Evaluating patient functional assessment data reported by post-acute care providers

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Patient's functional status is used for multiple purposes so it's important that it reflect actual patients' care needs

- Information is used to:
  - Adjust payments
  - Gauge provider performance (e.g., change in function)
  - Establish care plans for patients
- Providers respond to payment and quality reporting incentives
- These incentives may influence reporting of patients' functional status
  - Program spending will be unnecessarily high and will affect MA and ACO benchmarks
  - Payments for stays will not be aligned with patients' resource needs
  - Patient outcomes may appear better than they are

Incentives for recording patients' functional status

- Payment: Functional status at admission used to adjust HHA, SNF, and IRF payments
  - → Incentive to record patient's function as low (more dependent); lower function establishes higher payment
- Quality reporting: Change in function between admission and discharge, attainment of function at discharge
  - → Incentive to record patient's function to show improvement; higher function (more independent) at discharge compared to admission

Commission discussions of functional status recorded by post-acute care (PAC) providers

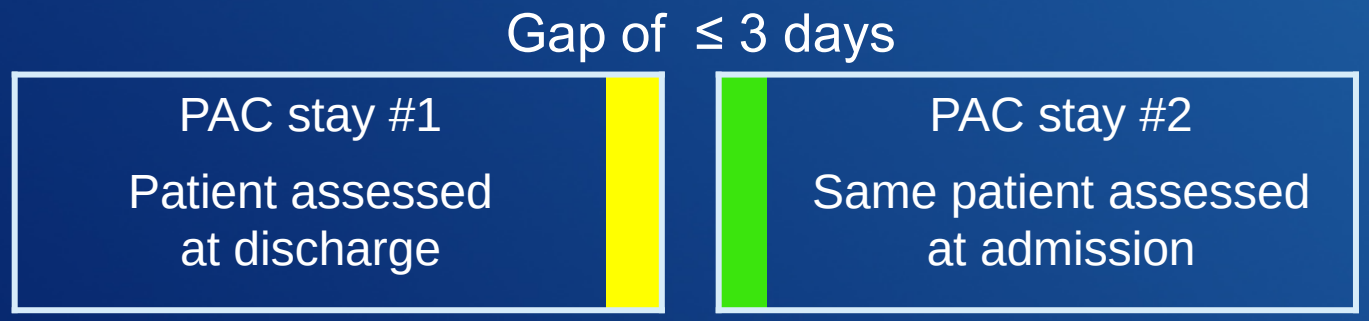
- November topics
  - Examples of the recording of patient function may be influenced by value-based purchasing (VBP) and PPS incentives
  - Examples of PAC providers responding to payment policies
  - Strategies to improve quality of the functional assessment data
  - Alternative measure of function: Patient-reported outcome measures
- Today: Evaluate the functional assessment data
  - Should the function data be used to establish payments and measure patient outcomes?

How did we compare the patient function data collected using four different assessment tools?

- To create a crosswalk between the setting-specific items used for payment
  - For each tool, systematically defined levels of function in terms of points
  - Examined four activities: eating, transferring, walking, and toileting
- For each patient's assessment
  - Assigned points to the level of function recorded. Created a total score by summing the points for each activity.
  - Based on the total score, each patient assessment was assigned a broad category of function (highest, high, medium, low, lowest)
- Uniform function items are directly comparable

Three comparisons made to evaluate the consistency of recorded functional status

1. Compared function level to other beneficiary characteristics
2. Compared assessment conducted for the same patient at discharge from one setting and at admission to the next setting



3. For the same patient, compared assessments of items used for payment with the uniform items used for quality reporting

