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

Making connections

Measuring Quality: The IMPACT Act and Beyond

Akin Demehin
American Hospital Association

CALIFORNIA HOSPITAL ASSOCIATION
Center for Post-Acute Care

CHA Post-Acute Care Conference

Measuring Quality:
The IMPACT Act and Beyond

Akin Demehin
Director of Policy
February 16, 2017

American Hospital Association

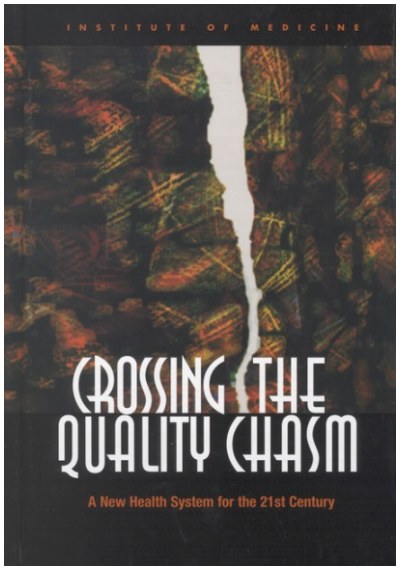
Agenda

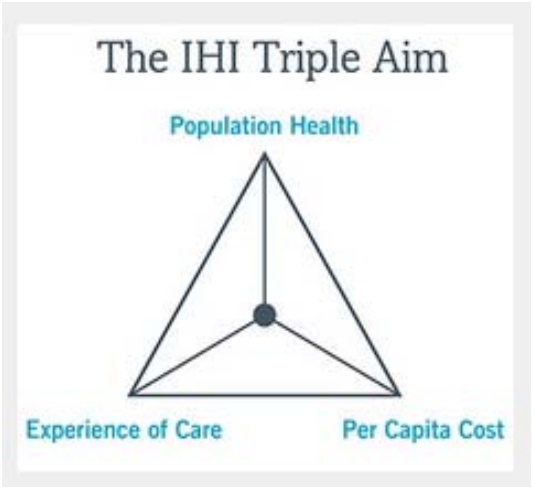
- Policy context
- CMS implementation of IMPACT Act
- Looking ahead
  - Pay-for-performance

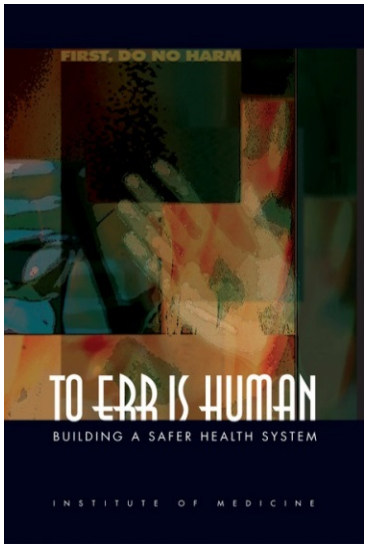
American Hospital Association

Our Shared Goals

- Better health
- Better care
- Greater efficiency



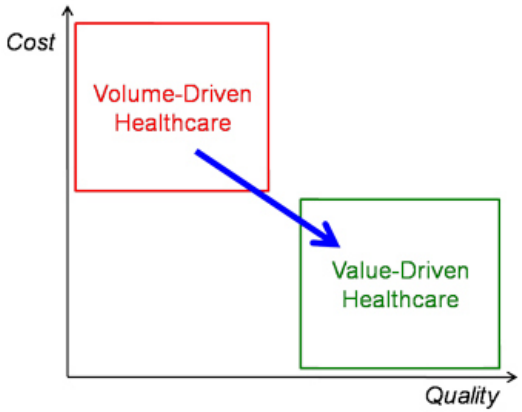




American Hospital Association

Measurement as a Policy Lever

- Data for improvement
- Transparency for patients, policymakers
- Provider accountability



American Hospital Association

Federal Quality Measurement Landscape

= Mandated by the Affordable Care Act

Pay-for-performance

Pay-for-Reporting	Upside and Downside Risk	Payment Penalty Only
Hospitals: • IQR • OQR *Post-Acute Care:* • IRF QRP • LTCH QRP • SNF QRP • HH QRP *Physicians* • PQRS (through 2018) *Other* • ASCQR • IPF QRP • Hospice	*Hospitals* • Value-Based Purchasing *Physicians* • Value Modifier (though 2018) • MIPS/APMs (starting 2019) *Post-Acute Care* • SNF VBP *Others* • Medicare Shared Savings Program • ESRD QIP	*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?

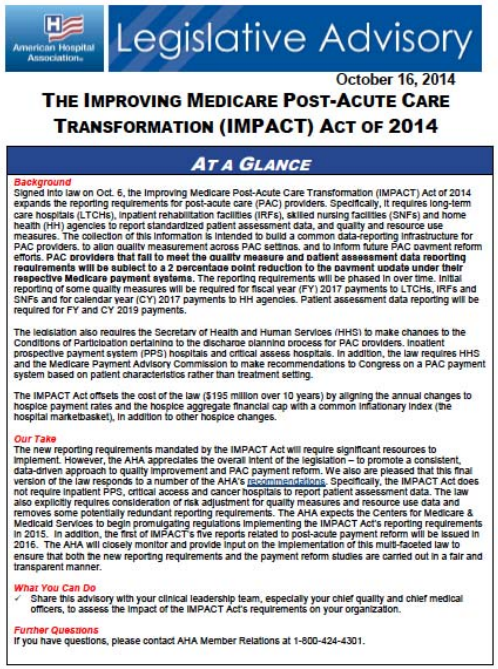
American Hospital Association

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**



American Hospital Association Legislative Advisory

October 16, 2014

THE IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT OF 2014

AT A GLANCE

Background

Signed into law on Oct. 6, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 expands the reporting requirements for post-acute care (PAC) providers. Specifically, it requires long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health (HH) agencies to report standardized patient assessment data, and quality and resource use measures. The collection of this information is intended to build a common data-reporting infrastructure for PAC providers, to allow quality measurement across PAC settings, and to inform future PAC payment reform efforts. PAC **providers that fail to meet the quality measure and patient assessment data reporting requirements will be subject to a 2 percentage point reduction to the payment update under their respective Medicare payment systems.** The reporting requirements will be phased in over time. Initial reporting of some quality measures will be required for fiscal year (FY) 2017 payments to LTCHs, IRFs and SNFs and for calendar year (CY) 2017 payments to HH agencies. Patient assessment data reporting will be required for FY and CY 2019 payments.

The legislation also requires the Secretary of Health and Human Services (HHS) to make changes to the Conditions of Participation pertaining to the discharge planning process for PAC providers. Inpatient prospective payment system (PPS) hospitals and critical assess hospitals. In addition, the law requires HHS and the Medicare Payment Advisory Commission to make recommendations to Congress on a PAC payment system based on patient characteristics rather than treatment setting.

The IMPACT Act offsets the cost of the law ($195 million over 10 years) by aligning the annual changes to hospice payment rates and the hospice aggregate financial cap with a common inflationary index (the hospital marketbasket), in addition to other hospice changes.

