Making connections
Creating the Community of Care

A two-day conference for
CHA's Center for Post-Acute Care

CALIFORNIA HOSPITAL ASSOCIATION
Center for Post-Acute Care
Measuring Quality:
The IMPACT Act and Beyond

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Director of Policy
February 16, 2017
Agenda

• Policy context

• CMS implementation of IMPACT Act

• Looking ahead
  – Pay-for-performance
Our Shared Goals

• Better health
• Better care
• Greater efficiency
Measurement as a Policy Lever

• Data for improvement

• Transparency for patients, policymakers

• Provider accountability
# Federal Quality Measurement Landscape

$\star = \text{Mandated by the Affordable Care Act}$

## Pay-for-Performance

### Pay-for-Reporting
- **Hospitals:**
  - IQR
  - OQR

- **Post-Acute Care:**
  - IRF QRP
  - LTCH QRP
  - SNF QRP
  - HH QRP

- **Physicians**
  - PQRS (through 2018)

- **Other**
  - ASCQR
  - IPF QRP
  - Hospice

### Upside and downside risk
- **Hospitals**
  - Value-Based Purchasing

- **Physicians**
  - Value Modifier (through 2018)
  - MIPS/APMs (starting 2019)

- **Post-Acute Care**
  - SNF VBP

- **Others**
  - Medicare Shared Savings Program
  - ESRD QIP

### Payment penalty only
- **Hospitals**
  - Readmissions
  - Hospital Acquired Conditions (HACs)
  - Medicare EHR Incentive Program (AKA – Meaningful Use)
PAC Quality Measurement Policy: Overarching Themes

• **Measures, measures, measures**
  – But how to focus on what’s most important?

• **Demands for greater standardization…**
  – How far can/should this go?

• **Links to payment**
  – How will incentives drive change?
  – Are there unintended consequences?

• **Public accountability**
  – What information does the public want/need?
What is the IMPACT Act?

- Bipartisan legislation signed into law on Oct. 6, 2014

- Requires collection and reporting of “standardized and interoperable”:
  - Patient assessment data
  - Quality measures

- Expands data collection and reporting requirements for LTCHs, IRFs, SNFs and HH agencies
  - Payment penalties for non-reporting
What is the IMPACT Act Supposed to Achieve?

• Provide “building blocks” for PAC delivery system reforms
  — E.g., Unified PAC payment system based on patient characteristics

• Standardized measures and assessment data to facilitate:
  — Enhanced care coordination (among PACs and with hospitals)
  — Data to inform choices on most appropriate care settings
  — Transparency, and cross-PAC performance comparisons
Measures must address:

- Functional status
- Skin integrity
- Medication reconciliation
- Major falls
- Transfer of care information and care preferences
- Resource use, including at a minimum:
  - Medicare spending per beneficiary
  - Discharges to community
  - Potentially preventable admissions and readmissions
IMPACT Act:
Patient Assessment Data Domains

- **Functional status** (e.g., mobility, self care)
- **Cognitive function and mental status** (e.g., depression, ability to understand)
- **Special services, treatments, and interventions** (e.g., ventilator use, dialysis, chemotherapy, central line placement, TPN)
- **Medical condition** (e.g., diabetes, CHF, comorbidities such as severe pressure ulcers)
- **Impairments** (e.g., incontinence, impaired and an impaired ability to hear, see, or swallow)
- Other categories deemed necessary and appropriate by the Secretary of HHS
Is this déjà vu all over again?

IMPACT Act gives teeth to some existing policy ideas asking for more standardization.
Does IMPACT Act Mandate the CARE Tool?
(or any single assessment tool for all PAC Providers?)

No ... but aspects of CARE tool are part of CMS’s implementation of IMPACT Act

- Data can be collected through existing assessment instruments (e.g., IRF-PAI)
  - But CMS must revise or replace “duplicative” or “overlapping” data elements for “interoperable” data

- Some quality measures (particularly functional status) being collected using questions/rating scale from CARE tool
Other Key IMPACT Act Provisions

• Changes to Medicare Conditions of Participation for hospitals and PAC providers
  – Requires use of IMPACT Act quality data in discharge planning
  – Proposed rule in Oct. 2015, final rule pending

• Development of a PAC PPS “prototype”
  – CMS, with input from MedPAC

• Reports on the impact of sociodemographic factors on ALL Medicare quality and pay-for-performance programs
  – Next report due in 2019
Timeline for IMPACT Act Payment Reform Reports

- Fall 2016: HHS and ASPE report on socio-economic status.
- Fall 2018: HHS report on Post-Acute PPS prototype.
• Encourages (but does not require) use of NQF-endorsed measures

• Review by Measure Applications Partnership (MAP) required prior to being proposed in a rule
  – But can be waived to meet statutory deadline

• Quality data must be publicly reported
  – Feedback reports to PAC providers with opportunity for review/corrections
  – Accessible through CASPER
Measure Development is Ongoing (and Fast-Paced)

Measures Management System

Quality measures are tools that help measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care. CMS uses quality measures in its quality improvement, public reporting, and pay-for-reporting programs for specific healthcare providers.