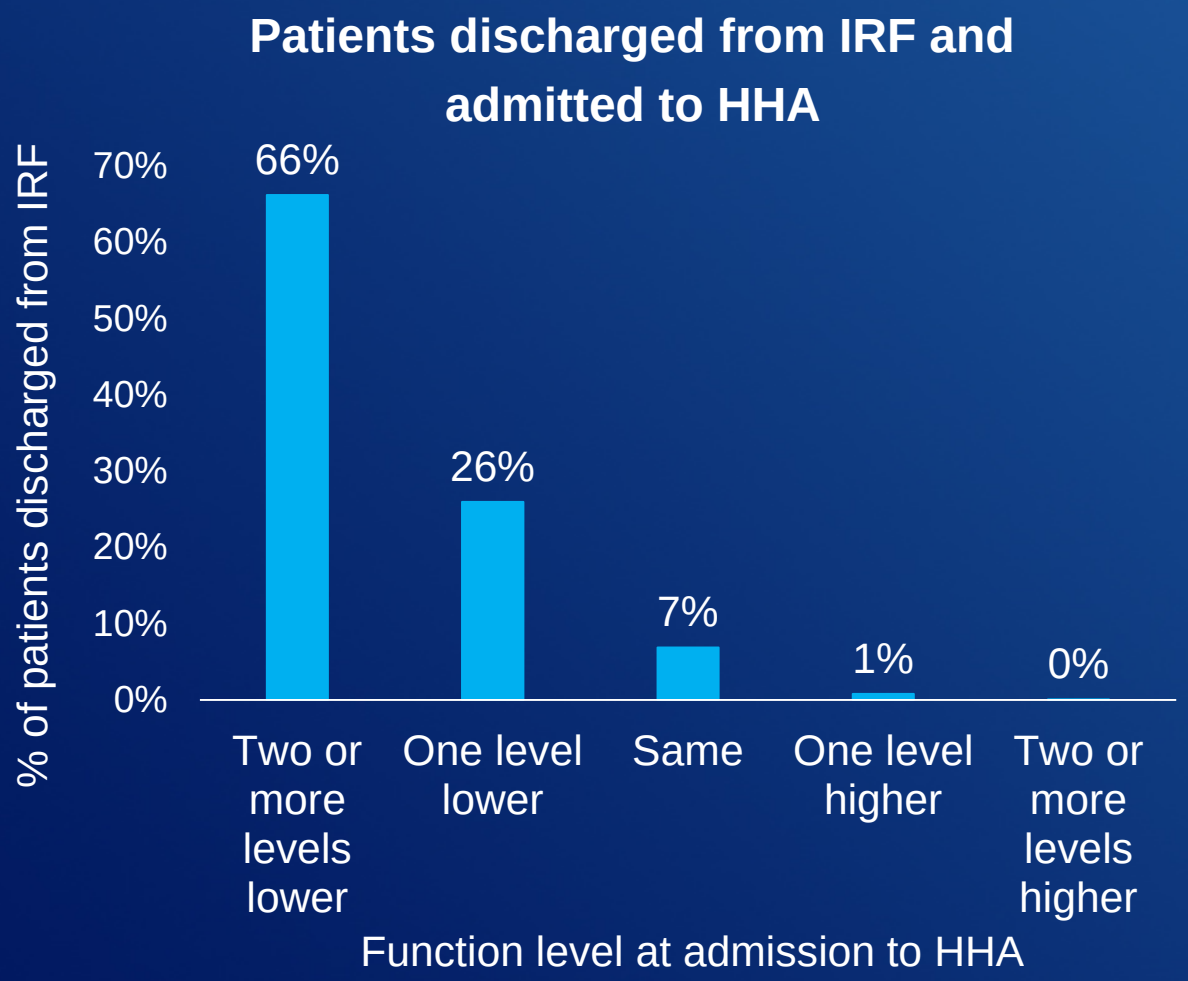
We looked for general agreement between broad categories of function assigned by different assessments for the same patient

1. Reported function levels were associated with other patient characteristics

	Function level recorded at admission	
Characteristic	Highest	Lowest
Average age	73	78
Average risk score	1.77	2.24
% stays with 5+ body system diagnoses	10%	29%
% stays with cognitive impairment	9%	30%
% stays with highest severity (level=4 out of 4)	13%	22%

Source: MedPAC analysis of 2017 patient assessment data. Results are preliminary and subject to change.

2. Comparison of assessments conducted at discharge from one setting and at admission to next setting: IRF to HHA



Takeaways

- 7% of assessments recorded the same broad level of function for the same patients
- Recorded function on HHA admission assessment was lower than that on prior IRF discharge assessment for 92% of patients
- Lower function recorded on admission to HHAs would establish higher HHA payment and more likely to show improvement. Higher function at discharge from IRFs would be more likely to show improvement.

