The Evolution of Quality in Medicare Part A

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Statement of
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Good afternoon, Chairman Tiberi, Ranking Member McDermott, and distinguished members of the Subcommittee. Thank you for the opportunity to testify today on Incentivizing Quality Outcomes in Medicare Part A. I am a Health Services Researcher and Associate Professor at George Washington University. Over the years, I have been fortunate to lead many of the Federal studies of Post-Acute Care Payment Reforms and Quality Measurement initiatives funded by the Centers for Medicare & Medicaid Services. These studies have laid the groundwork for understanding the health care utilization trajectories common for the one in five Medicare beneficiaries who are hospitalized each year.

My early work showed that almost 40 percent of all hospitalized beneficiaries were discharged to one of several additional providers, or post-acute providers, for continuing medical or physical rehabilitation treatments during their episode of care. Subsequent work by the Medicare Payment Advisory Commission (MedPAC) shows that number continues to grow. Exhibit 1 shows the national care trajectories in 2008 – following hospital discharge, 37 percent were discharged to home health agencies (HHA), 42 percent were admitted to skilled nursing facilities (SNF); 8.6 percent went to inpatient rehabilitation facilities (IRFs) or hospitals, 1.7 percent to long term care hospitals (LTCH), and another 10 percent to community-based therapy services, either in outpatient hospital settings or other Part B covered therapy offices. About 20 percent of the PAC users were readmitted to the hospital within 60 days of having left the hospital (Gage et al, 2012). More importantly, a substantial number of the PAC patients used multiple PAC services during their episode of care. This work laid the foundation for many of the subsequent initiatives to improve the coordination of care and reduce the costs of the

Medicare program by creating patient-centered initiatives that could hold entities accountable for an entire episode of care, whether it was via medical homes, accountable care organizations, bundled payments, or other efforts to reach the Triple Aim by improving the quality of care, and thereby, reducing costs in the Medicare program.

Congress has passed some very important legislation over the past 10-15 years to move away from policies that focus on the individual silos of care, and instead, create accountable entities to manage a patient's entire episode of care. When Congress passed the Deficit Reduction Act (DRA) of 2005, one directive was to re-align the different parts of the post-hospital service system to improve the management of patient costs and outcomes across an episode of care. It was obvious from related research that patients admitted to the hospital for the same treatment were being discharged to different types of post-acute care settings, depending on the availability of beds and other factors (Gage et al, 2009).

One of the most important directives in the DRA was the development of standardized assessment items to enable consistent measurement of a person's medical status, functional status, cognitive status, and social support system factors regardless of which type of PAC setting the patient used during their episode of care. Under a CMS contract with RTI where I directed their post-acute research program, my team and I worked with clinicians across the country in acute hospitals and each of the four PAC settings to identify the "best" approach for measuring medical, functional, and cognitive status of a patient, regardless of complexity so the patient's severity could be consistently measured and monitored for improvement across an

episode of care. More importantly, standardized data would allow Congress and the Medicare Payment Advisory Commission (MedPAC), to determine whether the Medicare program was paying different rates for the "same" patient treated in alternative PAC settings. The standardized elements were tested for psychometric performance to ensure that only statistically valid and reliable items were considered in subsequent payment and outcomes modeling, including the analysis submitted by the MedPAC this past June in their 2016 Report to Congress on unified PAC payment or case-mix approaches.

In 2014, Congress passed the IMPACT Act which is enabling CMS to implement the standardized data elements in the Federally-required PAC assessment tools so that beneficiary severity of illness can be measured consistently across settings. At this time, many of the standardized elements tested in the Post-Acute Care Payment Reform Demonstration (PAC PRD) are being incorporated into CMS' four individual quality reporting programs (QRP) for PAC. Currently, the LTCH QRP monitors the outcomes of the small number of highly complex patients discharged to LTCHs following at least 3 days in the intensive care unit at the short stay hospital, many with severe infections affecting their respiratory or integumentary areas. The standardized items are being used to adjust for patient severity differences while monitoring LTCH outcomes.

Similarly, the IRF QRP monitors the outcomes for patients discharged to IRFs following short stay hospital treatments for injuries and conditions, such as brain injury, spinal cord injury, neurological conditions such as strokes, Parkinson's Disease, or Multiple Sclerosis, or major

multiple traumas, amputations and other acute conditions. The standardized items are also being incorporated into the assessment tools used to monitor the outcomes of the substantial number of beneficiaries discharged from hospitals to SNFs following hip replacements or treatments for pneumonia or other medical complications following surgery. Home health assessment tools also fall under the IMPACT Act requirements so that regardless of where a patient goes following hospital discharge, the quality of the services and the outcomes associated with care can be consistently measured.

