome or technical flaws in the qualification process. And because CMS views the DMEPOS industry as suppliers of commodities, not clinical care, the on-going care beneficiaries receive post discharge is compromised by the lack of reimbursement for respiratory therapists, dieticians and other key players in assessing and monitoring beneficiaries in their homes.

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

In summary, it is impossible to overstate the importance of furnishing beneficiaries who have chronic condition with the appropriate equipment and services to manage their condition post discharged from post-acute-care. Numerous recent studies show that homecare technologies are effective for managing the health needs of the chronically ill while reducing the costs associated with inpatient care.¹ The product innovations brought about by DME manufacturers, and the care and oversight furnished by suppliers to beneficiaries in their homes allow Medicare to harness technology that ensures beneficiaries receive effective care quickly and safely without incurring expensive hospital readmissions. Again, AAHomecare believes the proposed measures are incomplete because they do not account for DMEPOS technologies' role in reducing post-acute-care hospital readmissions. We recommend that you consider expanding the focus of the measures as we suggest above.

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.