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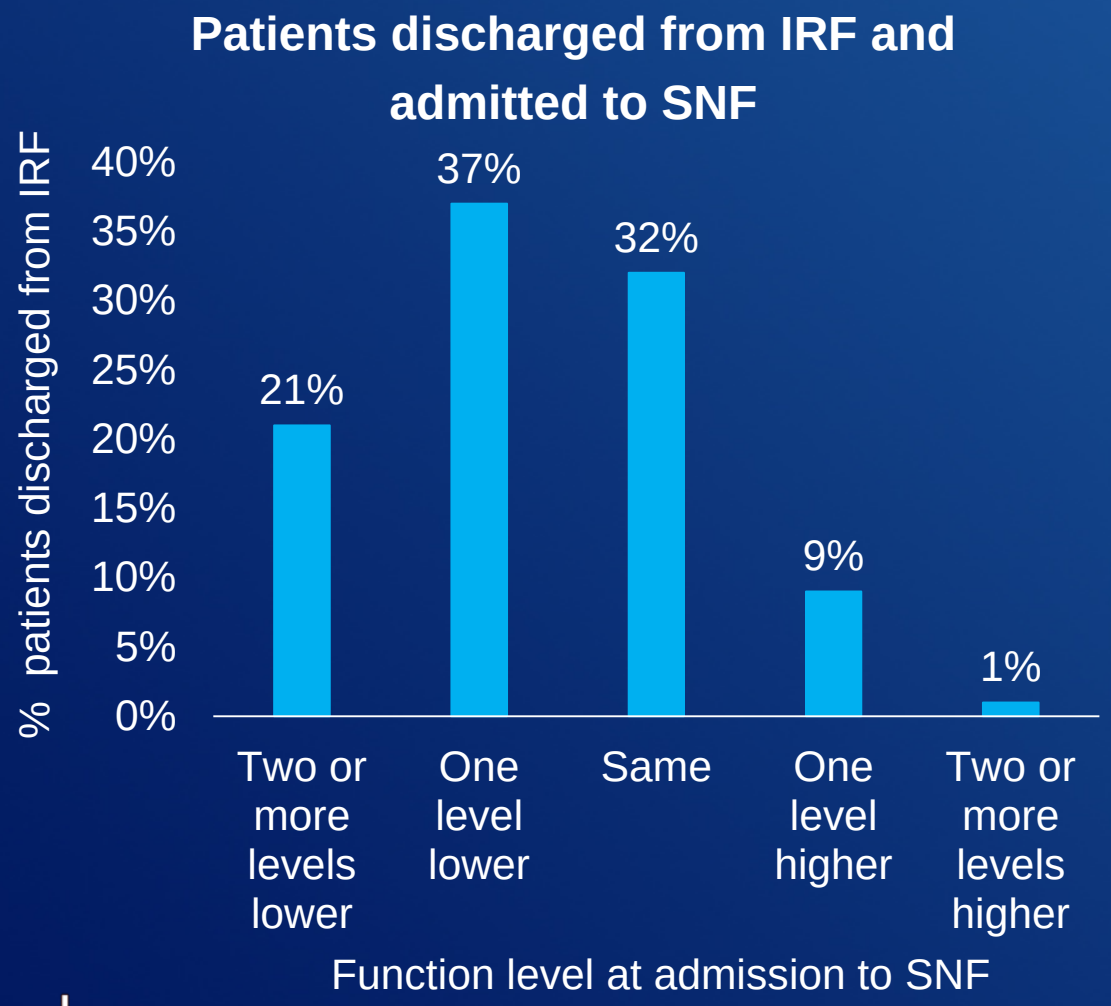
Source: MedPAC analysis of 2017 patient assessments. Data are preliminary and subject to change

2. Comparison of assessments conducted at discharge from one setting and at admission to next setting: IRF to SNF



Takeaways

- Discharge and admission assessments for the same patients recorded the same broad level of function less than one-third of the time
- Recorded function on SNF admission assessment was lower than the level recorded on the IRF discharge assessment for 58% of patients
- Lower function recorded at admission to SNF would establish a higher payment and more likely to show improvement. Higher function recorded at discharge from the IRFs would be more likely to show improvement.

