MEDPAC Medicare Payment Advisory Commission

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March 25, 2016

Mr. Andrew Slavitt, Acting Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: Development and Use of Post-Acute Care (PAC) quality measures

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) would like to provide the Centers for Medicare & Medicaid Services (CMS) with feedback as the agency continues to develop and implement quality measures for post-acute care (PAC) settings. We hope that these comments are helpful for continued refinement of measures and for future measure development. The Commission appreciates CMS's ongoing efforts to develop quality measures that can improve care for Medicare beneficiaries.

The Improving Post-Acute Care Transformation Act of 2014 (IMPACT) and Protecting Access to Medicare Act of 2014 (PAMA) requires the Secretary to develop and implement a number of PAC quality and resource use measures by October 1, 2016. These measures aim to reflect quality of care and resource use in the four PAC settings— home health agencies (HHA), skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH). We believe the intent of the legislation is for these measures to allow direct comparison of quality across the settings, so they should use uniform definitions, specifications, and risk adjustments. Otherwise, differences among providers could reflect differences in the way the measures were constructed in each setting rather than underlying differences in quality. Further, the Commission supports measures that hold providers accountable for the care they furnish and for safe transitions to the next setting or home.

Measures of resource use, medication reconciliation, and potentially preventable readmissions are required by the IMPACT Act and PAMA and this letter addresses the Commission's comments on each of them.

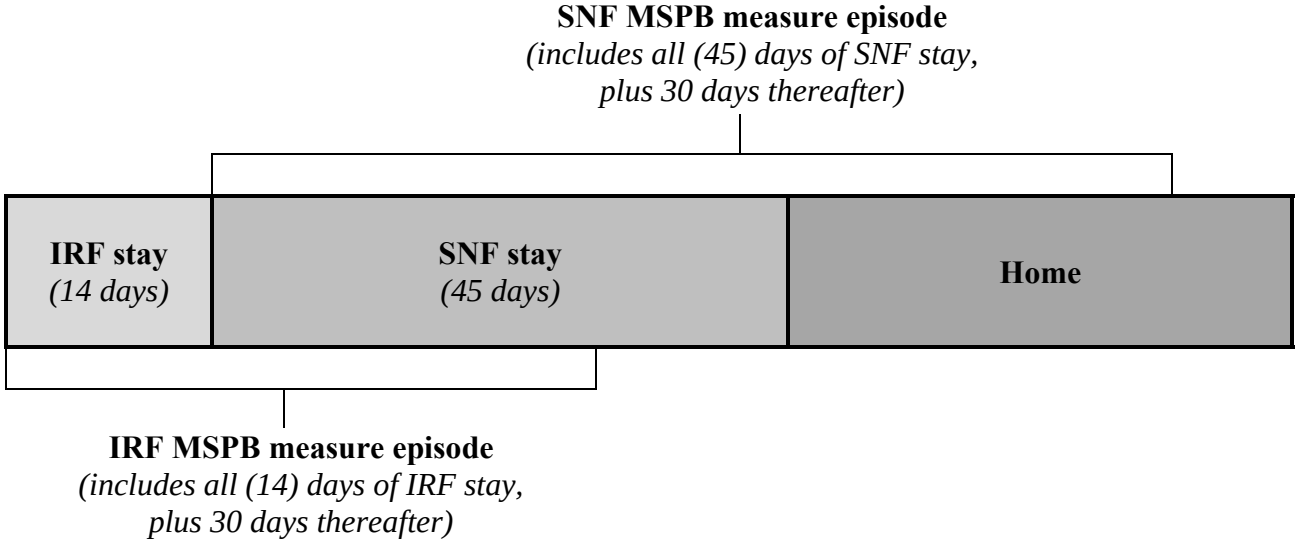
Medicare spending per beneficiary (MSPB)

The IMPACT Act requires the Secretary to develop and implement by October 1, 2016 a PAC total estimated Medicare spending per beneficiary measure. CMS's draft specifications for the MSPB-PAC state that the purpose of the resource use measures is to provide transparent, actionable information to support PAC providers' efforts to promote care coordination and

improve the efficiency of care furnished to their patients (Acumen 2016). By holding providers accountable for spending over an episode of care, the measure will create a continuum of accountability between providers for the care furnished during their own "watch" and during an immediately following period. The measures would discourage the provision of unnecessary services, since this would raise total episode spending.

The proposed measures would compare a PAC provider's resource use relative to the resource use of the national median PAC provider of the same type—with separate MSPB-PAC measures for SNFs, HHAs, LTCHs, and IRFs. Resource use is measured by total Medicare parts A and B spending during the initial PAC stay and the 30 days thereafter. Episode duration may overlap care provided in multiple settings. For example, if a beneficiary is first admitted to an IRF and then discharged to a SNF, the IRF episode would begin with the admission to the IRF and continue for 30 days after discharge from the IRF (and include the spending for the first 30 days of a SNF stay). The SNF's episode would begin with the first day of the SNF claim, include the duration of the SNF day, and end 30 days after the SNF stay ends.

Example of episodes for the current MSPB measures



This episode duration across multiple care settings ensures that providers' incentives for integrated, efficient care are aligned. The draft specifications state that setting-specific measures allow for more meaningful comparisons between providers than if a single measure were calculated across all providers in all PAC settings because there are substantial differences across PAC settings in terms of patient populations, payment policy, and the types of data that are available for risk adjustment.

Comments

MedPAC commends CMS in developing a MSPB-PAC measure that aims to promote care coordination and efficiency. The measure would hold each PAC provider accountable for the care it furnishes during the initial PAC stay as well as any subsequent PAC (e.g., home health care following an IRF stay), hospital readmissions, and physician and other outpatient care after

discharge from the initial PAC stay. By incorporating all care over an episode, PAC providers are encouraged to furnish efficient, high quality care themselves and to partner with other providers that do the same.