Our Take

The new reporting requirements mandated by the IMPACT Act will require significant resources to implement. However, the AHA appreciates the overall intent of the legislation – to promote a consistent, data-driven approach to quality improvement and PAC payment reform. We also are pleased that this final version of the law responds to a number of the AHA's recommendations. Specifically, the IMPACT Act does not require inpatient PPS, critical access and cancer hospitals to report patient assessment data. The law also explicitly requires consideration of risk adjustment for quality measures and resource use data and removes some potentially redundant reporting requirements. The AHA expects the Centers for Medicare & Medicaid Services to begin promulgating regulations implementing the IMPACT Act's reporting requirements in 2015. In addition, the first of IMPACT's five reports related to post-acute payment reform will be issued in 2016. The AHA will closely monitor and provide input on the implementation of this multi-faceted law to ensure that both the new reporting requirements and the payment reform studies are carried out in a fair and transparent manner.

What You Can Do

✓ Share this advisory with your clinical leadership team, especially your chief quality and chief medical officers, to assess the impact of the IMPACT Act's requirements on your organization.

Further Questions

If you have questions, please contact AHA Member Relations at 1-800-424-4301.

American Hospital Association

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

American Hospital Association

IMPACT Act: Quality Measures

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

American Hospital Association

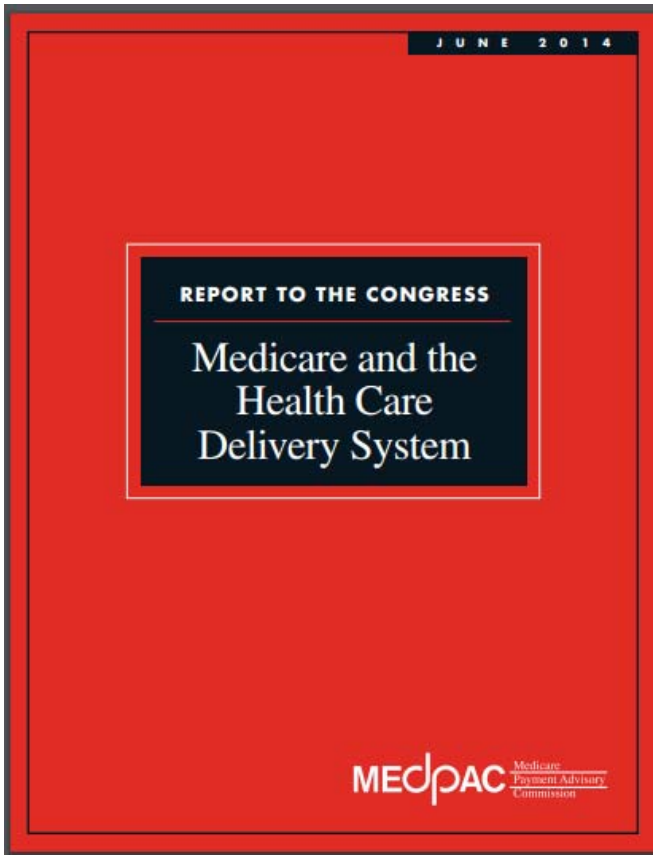
IMPACT Act: Patient Assessment Data Domains

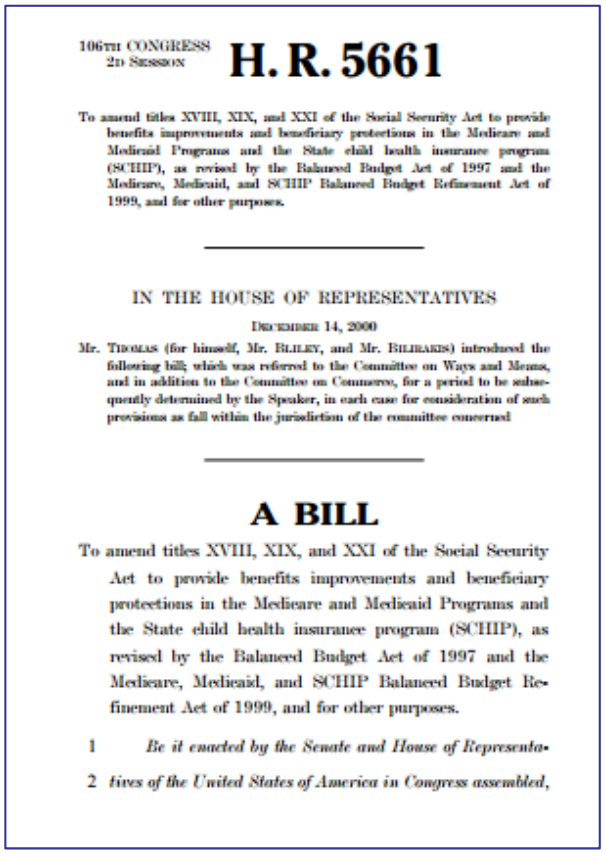
- **Functional status** (e.g., mobility, self care)
- **Cognitive function and mental status** (e.g., depression, ability to understand)
- **Special services, treatments, and interventions** (e.g., ventilator use, dialysis, chemotherapy, central line placement, TPN)
- **Medical condition** (e.g., diabetes, 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

American Hospital Association

Is this déjà vu all over again?

IMPACT Act gives teeth to some existing policy ideas asking for more standardization





106TH CONGRESS
2D SESSION

H. R. 5661

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

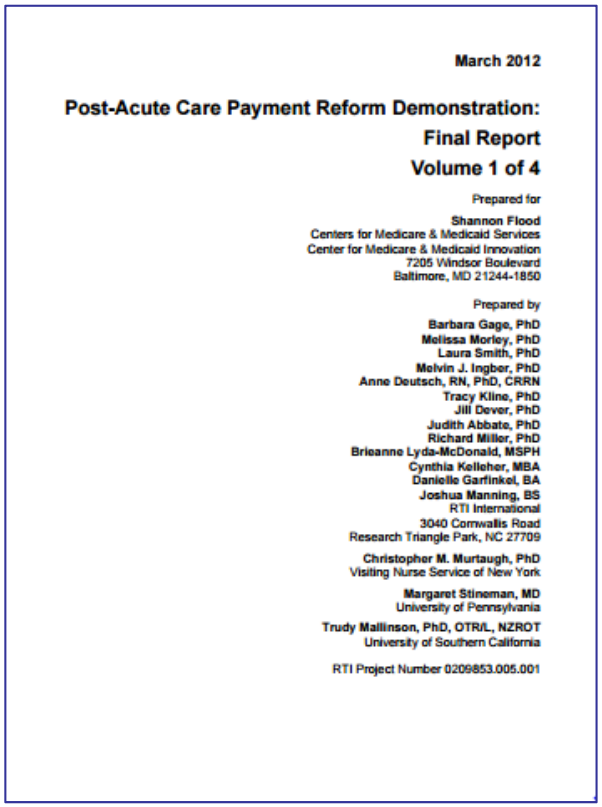
DECEMBER 14, 2000

Mr. THOMAS (for himself, Mr. BILIRAKIS, and Mr. BILIRAKIS) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,



March 2012

Post-Acute Care Payment Reform Demonstration:
Final Report
Volume 1 of 4

Prepared for

Shannon Flood
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
7205 Windsor Boulevard
Baltimore, MD 21244-1850