In response to an ever-increasing demand for quality measures, the Centers for Medicare & Medicaid Services (CMS) developed a standardized system for developing and maintaining the quality measures used in its various accountability initiatives and programs. Known as the Measures Management System (MMS), measure developers (or contractors) should follow this core set of business processes and decision criteria when developing, implementing, and maintaining quality measures.

Best practices for these processes are documented in the manual, A Blueprint for the CMS Measures Management System (the Blueprint). CMS uses the standardized processes documented in the Blueprint to ensure that the resulting measures form a coherent, transparent system for evaluating quality of care delivered to its beneficiaries.

CMS wants you to get involved! There are numerous opportunities to actively engage in MMS efforts, such as through information sessions, calls for measures, expert panels and public comment periods. Select the link below based on your role in healthcare to see how you can help make the measure development process better.

Measures Management website
### Timing of IMPACT Quality Measure Reporting Requirements

<table>
<thead>
<tr>
<th></th>
<th>LTCH</th>
<th>IRF</th>
<th>SNF</th>
<th>HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin integrity (i.e., pressure ulcer)</td>
<td>Apr 2016</td>
<td>Oct 2016</td>
<td>Oct 2016</td>
<td>Jan 2017</td>
</tr>
</tbody>
</table>

**Green = Measure finalized**  **Red = Measure not yet proposed**

*Source: Adapted from CMS Open Door Forum, Feb. 2016*
“Functional Status” Measurement
Prior to IMPACT Act

• LTCHs
  – No specific tool required in LTCH QRP

• IRFs
  – Function items in the IRF-PAI

• SNFs
  – Function items part of ADLs in MDS

• Home Health
  – Function items incorporated in OASIS
Five new functional status measures finalized for FY 2018 IRF QRP

- One assessing whether functional status assessment completed at admission and discharge
- Two assessing change in self-care and mobility functional status between admission and discharge
- Two assessing whether self-care and mobility scores at discharge meet or exceed “expected” level

Reporting began Oct. 1, 2016
IRFs: Double Data Collection on Functional Status

- Measure data collected in addition to (not in place of) FIM functional status items on the IRF-PAI
- FIM uses 7-level scale, proposed measures use 6-level scale
Functional Status Measurement: Double Trouble for SNFs, Too

- Functional status measure data collected in addition to (not in place of) activities of daily living (ADLs) section of the MDS
Regulatory Relief

The balance of flexibility in patient care and regulatory burden seems to have reached a tipping point. The Centers for Medicare & Medicaid Services (CMS) and other agencies of the Department of Health and Human Services (HHS) released 43 proposed and final rules in the first 10 months of the year alone, comprising almost 21,000 pages of text. In addition to the sheer volume, the scope of changes required by the new regulations is beginning to outstrip the field’s ability to absorb them. Moreover, this does not include the increasing use of sub-regulatory guidance (FAQs, blogs, etc.) to implement new administrative policies.

There are numerous duplicative and excessive rules and regulations. The AHA suggests the following actions to immediately reduce burdens on hospitals and patients. These regulations are promulgated by CMS (Table 1), other agencies within HHS (Table 2) and other departments of the federal government (Table 3).

### Table 1. Actions to be Taken by CMS

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Suspend hospital star ratings</td>
<td>Despite objections from a majority of the Congress, CMS published a set of deeply flawed hospital star ratings on its website this fall. The ratings were broadly criticized by quality experts and Congress as being inaccurate and misleading to consumers seeking to know which hospitals were more likely to provide safer, higher quality care. The AHA calls on the Administration to suspend the faulty star ratings from the Hospital Compare website.</td>
</tr>
<tr>
<td>Cancel Stage 3 of “meaningful use” program</td>
<td>Hospitals face extensive, burdensome and unnecessary ‘meaningful use’ regulations from CMS that require significant reporting on use of electronic health records (EHRs) with no clear benefit to patient care. These excessive requirements are set to become even more onerous when Stage 3 begins in 2018. They also will raise costs by forcing hospitals to spend large sums upgrading their EHRs solely for the purpose of meeting regulatory requirements. The AHA urges the Administration to cancel Stage 3 of meaningful use by removing the 2018 start date from the regulation. The Administration also should institute a 90-day reporting period in every future year of the program, and gather input from stakeholders on ways to further reduce the burden of the meaningful use program from current requirements.</td>
</tr>
<tr>
<td>Suspend electronic clinical quality measure reporting requirements</td>
<td>Hospitals have spent significant time and resources to meet certified EHRs to meet CMS electronic clinical quality measure requirements for 2016, with no benefit for patient care. Moreover, CMS acknowledges that the electronic test submissions by hospitals and physicians do not accurately measure the quality of care provided. Despite these facts, CMS regulations define the electronic clinical quality measure reporting requirements for hospitals for 2017, creating additional burden without an expectation that the data generated by EHRs will be accurate. The AHA urges the new Administration to suspend all regulatory requirements that mandate submission of electronic clinical quality measures.</td>
</tr>
</tbody>
</table>