Partly in response to Congressional action, the PAC landscape will undergo substantial changes with a unified PAC payment system and uniform patient assessment data and quality measures. Consistent with this direction, the Commission believes a single resource use measure, rather than four separate measures, will better meet the intent of the IMPACT Act to enable comparisons across the PAC settings.

Our work exploring the design of a unified payment system indicates considerable overlap in PAC settings where beneficiaries are treated. These results suggest it is imperative that quality and resource use measures are directly comparable across settings to the extent possible, so that Medicare can evaluate the value of its purchases. Separate measures, with separate risk-adjustment models, could result in differences in providers' performance that reflect differences in the measure construction rather than differences in spending. Further, separate measures will continue to treat each setting separately even though similar patients are often treated in more than one initial PAC setting. For example, if an IRF treats the types of patients who are also admitted to SNFs, Medicare would want to know how the IRF's resource use compares to other IRFs *and* to SNFs.

In contrast, a single resource use measure will enable direct comparisons of resource use across settings. Because there is a single measure, any differences in rates will reflect differences in resource use adjusted for case mix and could not be attributed to differences in the definitions of the measure or risk adjustment. Therefore, to facilitate comparisons across settings, MedPAC urges CMS to develop and use an all-PAC setting measure rather than separate measures for each PAC setting.

Until there is a unified PAC PPS and payment differences between settings are eliminated, the Commission appreciates that a single measure would, without any adjustment, consistently advantage HHAs and disadvantage IRFs and LTCHs due to the large spending differences in the spending associated with the initial PAC stay across the settings. Until then, comparisons could focus on providers within a setting, but using the single MSPB-PAC measure. For example, each IRF's performance would be compared to other IRFs but the spending measure would include the averaging of similar cases treated in lower-cost settings such as SNFs.

Both the CMS approach of developing four MSPB measures (one for each PAC sector) and the approach we discuss above, would correct for the systematically lower costs incurred in a PAC episode where a home health agency is the primary provider, compared to the generally higher costs for episodes driven by the institutional providers. However, we believe the approach described above is preferable to developing four separate measures, given the strong policy benefit of moving to a unified PAC PPS. Four independently-developed measures of the same concept (MSPB) could introduce and perpetuate artifacts of the current PAC provider silos, whereas a single measure would reinforce the future policy objective of a unified PAC PPS. Over the shorter term, having calculated rates for each provider using a single measure, each provider's rate could

be compared to the setting average. This way, HHAs would be compared to other HHAs, LTCHs to other LTCHs, and so on, which would ensure that home health agencies were not unfairly advantaged, and institutional PAC providers disadvantaged, under a single MSPB measure approach. Over the longer term, this approach would also allow providers across settings to be compared.

Finally, the Commission offers specific comments on two aspects of the episode definition. First, the draft specifications propose to define standard HHA treatment period as 60 days even if the beneficiary is discharged sooner. This definition is inconsistent with the definitions for other PAC episodes, and for HHA stays shorter than 60 days could hold HHAs responsible for care for longer periods of time compared with other PAC providers. Further, services provided after HHA discharge could appear to be concurrent with HHA care even though the patient had been discharged from the HHA. In examining resource use, one may want to delineate services furnished concurrent with or after discharge from any given provider yet the proposed definition of HHA treatment periods will confound these. The Commission urges reconsideration of the definition of the HHA treatment period. Second, the list of excluded services from the episode should be short and the rules should be straightforward. A long list of excluded services—coupled with complex rules about when a service is and is not excluded—will undermine the intent of the measure: to increase provider accountability for the care of beneficiaries.

Drug regimen review conducted with follow-up for identified issues

The IMPACT Act requires CMS to develop and implement a standardized PAC setting measure for medication reconciliation. CMS has drafted a measure of the percentage of IRF, LTCH, SNF or HH care episodes in which a drug regimen review was conducted at admission, start of care or resumption and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the stay or care episode. The purpose of the measure is to encourage PAC providers to perform a review of all medications patients are currently using in order to identify and resolve any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

Comments

The Commission supports CMS's proposed medication reconciliation measure because it measures not only whether a review of medication was performed, but also follow-up with a physician if a clinically significant issue was identified. The medication reconciliation and follow-up process can help reduce medication errors that are especially common among patients who have multiple health care providers. In addition to the drug regimen review measure, MedPAC encourages CMS to measure how PAC providers are supporting medication reconciliation throughout the care continuum. To that end, CMS also could measure whether a PAC provider is sending medication lists to either the next PAC provider, or, if being discharged home, to the patient's primary care provider.

Readmissions

In April, CMS will begin publicly reporting on Nursing Home Compare each SNF's percentage of short-stay residents who were re-hospitalized after a skilled nursing facility admission. This is a

measure of unplanned hospital admissions for any cause during the first 30 days of the SNF stay. As required by PAMA, CMS is also currently developing a measure of potentially preventable-30 day post- prior hospitalizations for SNFs to be implemented October 1, 2016.

Comments
MedPAC commends CMS for holding SNF providers publicly accountable for outcomes measures such as readmissions. But, when feasible, CMS should replace the all-cause, un-planned readmissions measure with the PAMA measure on potentially preventable hospital readmissions. Measuring potentially preventable readmissions holds the provider accountable only for conditions that generally can be managed in the SNF, as opposed to all-cause readmissions measure, which captures readmissions for any condition, including those that generally are not considered preventable.

Conclusion
The Commission values the ongoing cooperation and collaboration between CMS and our staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions, or require clarification of these comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman