MEDPAC Medicare Payment Advisory Commission

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Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 310G.05, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Development of discharge to community and potentially avoidable readmission quality measures

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the development of a discharge-to-community quality measure and the development of potentially preventable readmission measures for post-acute (PAC) care providers. We appreciate CMS's ongoing efforts to develop and test quality indicators for the Medicare program.

The discharge to community and potentially preventable readmission measures are required by the Improving Post-Acute Care Transformation (IMPACT) Act of 2014 and Protecting Access to Medicare Act of 2014. The measures aim to reflect the quality of care furnished in the four PAC settings—home health agencies (HHA), skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH). MedPAC fully supports the development of outcome measures that gauge the quality of care across all four PAC settings. In its own work, MedPAC has used both measures to evaluate the quality of care in SNFs and IRFs.

The goal of the cross-cutting measures is to gauge and compare the quality of care provided across PAC settings. As such, it is critical that the measures use a uniform definition, specification (such as inclusions and exclusions), and risk adjustment method. Otherwise, differences in rates could reflect differences in the way the rates were constructed rather than underlying differences in the quality of care. Further, the Commission believes that providers should be held accountable for the care furnished during "their watch" and for safe transitions to the next setting or home. To that end, the Commission's comments focus on additional measures

needed to assess both aspects of care and ways to standardize the measures so that the rates reflect actual differences in the care furnished, not in the measure specification.
The Commission's comments in response to this specific solicitation are organized into three sections: the proposed discharge to community measure, the proposed readmission measures, and issues relevant to both measure sets.

Discharge to community measure

The discharge to community measure is a risk-adjusted rate of FFS beneficiaries who are discharged to the community following a PAC stay and do not have an unplanned hospital readmission (to an acute care hospital or LTCH) during the 31 days following discharge to the community. This measure relies on the discharge status codes on claims to determine community discharge. Our work has indicated that this field is not as reliable as matching claims from one provider with admissions to another to confirm the discharge destination. In its final specification of these rates, CMS and its contractor (RTI International) should consider an approach that verifies discharge destination by matching consecutive claims for the same beneficiary.

Potentially preventable hospital readmission measures

CMS's contractor proposes six measures of potentially preventable readmissions. Four are setting-specific rates of readmissions during the 30 days after discharge from the PAC setting. These measures gauge how well the PAC provider prepares beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting or home. A fifth measure calculates the readmission rate during the first 30 days after discharge from an acute care hospital and admission to a SNF. The last measure gauges the rate of readmissions during IRF stays.

The key problem with these measures is that they do not gauge the rate of readmissions during the stay in HHAs and LTCHs. This is a substantial omission. All PAC providers should be held accountable for readmissions that occur while they are caring for beneficiaries, not just for the period after beneficiaries are discharged from their care. CMS should move as expeditiously as possible to develop measures of readmission rates during stays in HHAs and LTCHs. In addition, HHAs should be held accountable for hospital admission rates for stays that do not have prior hospitalization, which comprise the majority of HHA stays. We urge CMS to develop a measure of hospital admissions that occur during HHA stays.

In addition, there are two problems with the proposed SNF stay measure. First, it gauges readmissions during the first 30 days after discharge from an acute care hospital even though one-third of SNF stays are longer than this period. This could encourage SNFs to delay

readmissions for beneficiaries who require rehospitalization until after the post-period ends. Second, the measure can include a mix of days while the beneficiary is in the SNF and days after discharge from the SNF. The factors (such as diagnoses and comorbidities) that influence the risk of readmission and their importance of the factors may differ for the two periods (during the stay and the post-period). Therefore, separate measures are required and should use separate risk adjustment. Separate measures have the added advantage of giving SNFs more actionable information since the processes and actors differ for the two periods.

CMS plans to test the inclusion of dual eligibility, race, and possibly other measures of socio-demographic status (SES) into the risk adjustment based on work it is conducting on the all-cause readmission rate measures. The Commission has stated that the best way to examine differences in outcomes across providers with varying shares of low-income beneficiaries is to calculate rates without SES adjustment and then compare the rates across providers with similar shares of these patients. This way, the actual readmission rates remain intact. If the rates themselves are adjusted, the reported rates will "adjust away" any differences in outcomes, hide actual disparities in care, and could reduce the pressure on providers to improve care for the poor. We appreciate that the IMPACT Act requires the Secretary to study the effect of SES on quality and resource use measures. We urge CMS to calculate the rates without SES adjustment, divide providers into peer groups (with similar shares of low-income beneficiaries), and compare each provider to its peer group.