Prepared by

Barbara Gage, PhD
Melissa Morley, PhD
Laura Smith, PhD
Melvin J. Ingber, PhD
Anne Deutsch, RN, PhD, CRRN
Tracy Kline, PhD
Jill Dever, PhD
Judith Abbate, PhD
Richard Miller, PhD
Brieanne Lyda-McDonald, MSPH
Cynthia Kelleher, MBA
Danielle Garfinkel, BA
Joshua Manning, BS
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

Christopher M. Murtaugh, PhD
Visiting Nurse Service of New York

Margaret Stineman, MD
University of Pennsylvania

Trudy Mallinson, PhD, OTR/L, NZROT
University of Southern California

RTI Project Number 0209853.005.001

American Hospital Association

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

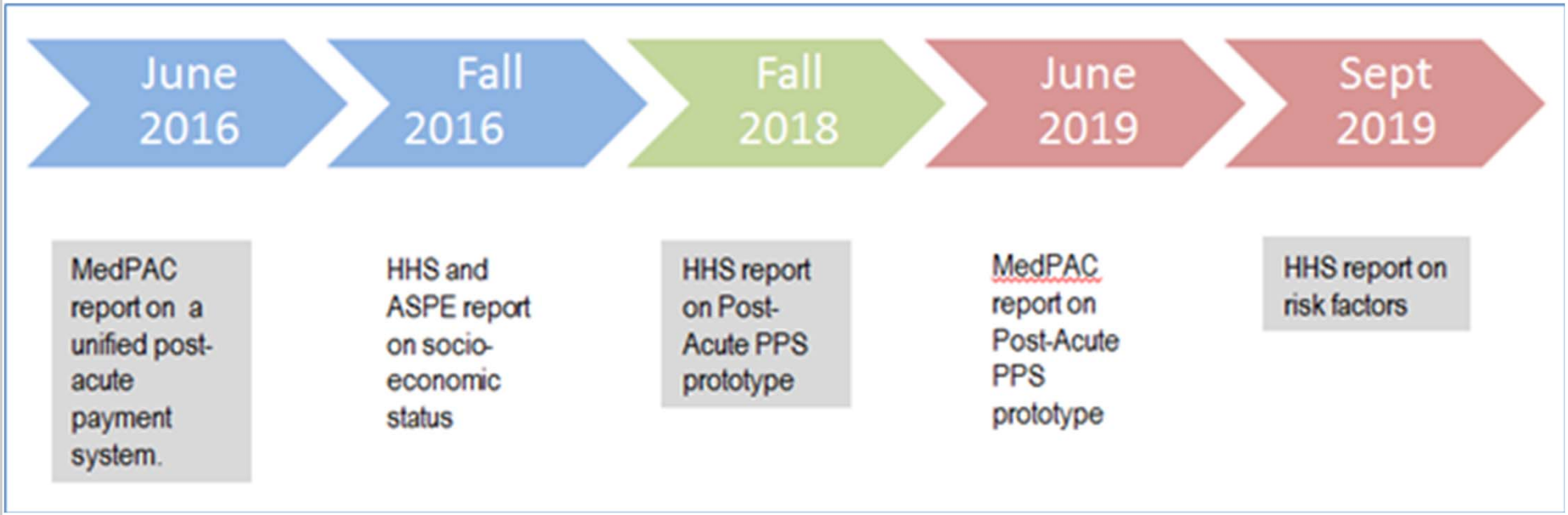
American Hospital Association

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**
  - First report released Dec. 2016
  - Next report due in 2019

American Hospital Association

Timeline for IMPACT Act Payment Reform Reports



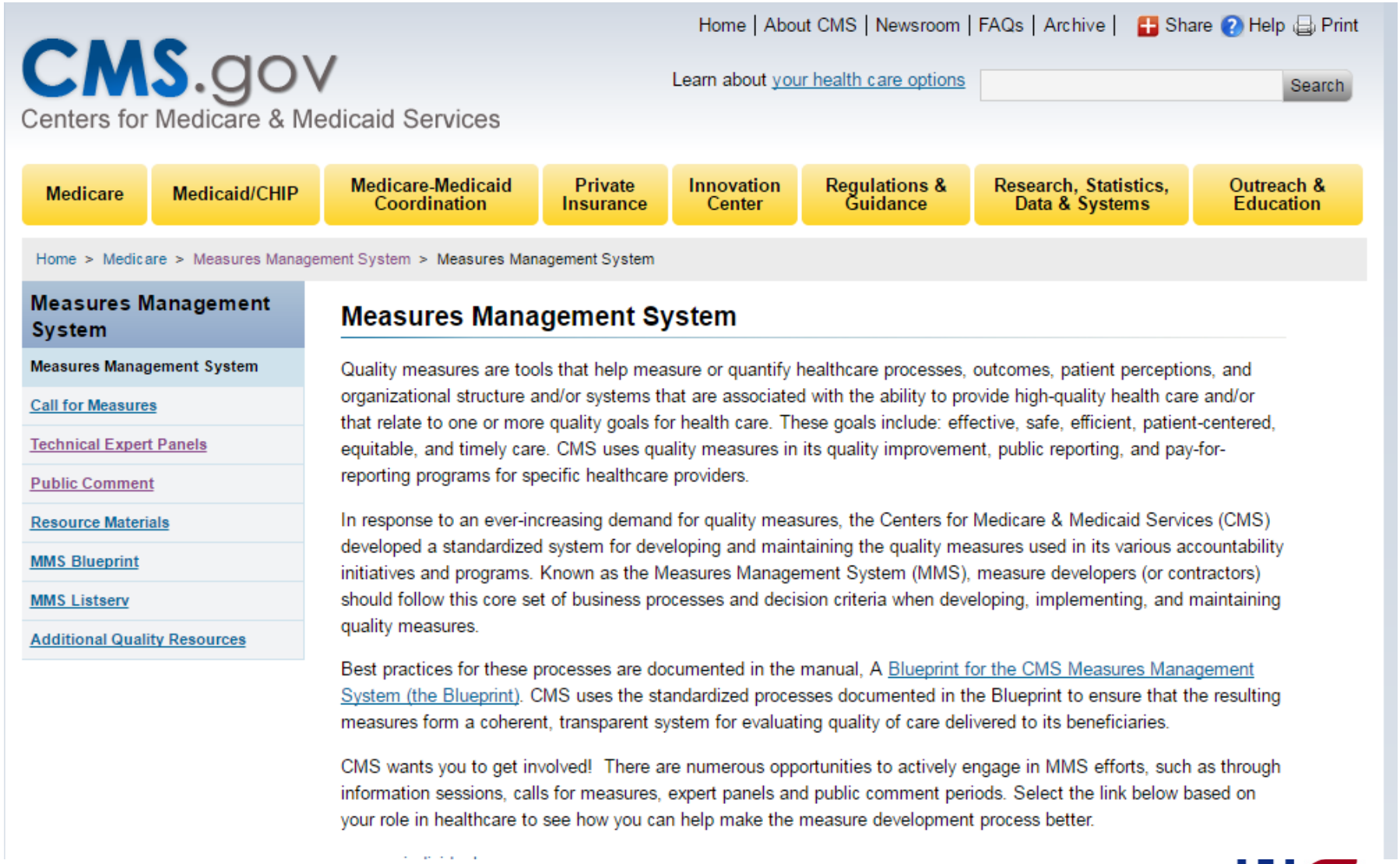
American Hospital Association

IMPACT Act Quality Measures: Administrative Requirements

- 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

American Hospital Association

Measure Development is Ongoing (and Fast-Paced)



