Evaluating patient functional assessment data used in Medicare payment and quality measurement

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November 1, 2018

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Functional status information is used for multiple purposes but may not reflect patients' care needs

- Information is used to:
  - Adjust payments (e.g., function at admission)
  - Gauge provider performance (e.g., change in function)
  - Design care plans
- Providers respond to the incentives of payment policies and quality reporting
- If the recording of functional status does not reflect care needs of patients:
  - Program spending will be unnecessarily high
  - Payments for stays will not be aligned with resource needs
  - Outcomes may appear better than they are

Dimensions of function used to establish current FFS payments

Setting	Dimensions of functional status used to establish payments
HHA	Toileting, bathing, walking, dressing, transferring
SNF	Toileting, eating, transferring, bed mobility
IRF	Toileting, bathing, walking, dressing, transferring, grooming, eating, bladder and bowel control, cognition, communication
LTCH	None

Note: HHA (home health agency), IRF (inpatient rehabilitation facility), SNF (skilled nursing facility), LTCH (long-term care hospital).

Functional status in quality programs

- Functional outcome measures in the quality reporting programs (QRP) vary by setting
  - Self care and mobility (SNF, IRF)
  - Ambulation, bathing, bed transferring (HHA)
  - Mobility of ventilator patients (LTCH)
- Functional outcomes reported on Home Health and Nursing Home Compare websites
- CMS includes functional status in the risk adjustment for some outcomes and settings

Questions guiding this work

- Do the current provider-reported function data appear to be accurate?
- What can CMS do to improve or help ensure the accuracy these data?
- Are there alternative measures of function that would be more accurate?

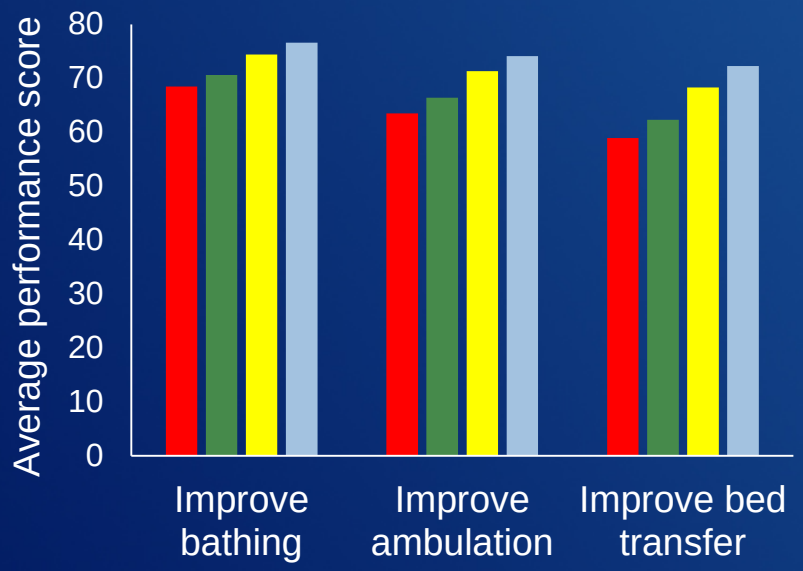
- Should provider-reported function be used to establish payments and measure patient outcomes?

IRFs' reporting of functional status appears related to payment incentives

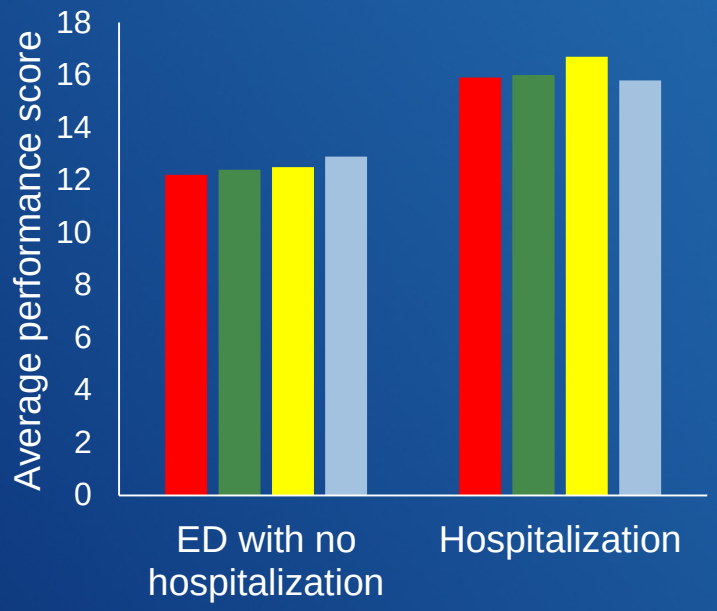
- High-margin IRFs appear to record lower patient function at admission compared to low-margin IRFs
  - Patients had lower acuity during hospital stay but were coded as more disabled once admitted to IRF
  - Stroke example: High-margin IRF patients who were not paralyzed had the same motor impairment score as paralyzed patients in low-margin IRFs
- Assessment and scoring practices contribute to higher profitability of some IRFs

Differences in outcome trends raise questions about the accuracy of assessment data

Provider-reported assessment measures improved over time



Claims-based measures stayed the same or worsened over time



Source: MedPAC analysis of Home Health Compare data.
Data preliminary and subject to change.

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Examples of the responsiveness of PAC providers to changes in payment policy

Setting	Provider response to changes in payment policy
HHA	• Changes in coding when case-mix groups used certain hypertension codes • Therapy visit counts with new thresholds
SNF	• Amount of therapy • Mix of therapy modalities (individual, group, or concurrent)
LTCH	• Lengths of stay extended to avoid the short-stay outlier policy

- If functional status is included in the risk adjustment for payments, the recording of disability is likely to increase even though there will have been no actual change

Work planned to evaluate the functional assessment data

- Compare assessments conducted for the same patient at discharge from one setting and at admission to the next PAC setting

PAC stay #1	PAC stay #2
Patient assessed at discharge	Same patient assessed at admission

- For the same patient, compare assessments of items used for payment versus those used for quality reporting
- Compare assessment information and other beneficiary characteristics

Strategies to enhance provider-reported assessments

- Improve monitoring of provider-reported assessments and penalize misreporting
- Require hospitals to complete discharge assessments for patients referred to post-acute care
- Gather patient-reported outcomes (PROs)

Improve monitoring of provider-reported assessments and penalize misreporting

- Medicare does not currently audit assessment data through medical record review or other methods
- CMS could implement an audit program and penalize providers found misreporting information
  - For example, conduct follow-up activities on providers with aberrant patterns
  - Could use Recovery Audit Contractors (RACs) or Quality Improvement Organizations (QIOs)

Require hospitals to complete discharge assessments for patients referred for PAC

- Medicare could require hospitals to complete a short assessment for patients discharged to PAC providers
- CMS could then compare functional status at discharge from the hospital to the PAC provider's admission assessment
- Would not include community-admitted beneficiaries

Could Medicare collect function measures through PRO tools?

- Examples of using PROs to measure function
  - Improvement or maintenance of physical health from Health Outcome Survey (HOS) used in MA star ratings
    - Commission has expressed concerns about the usefulness of the HOS to detect differences between plans
  - Single-item functional status captured in ACO CAHPS
  - Some health systems collecting PRO functional status before and after interventions
- PROs have growing support but limited research experience, especially with PAC providers

Discussion

- Clarifying questions
- Feedback on
  - Analysis plan
  - Strategies to improve functional assessment and alternative measures