Issues relevant to both measures

Accurate risk adjustment requires clinical information about beneficiaries—their diagnoses and comorbidities. A patient's comorbidities can be gathered looking at the prior year's claims (and are captured in the hierarchical condition categories). However, PAC users without a preceding hospitalization will not have clinical information from an immediately preceding hospitalization. For HHA, LTCH, and IRF stays without a preceding hospitalization, CMS should gather diagnostic information from the PAC claim. This will increase the likelihood that a patient's condition is accurately captured.

CMS and its contractor note that the measures for some settings may require pooling data over two years to increase the sample of stays and stability of the measures. It also discusses adjusting rates towards the average for providers with low counts, sometimes referred to as a "shrinkage" methodology because it shrinks the difference between the observed rate and the average. Small counts are not limited to particular PAC settings. Therefore, for each measure, the contractor should establish the minimum number of stays for stable measures and pool data for any provider with insufficient Medicare stays during one year. This will increase the stability of the measures for small providers in any setting. CMS should avoid using shrinkage because it hides the actual rates, thereby undercutting the ability to assess the quality of individual providers.

Consistent with the goal that cross-setting quality measures should be easily compared across settings, the risk adjustment methods for both measures should include the same factors for the four settings. This way, the rates across settings can be compared. If different factors are used in each setting's models, the rates will not be directly comparable because they will have been adjusted for some factors in one setting but a different set of factors in another. Therefore, the Commission urges CMS and its contractor to avoid setting-specific risk adjustment factors (such as prior PAC and emergency department use in the risk adjustment model for HHAs) and factors that cannot be included for each setting's methodology (such as the severity score of the activities of daily living).

The risk adjustment models should also avoid factors that measure service use in the PAC setting because providers can control whether and how much service to furnish. Including measures of particularly discretionary service use could influence the care beneficiaries receive.

Finally, the proposed risk-adjustment methods include a factor for the number of hospital stays during the past year. By controlling for beneficiaries who repeatedly cycle through hospital and PAC stays, the risk adjuster effectively accepts this pattern of care. A PAC provider could have a high rate of potentially avoidable readmissions in the prior year and yet this would improve a provider's readmission rate because the risk adjustment would control for these prior hospitalizations. Including this factor in the risk adjustment model undercuts our ability to assess the quality of care furnished by a provider, and we urge CMS to drop this factor from its risk adjustment model.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the CMS and its contractors. The Commission also values the ongoing cooperation and collaboration between MedPAC and CMS staff on technical policy issues. We look forward to continuing this productive relationship.

To that end, we feel compelled to make a general comment on the timelines for submitting comments in recent solicitations. We are concerned that we are observing a trend towards shorter and shorter comment periods in CMS's recent solicitations for comments and requests for information (RFI). The comment period for this notice is two weeks; the comment period for CMS's recent RFI on the advanced payment models (APM) mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 was 30 days (subsequently extended by two additional weeks).

While we understand CMS's desire to move as expeditiously as possible in its policy development process, we do not believe that the process is well-served by these short deadlines. CMS is requesting information and comments on issues that are both technically complex and that have broad implications for the Medicare program. Stakeholders need sufficient time to digest the issues on which CMS is seeking comment, to develop an appropriate

technical response, and to clear their technical responses through any applicable administrative structures within their organizations. Based on our extensive track record in responding to CMS notices of proposed rulemaking (which we are required to do by law), a 14-day, or even 30-day comment period may be insufficient time to produce well-considered, and optimally useful comments.

We will, of course, make every effort to meet CMS's deadlines for comments or information in response to agency solicitations. However, in cases where the set comment periods are extremely short, we reserve the prerogative of submitting our comments, consistent with our legal mandate, on the best timeline that we are able. We urge CMS, in the interest of engaging the various stakeholders in the policy development process, to grant a full 60-day comment period on major initiatives, whether done through the regulatory process or otherwise, whenever possible.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,

Francis J. Crosson, MD
Chairman

FJC/cc/w