Updated Nov. 30, 2016
Calculated for each PAC setting
  – Compared within PAC provider type, NOT across PAC provider types

Assesses risk adjusted, standardized Medicare part A and B payments during a defined episode of care
  – Ratio of observed to expected

Comparable to hospital MSPB measure
• Episode “trigger”
  – Patient is admitted to an PAC setting

• One episode, two timeframes:
  – Treatment Period
    • Begins at trigger, ends on day of PAC discharge
    • Includes part A and B services “directly or reasonably managed” by PAC
  – Associated Services Period
    • Begins at trigger, ends 30 days after the end of treatment period
PAC-MSPB Measure —
Intentional Overlap with Other Providers

Adapted from Acumen, Measure Specifications: Medicare Spending per Beneficiary – Post Acute Resource Use Measures. April 2016.
PAC-MSPB Measures — Other Details

- Excluded from PAC-MSPB calculation
  - Planned hospital admissions within episode
  - Certain services outside PAC provider’s control
    - Management of some preexisting chronic conditions (e.g., dialysis)
    - Treatment for preexisting cancers, organ transplants, preventive screenings

- Measure is standardized and risk adjusted
  - Standardization removes geographic variation like wage index and other add-on payments
  - Risk adjusted for clinical factors contributing to spending
  - NOT adjusted for socioeconomic factors
IMPACT Act Resource Use Measures: Discharge to Community

- Measure assesses “successful discharge to the community” in the 31 days after discharge from PAC care

- “Successful” in this context means risk standardized rate of Medicare FFS patients discharged to community who
  - Are NOT readmitted to acute hospital or LTCH; and
  - Remain alive during time period

- “Community” defined as
  - Home/self-care (with or without home health services)
  - Uses patient discharge status codes 01, 06, 81 and 86 on the FFS claim
Discharge to Community: Other measure details

- Key Exclusions
  - Discharges to inpatient psych
  - Discharges to hospice
  - Planned discharges to acute or LTCH setting
  - Part A benefits exhausted
  - Swing bed stays in CAHs

- Risk adjusted for clinical factors contributing to likelihood of readmission or death, but **not adjusted for socioeconomic factors**
PAC Resource Use Measures: Potentially Preventable Readmissions

- Assesses risk-adjusted rate of unplanned, potentially preventable hospital readmissions in the 30 days post-PAC discharge

- IRF discharge must have occurred within 30 days of a prior proximal hospital stay

- Measure is risk adjusted for clinical factors contributing to likelihood of readmission, but not for socioeconomic factors
CMS uses ICD-9 codes (and preliminary list of ICD-10 codes) codes to define three broad categories of potentially preventable readmissions

<table>
<thead>
<tr>
<th>PPR Category</th>
<th>Conditions</th>
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</thead>
<tbody>
<tr>
<td>Inadequate management of chronic conditions</td>
<td>• Adult asthma</td>
</tr>
<tr>
<td></td>
<td>• Chronic obstructive pulmonary disease (COPD)</td>
</tr>
<tr>
<td></td>
<td>• Congestive heart failure (CHF)</td>
</tr>
<tr>
<td></td>
<td>• Diabetes short-term complications</td>
</tr>
<tr>
<td></td>
<td>• Hypertension / hypotension</td>
</tr>
<tr>
<td>Inadequate management of infection</td>
<td>• Influenza</td>
</tr>
<tr>
<td></td>
<td>• Urinary tract infection / kidney infection</td>
</tr>
<tr>
<td></td>
<td>• <em>C. Difficile</em> infection</td>
</tr>
<tr>
<td></td>
<td>• Sepsis</td>
</tr>
<tr>
<td></td>
<td>• Skin and subcutaneous tissue infections</td>
</tr>
<tr>
<td>Inadequate management of other unplanned events</td>
<td>• Dehydration / electrolyte imbalance</td>
</tr>
<tr>
<td></td>
<td>• Aspiration pneumonitis ; food/vomitus</td>
</tr>
<tr>
<td></td>
<td>• Acute renal failure</td>
</tr>
<tr>
<td></td>
<td>• Arrhythmia</td>
</tr>
<tr>
<td></td>
<td>• Intestinal impaction</td>
</tr>
<tr>
<td></td>
<td>• Pressure Ulcers</td>
</tr>
</tbody>
</table>
How Many Readmission Measures Do We Need?