Measures Management website

American Hospital Association

Timing of IMPACT Quality Measure Reporting Requirements

	LTCH	IRF	SNF	HH
Functional status	Apr 2016	Oct 2016	Oct 2016	Jan 2019
Skin integrity (i.e., pressure ulcer)	Apr 2016	Oct 2016	Oct 2016	Jan 2017
Medication reconciliation	Oct 2018	Oct 2018	Oct 2018	Jan 2017
Incidence of major falls	Apr 2016	Oct 2016	Oct 2016	Jan 2019
Transfer of health information and care preferences	Oct 2018	Oct 2018	Oct 2018	Jan 2019

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

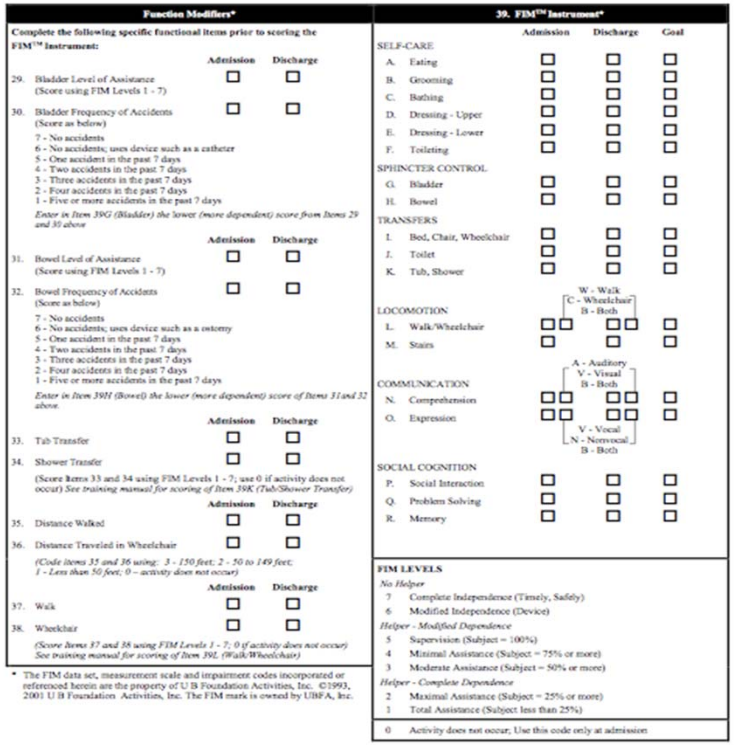
American Hospital Association

Standardizing Functional Assessment: IRFs

- **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



Function Modifiers*

Complete the following specific functional items prior to scoring the FIM℠ Instrument:

		Admission	Discharge
29.	Bladder Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
30.	Bladder Frequency of Accidents (Score as below)	☐	☐

7 - No accidents
6 - No accidents; uses device such as a catheter
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above

		Admission	Discharge
31.	Bowel Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
32.	Bowel Frequency of Accidents (Score as below)	☐	☐

7 - No accidents
6 - No accidents; uses device such as a ostomy
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31and 32 above.

		Admission	Discharge
33.	Tub Transfer	☐	☐
34.	Shower Transfer	☐	☐

(Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) *See training manual for scoring of Item 39K (Tub/Shower Transfer)*

		Admission	Discharge
35.	Distance Walked	☐	☐
36.	Distance Traveled in Wheelchair	☐	☐

(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 – activity does not occur)

		Admission	Discharge
37.	Walk	☐	☐
38.	Wheelchair	☐	☐

(Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) See training manual for scoring of Item 39L (Walk/Wheelchair)

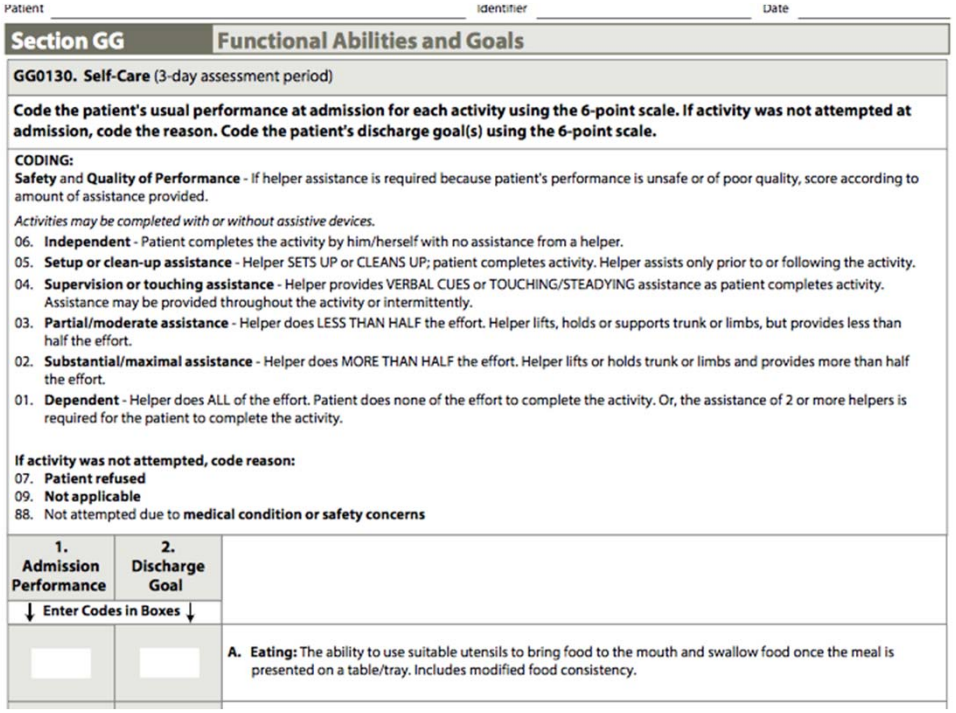
39. FIM℠ Instrument*

		Admission	Discharge	Goal
SELF-CARE				
A.	Eating	☐	☐	☐
B.	Grooming	☐	☐	☐
C.	Bathing	☐	☐	☐
D.	Dressing - Upper	☐	☐	☐
E.	Dressing - Lower	☐	☐	☐
F.	Toileting	☐	☐	☐
SPHINCTER CONTROL				
G.	Bladder	☐	☐	☐
H.	Bowel	☐	☐	☐
TRANSFERS				
I.	Bed, Chair, Wheelchair	☐	☐	☐
J.	Toilet	☐	☐	☐
K.	Tub, Shower	☐	☐	☐
LOCOMOTION	(W - Walk; C - Wheelchair; B - Both)			
L.	Walk/Wheelchair	☐☐	☐☐	☐
M.	Stairs	☐	☐	☐
COMMUNICATION	(A - Auditory; V - Visual; B - Both)			
N.	Comprehension	☐☐	☐☐	☐
O.	Expression	☐☐	☐☐	☐
	(V - Vocal; N - Nonvocal; B - Both)			
SOCIAL COGNITION				
P.	Social Interaction	☐	☐	☐
Q.	Problem Solving	☐	☐	☐
R.	Memory	☐	☐	☐

FIM LEVELS

No Helper
7 Complete Independence (Timely, Safely)
6 Modified Independence (Device)
Helper - Modified Dependence
5 Supervision (Subject = 100%)
4 Minimal Assistance (Subject = 75% or more)
3 Moderate Assistance (Subject = 50% or more)
Helper - Complete Dependence
2 Maximal Assistance (Subject = 25% or more)
1 Total Assistance (Subject less than 25%)

0 Activity does not occur; Use this code only at admission



Patient _____ Identifier _____ Date _____

Section GG **Functional Abilities and Goals**

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale.