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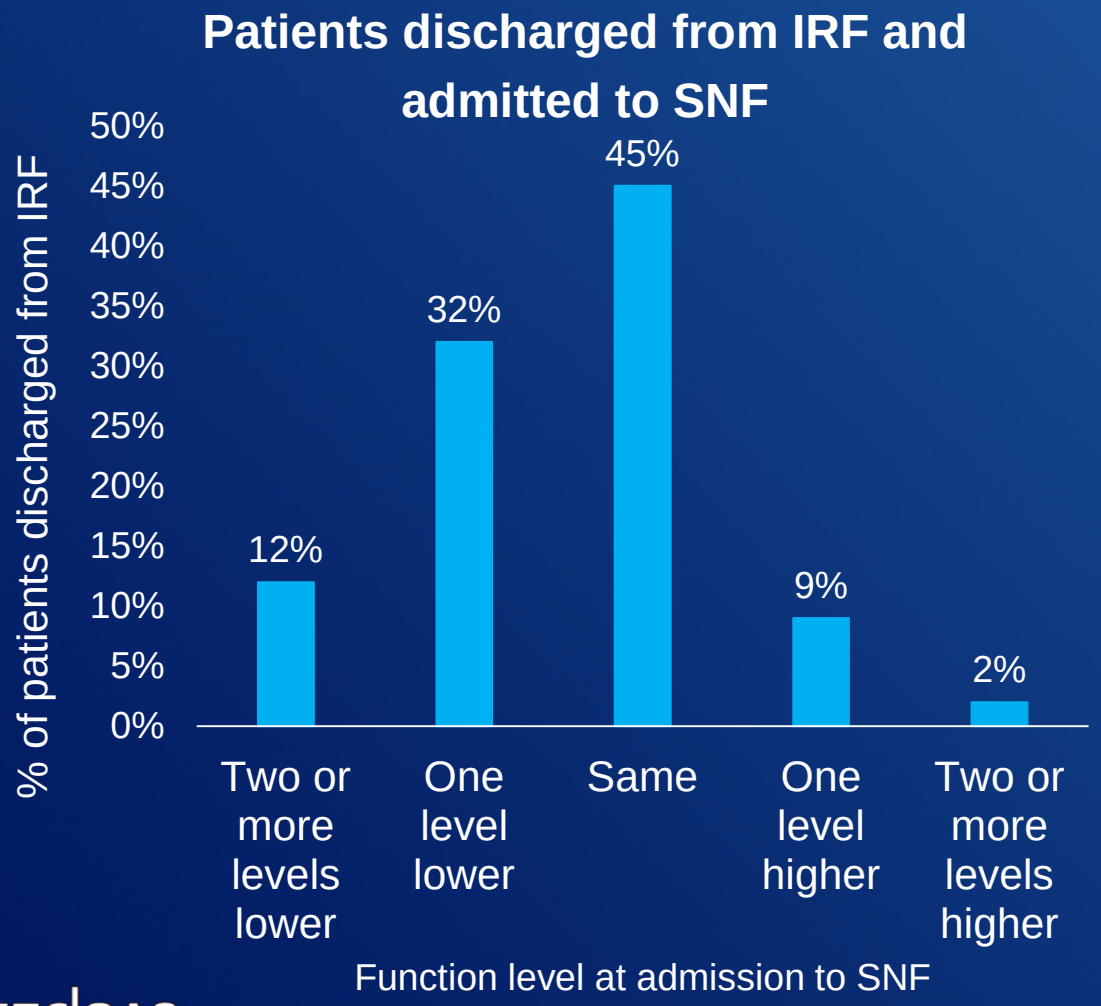
Source: MedPAC analysis of 2017 patient assessments. Data are preliminary and subject to change

2. Comparison of ***uniform*** assessment items recorded at discharge from IRF and at admission to SNF



Takeaways

- The function levels recorded in the discharge and admission assessments for the same patients were the same less than half of the time
- A much larger share of assessments at SNF admission recorded lower function compared with the share that recorded higher function
- IRFs have an incentive to record high function at discharge, while SNFs have an incentive to record low function at admission both to show improvement

Source: MedPAC analysis of 2017 patient assessments. Data are preliminary and subject to change

3. Comparison of assessment items used for payment with uniform items used for quality reporting

- For IRFs and SNFs, level of function reported using uniform quality items matched the level reported using payment items less than half of the time
- Items recorded for quality reporting were more likely to be recorded one function level higher than the information used to establish payments
- Takeaway: Even the uniform items are recorded inconsistently

Factors that may contribute to the differences in recorded function

- PPS designs that adjust payments based on patient function at admission
- Quality reporting and VBP that encourage recording of function to show improvement
- Differences in the assessment tools
- Uniform items are a relatively recent requirement, data may improve over time
- Some degree of subjectivity of the assessments

But the magnitude and biases of the differences raise questions about the integrity of the data

Conclusions

- Our examination of the functional assessment information indicates that the information is inconsistent
  - Shows signs of being influenced by payment incentives
- Our analyses indicate that Medicare should not use this information to adjust payments
- However, maintaining and improving function is a key outcome measure for PAC providers, so commissioners may want to encourage CMS to improve the reporting of this information

Strategies for CMS to improve PAC provider-reported assessments and alternatives

- Improve provider-reported assessments
  - Monitor provider-reported assessments
    - Conduct on-site audits of providers that have aberrant data; assess penalties for poor data quality
    - Require PAC medical records to include sufficient documentation to support patient assessments
  - Require hospital discharge assessments
    - However, a large share of PAC not preceded by hospital stay
- Gather patient-reported outcomes
  - Currently not collected by PAC providers
  - More research needed on use of proxies

Discussion

- Questions on the analysis and results
- Feedback on:
  - Future recommendation on the use of function in payment
  - Strategies to improve and alternatives to PAC provider-reported completed assessments