HRRP Measures

IRF Within Stay

PPR Measure

IRF Stay

IRF PPR Measure

IRF All-Cause Readmissions

Post-Discharge Day 1

Post-Discharge Day 30
SNF VBP Program

- Required by PAMA of 2015
- Applies to payment starting in FY 2019
- CMS must select measure of either all-cause readmissions or potentially avoidable readmissions, and publicly report both
  - All-cause measure will be used in first year
- 2.0 percent withhold to create pool (but only 50-70 percent of funds paid back)
  - Non-budget neutral
SNF VBP Measures:
All-Cause Readmissions

- All-cause, unplanned hospital readmissions for SNF residents within 30 days discharge from IPPS hospital, CAH, IPF)

- Only includes patients directly admitted to SNF (i.e., SNF admission must be within one day of prior proximal acute hospitalization)

- However, also includes patients who may have already been discharged from SNF within the 30-day timeframe
SNF VBP Measures:  
PPR Measure

• Unplanned, potentially preventable readmission rate within 30 days (definition of “potentially preventable” similar to SNF QRP measure)

• Only includes patients directly admitted to SNF (i.e., SNF admission must be within one day of prior proximal acute hospitalization)
  – However, also includes patients who may have already been discharged from SNF within the 30-day timeframe

• Risk adjusted, but lacks sociodemographic adjustment
SNF VBP — Scoring Methodology

• Each SNF will get a “Total performance score” (TPS) based on the better of “achievement” or “improvement” scores on each measure
  – Baseline year for all program years is CY 2015
  – Performance period is CY 2017

• Achievement scores
  – “Achievement threshold” = 25th percentile of SNF performance
  – “Achievement benchmark” = top decile of scores
  – Receive 0 points if performance period score below threshold, and 100 points if at or above benchmark
  – If performance period score between threshold and benchmark, score of 0 to 100 using formula
**SNF VBP — Improvement Scores**

- Score of 0 if SNF scores worse in performance period than baseline

- Receive 0 to 90 points if score better than baseline but below achievement benchmark using formula

- Score of 90 if equal to or higher than benchmark
SNF VBP — Proposed Scoring Approach

FIGURE BB: SNF B Performance Scoring

0.79551 Achievement Threshold

0.83915 Benchmark

Achievement Range

SNF B Performance

Baseline Period

0.78756

Performance Period

0.81668

Achievement Range

0 100

0 90

Improvement Range

SNF B Earns: 49 points for achievement performance
51 points for improvement performance

SNF B SNF Performance Score: Higher of achievement or improvement
51 points
HH Value-Based Purchasing (VBP)

- CMS invoking its authority under the ACA to “test” payment models intended to improve quality / reduce cost

- CMS mandates participation in a VBP program for HH agencies in 9 states
  - AZ, FL, IA, MD, MA, NE, NC, TN, WA

- HH agencies in selected states subject to upward, neutral or downward adjustments of up to 8 percent based on performance on 24 measures

- Program will score HH agencies both on achievement versus CMS-established benchmarks, and improvement versus their own baseline
  - Somewhat like Hospital VBP
HH VBP — Assessment and Payment Adjustment Timeframes

<table>
<thead>
<tr>
<th>Performance Period</th>
<th>Payment Adjustment Year</th>
<th>Level of Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2016</td>
<td>CY 2018</td>
<td>+/- 3.0 percent</td>
</tr>
<tr>
<td>CY 2017</td>
<td>CY 2019</td>
<td>+/- 5.0 percent</td>
</tr>
<tr>
<td>CY 2018</td>
<td>CY 2020</td>
<td>+/- 6.0 percent</td>
</tr>
<tr>
<td>CY 2019</td>
<td>CY 2021</td>
<td>+/- 7.0 percent</td>
</tr>
<tr>
<td>CY 2020</td>
<td>CY 2022</td>
<td>+/- 8.0 percent</td>
</tr>
</tbody>
</table>

- Performance period occurs two years before payment adjustment
- Level of payment at stake will rise over time
- Payment adjustment is greater than existing hospital VBP program
PAC VBP Legislation

- Introduced in last Congress
- Bases performance on subset of IMPACT Act measures
  - MSPB and functional status
- Non-budget neutral design, with up to 5.0 percent of payment at risk
- Potential use of regional comparisons
- Work underway on updated bill in new Congress
A Few Thoughts About the Future …

• Measurement here to stay
  – Will pace remain the same?

• Pay-for-performance is attractive to many policymakers, but how will it be used?
  – For improvement? Medicare savings?

• More work needed on ensuring coordination of measurement across settings (i.e., creating a consistent incentive for all)
Measuring Quality:
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Questions?
Thank you

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