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

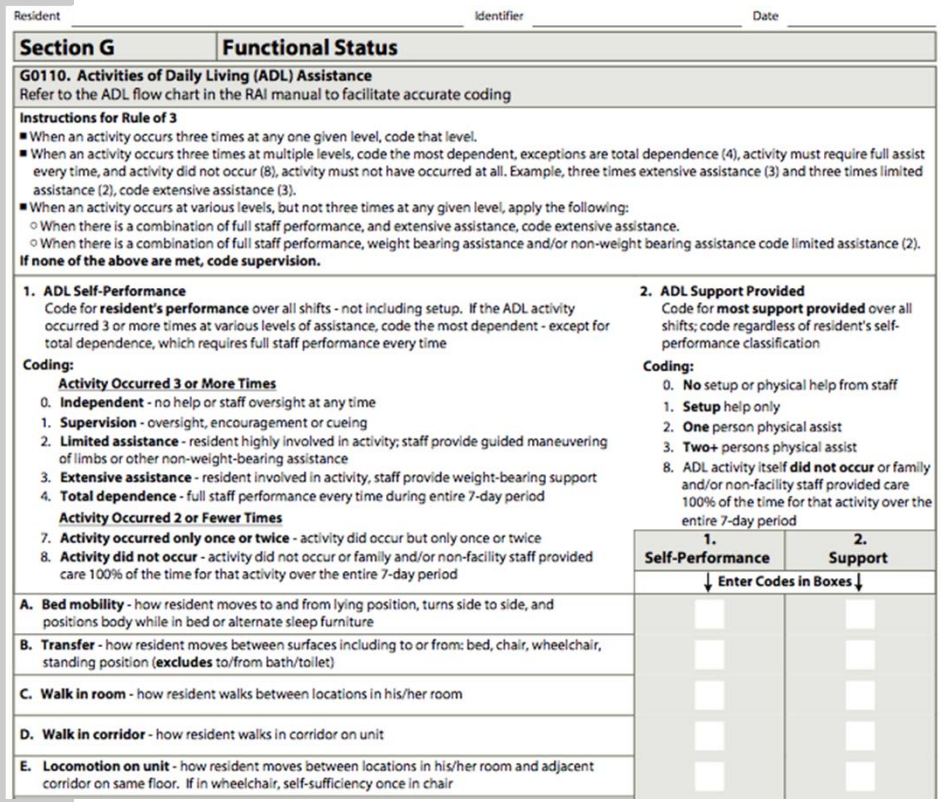
If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. **Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

- 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

American Hospital Association

Functional Status Measurement: Double Trouble for SNFs, Too



Resident _____ Identifier _____ Date _____

Section G | **Functional Status**

G0110. Activities of Daily Living (ADL) Assistance
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3
- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times
0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

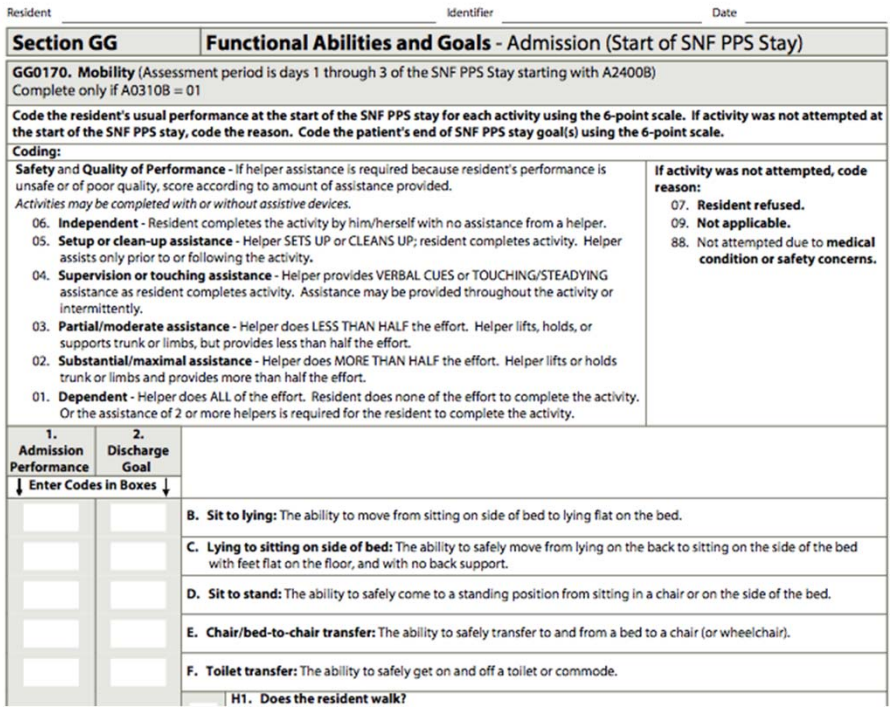
Activity Occurred 2 or Fewer Times
7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:
0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture		
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)		
C. **Walk in room** - how resident walks between locations in his/her room		
D. **Walk in corridor** - how resident walks in corridor on unit		
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		

&



Resident _____ Identifier _____ Date _____

Section GG | **Functional Abilities and Goals** - Admission (Start of SNF PPS Stay)

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6-point scale.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
		C. **Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		D. **Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
		E. **Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
		F. **Toilet transfer:** The ability to safely get on and off a toilet or commode.
		H1. **Does the resident walk?**

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

American Hospital Association

American Hospital Association

Regulatory Relief

The balance between 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

Action	Description
Suspend hospital star ratings	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.***
Cancel Stage 3 of "meaningful use" program	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.***
Suspend electronic clinical quality measure reporting requirements	Hospitals have spent significant time and resources to revise 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 double 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.***

Action	Description
Remove faulty hospital quality measures	Improvements in quality and patient safety are accelerating, but the ever increasing number of conflicting, overlapping measures in CMS programs take time and resources away from what matters the most – improving care. Most recent measure additions to the inpatient quality reporting (IQR) and outpatient quality reporting (OQR) programs provide inaccurate data, and do not focus on the most important opportunities to improve care. ***We urge the Administration to remove all IQR and OQR measures added to the programs on or after Aug. 1, 2014. These measures also should be removed from CMS pay-for-performance programs, such as readmissions and hospital value-based purchasing.***
Eliminate unfair Long-term Care Hospital (LTCH) regulation	With the implementation of site-neutral payments for LTCHs, which began in October 2015 (as mandated by the Bipartisan Budget Act of 2013), the LTCH "25% Rule" has become wholly outdated, excessive and unnecessary. The purpose of the 25% Rule is to reduce overall payments to LTCHs by applying a penalty to selected admissions exceeding a specified threshold, even if the patient meets LTCH medical necessity guidelines. Given the magnitude of the LTCH site-neutral payment cut – a 73% reduction, on average, to one out of two current cases – **CMS should rescind the 25% Rule and instead rely on the site-neutral payment policy to bring transformative change to the LTCH field.**
End onerous home health agency pre-claim review	Home health agencies in five states have been unfairly subjected to a mandatory Medicare demonstration launched in August 2016 that is testing a requirement for pre-claim review. This demonstration adds unnecessary paperwork and delays payment for an estimated 1 million claims per year. ***The AHA urges the Administration to end this onerous demonstration program.***
Restore compliant codes for inpatient rehabilitation facility (IRF) 60% Rule	During the transition to ICD-10-CM, CMS reduced the number conditions that qualify toward compliance under the IRF "60% Rule," which is a criterion that must be met for a hospital or unit to maintain its payment classification as an IRF. Yet certain codes that qualified under ICD-9-CM were inadvertently omitted as a result of the conversion to ICD-10-CM. ***We urge the Administration to restore those codes that counted toward the 60% Rule presumptive compliance test, but lost their eligibility as of June 1, 2016, during the transition to the new coding system.***
Postpone and reevaluate post-acute care quality measure requirements.	Recent laws and regulations are rapidly expanding the quality and patient assessment data reporting requirements for post-acute care providers. The requirements have been implemented aggressively, and without adequate time for stakeholder input. The result is duplicative reporting requirements – such as two different mandated ways of collecting patient functional status data for IRFs – and enormous confusion in the field. ***We urge the Administration to suspend any post-acute care quality reporting requirements finalized on or after Aug. 1, 2015, and to work with the post-acute care community to develop requirements that strike a more appropriate balance between value and burden.***
Withdraw proposed mandatory Part B drug demonstration	CMS has proposed a mandatory Medicare demonstration program that would unfairly hold hospitals financially accountable for the high prices charged by drug manufacturers. ***The AHA urges the Administration to. withdraw this proposed rule.***
Protect Medicaid DSH Hospital Payments	CMS's proposed rule that addresses how third-party payments are treated for purposes of calculating the hospital-specific limitation on Medicaid disproportionate share hospital (DSH) payments could deny hospitals access to needed Medicaid DSH funds. The Medicaid DSH program provides essential financial assistance to hospitals that care for our nation's most vulnerable populations. CMS has

IMPACT Resource Use Measures: Medicare Spending per Beneficiary

- 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

American Hospital Association

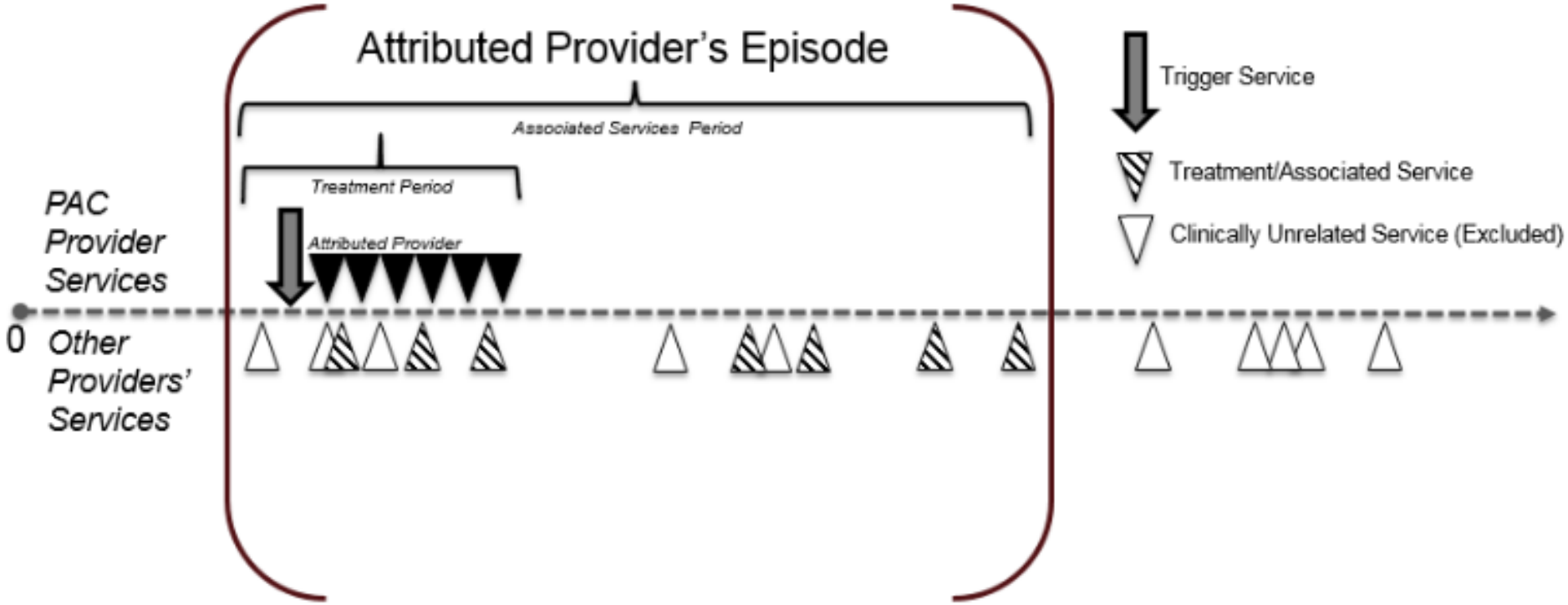
PAC MSPB — Episode Construction

- 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

American Hospital Association

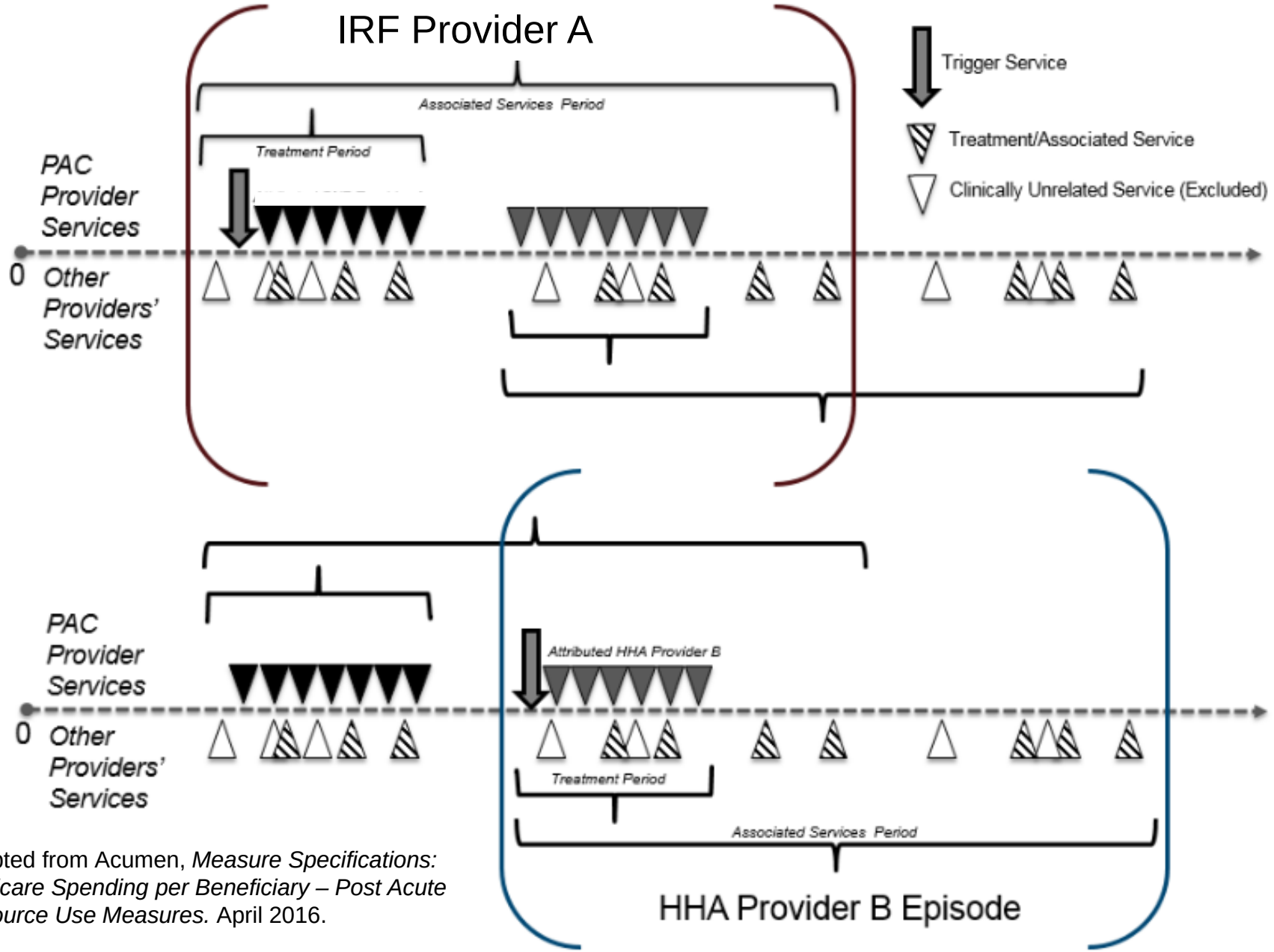
PAC-MSPB Measure Construction



Source: Acumen, *Measure Specifications: Medicare Spending per Beneficiary – Post Acute Resource Use Measures.* April 2016.

American Hospital Association

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**

American Hospital Association

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

American Hospital Association

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**

American Hospital Association

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**

American Hospital Association

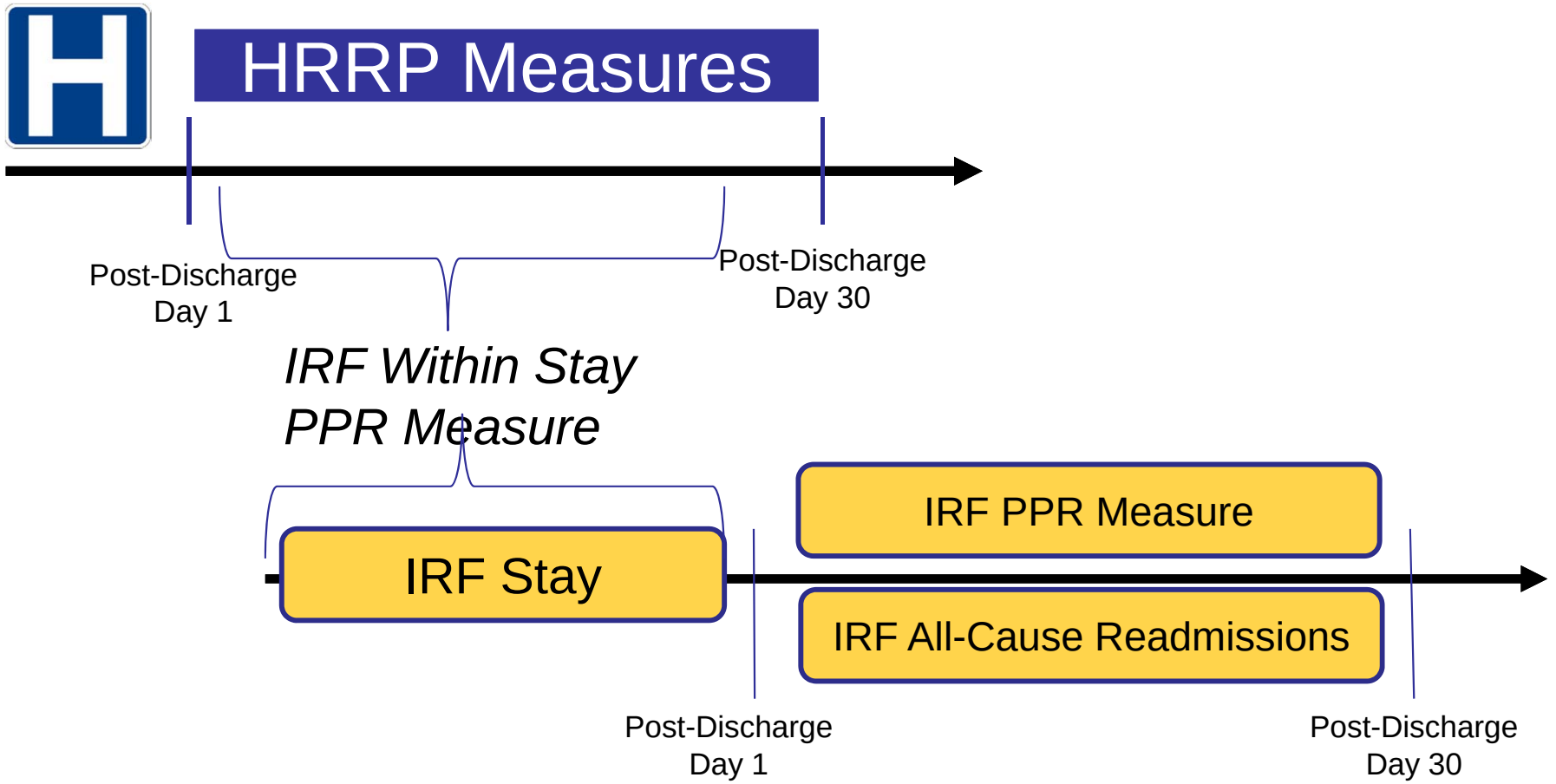
What is Potential Preventable??

CMS uses ICD-9 codes (and preliminary list of ICD-10 codes) codes to define three broad categories of potentially preventable readmissions

PPR Category	Conditions
Inadequate management of chronic conditions	• Adult asthma • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Diabetes short-term complications • Hypertension / hypotension
Inadequate management of infection	• Influenza • Urinary tract infection / kidney infection • *C. Difficile* infection • Sepsis • Skin and subcutaneous tissue infections
Inadequate management of other unplanned events	• Dehydration / electrolyte imbalance • Aspiration pneumonitis ; food/vomitus • Acute renal failure • Arrhythmia • Intestinal impaction • Pressure Ulcers

American Hospital Association

How Many Readmission Measures Do We Need?



American Hospital Association

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

American Hospital Association

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

American Hospital Association

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**

American Hospital Association

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

American Hospital Association

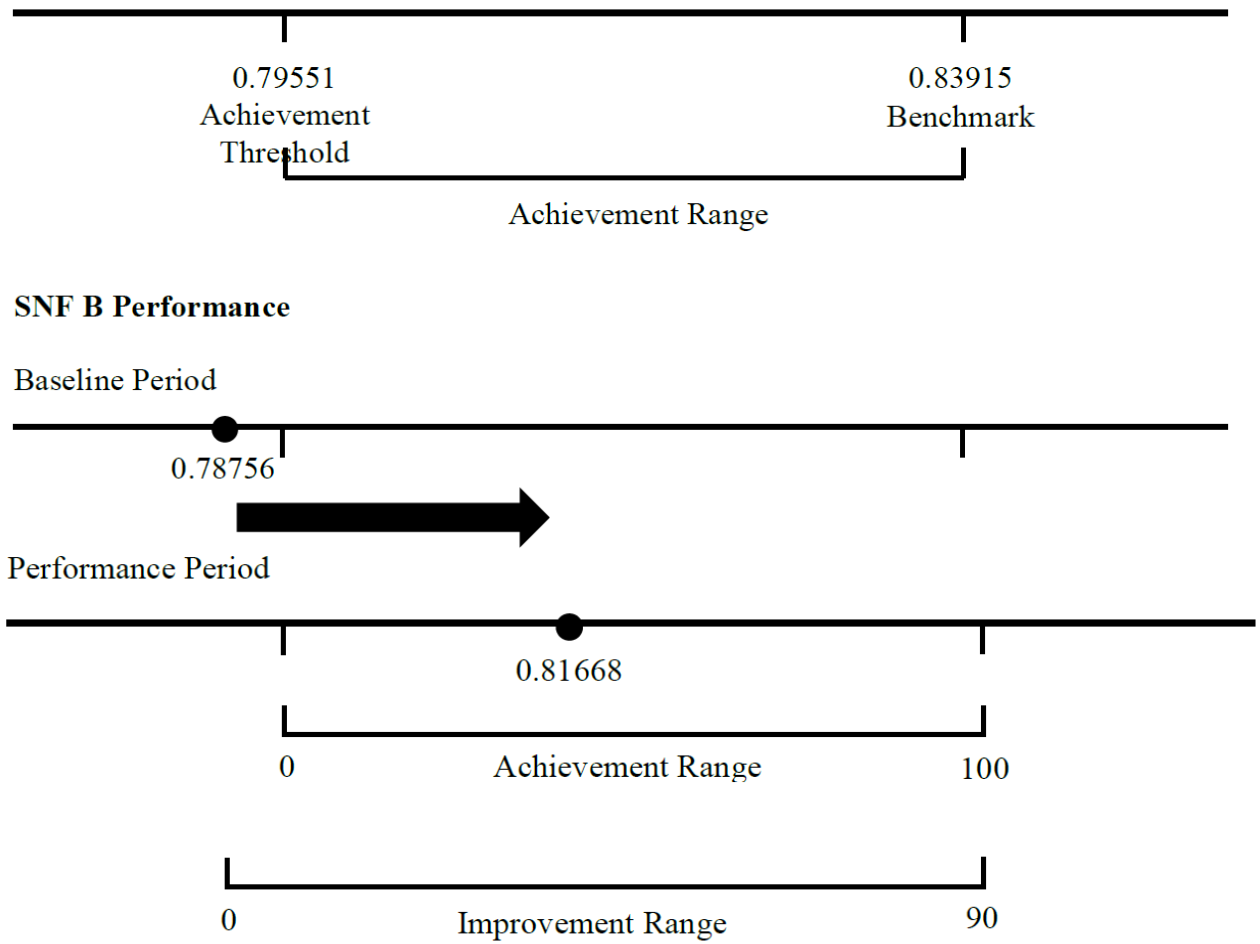
SNF VBP — Improvement Scores

- 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

American Hospital Association

SNF VBP — Proposed Scoring Approach

FIGURE BB: SNF B Performance Scoring



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

Source: FY 2017 SNF PPS Final Rule

American Hospital Association

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

American Hospital Association

HH VBP — Assessment and Payment Adjustment Timeframes

Performance Period	Payment Adjustment Year	Level of Payment Adjustment
CY 2016	CY 2018	+/- 3.0 percent
CY 2017	CY 2019	+/- 5.0 percent
CY 2018	CY 2020	+/- 6.0 percent
CY 2019	CY 2021	+/- 7.0 percent
CY 2020	CY 2022	+/- 8.0 percent

- 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**

American Hospital Association

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

American Hospital Association

September 20, 2016

The Honorable Kevin Brady
U.S. House of Representatives
301 Cannon House Office Building
Washington, DC 20515

The Honorable Ron Kind
U.S. House of Representatives
1502 Longworth House Office Building
Washington, DC 20515

Dear Representatives Brady and Kind:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations – including more than 3,300 institutionally based or affiliated providers of acute long-term care, inpatient rehabilitation facilities, hospitals with skilled nursing and extended care beds, and hospital-based or -affiliated home health agencies – the American Hospital Association (AHA) writes to share our continued concerns regarding H.R. 3298, the Medicare Post-Acute Care Value-Based Purchasing (PAC VBP) Act of 2015. While we appreciate the committee's willingness to make changes to this proposal based on stakeholder feedback, we believe the current changes do not go far enough to address the underlying problems with the legislation.

The AHA supports the concept of VBP programs that tie provider payment to performance. When appropriately designed, VBP approaches can support the transition from volume to value that already is underway in the health care field. Congress passed the Improving Medicare Post-Acute Care Transformation (IMPACT) Act in 2014 to expand the reporting requirements for post-acute care. The collection of this information is intended to build a common data reporting infrastructure for PAC providers in order to align quality measurement across PAC settings and to inform future payment reform efforts. The information that will be collected due to the IMPACT Act will be vital to the creation of any PAC VBP program. Until we have access to reliable, well validated data from the IMPACT Act, moving forward with a PAC VBP program would be premature.

In addition, the current design of the PAC VBP program is too narrowly focused on cutting provider payment rather than promoting "value" – that is, the delivery of consistently high-quality care at a lower cost. The PAC VBP program established in this legislation would withhold 5.0 percent of PAC payments in fiscal year (FY) 2020 and beyond. Regrettably, the program is not budget neutral – only 50 to 70 percent of the withheld funds could be paid back to providers, with the rest being retained by Medicare as savings. The AHA strongly opposes utilizing VBP to achieve reductions in the Medicare program; this proposal must be budget neutral overall and within each PAC payment system. The AHA also is very concerned that the PAC VBP program's payment withhold is too high, and is out of step with other Medicare VBP programs. The acute care hospital VBP program, the End-Stage Renal Disease Quality Improvement Program, and skilled nursing facility VBP program all have maximum withholds of no more than 2.0 percent. Any PAC VBP program should have a payment withhold amount that is consistent with these VBP programs and be developed around a multi-year transition period toward that withhold.

American Hospital Association

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)

American Hospital Association

CHA Post-Acute Care Conference

Measuring Quality:

The IMPACT Act and Beyond

Akin Demehin
Director of Policy
ademehin@aha.org

American Hospital Association

Questions?

Thank you

Akin Demehin

ademehin@aha.org