Standardizing the commonly used assessment concepts allows comparison of the severity of patients admitted to different PAC settings as well as comparison of the outcomes, given the potential substitution of PAC settings for continued medical and functional treatment. While some substitution is occurring, the PAC providers also treat significantly different populations whose care cannot be addressed in lower level PAC settings. The standardized assessment items allow for identifying these more complex cases that require the higher intensity, higher cost services provided in the acute-level PAC settings.

One provider that is missing from this effort to consistently measure a patient's acuity across the entire episode of care is the short stay acute hospital. While hospitals were originally included in the IMPACT Act, they were not included in the final legislation. Instead, they were given directives in their conditions of participation to include the type of information PAC providers submit in their discharge summaries but no direction to use the standardized items PACs must submit. However, the episode begins at the short stay hospital and in order to ensure

that hospital patients are discharged to the appropriate setting, it is critically important to understand the medical, functional, and cognitive complexity of the patient before discharging them to the next level of care, a concern that has been underscored since in both research and by the four PAC provider communities. The standardized data are also the foundation for creating exchangeable information when transferring the patient so the PAC provider receives accurate and timely information about the patient when they are admitted for continuing treatment.

I am currently co-directing a CMS contract with the RAND Corporation to further implement the IMPACT Act by testing additional data elements for PAC providers that may be important for monitoring quality and outcomes across settings. Unlike the PAC PRD which tested the reliability of the proposed elements in the acute hospital and PAC settings, the goal of this work is to complement the work underway for the four respective PAC QRPs to ensure that future elements are also reliable and valid when applied in more than one type of setting. Additional work under the IMPACT Act is underway to develop standardized quality metrics for use across the PAC settings. This work is important because hospitals now have numerous incentives under the value-based purchasing programs, the ACOs, and other initiatives to manage the costs of an episode and seek the lowest cost setting for delivering the PAC medical and functional treatments. While this has been a very effective use of market incentives to direct more efficient care, the value or impact of these incentives needs to be carefully monitored. The science of quality measurement has grown extensively over the past 10 years and provides a useful tool for ensuring beneficiaries have access to the high value care expected under the Medicare program.

These past few years we have seen many advances in incentivizing providers to deliver high-quality, cost-efficient care. Readmission rates during later parts of an episode have been dramatically reduced with many taking responsibility for the gains – the Accountable Care Organizations, the Bundled Payments for Care Improvements (BPCI) participants, the Medical Homes, the Value-Based Purchasing programs. Each have contributed by responding to the payment incentives to reach beyond their discharge door and manage the patient costs across the episode. CMS has been expanding these initiatives more recently with the Comprehensive Care for Joint Replacement and the Alternative Payment Models for Oncology but these efforts are limited to certain groups of patients. Medicare beneficiaries who are discharged to PAC tend to have multiple conditions underlying their declining health. Expanding these efforts to other types of PAC populations can further provide hospitals the incentive to provide high performing systems of care. Providers respond to financial incentives. Until financial incentives were tied to the readmission rates and other quality incentives, providers were slow to respond to the quality requirements. Tying payments to minimum quality thresholds to ensure that services are appropriate *and* cost-effective is key to effectively redesigning the Medicare program and not creating access barriers for the most vulnerable Medicare beneficiaries.

As you consider future directions, you now have the science and the tools to not only manage the costs of care as we have done for years in managed care plans, but also to manage the quality of care as the clinical communities reach consensus on standardized terminology to describe the complexity of the patients they treat, and the changes in patient complexity. This scientific gain allows you to tie outcomes into payments with a reassurance that realistic

expectations are being set. Not all beneficiaries will return to a prior state of health, but given the standardized assessment elements called for in the IMPACT Act, we can risk-adjust outcomes in a standard way that will recognize the differences in complexity of the hospital patient discharged to an LTCH, IRF, SNF, or HH. And by incorporating those differences into expected outcomes metrics through risk-adjustment, we can define value by setting realistic expectations for average outcomes given a hospital discharge to an IRF compared to a SNF. Patients who have suffered a stroke, for example, may be discharged to either of the two PAC settings for rehabilitation therapy; however, depending on their complexity, their outcomes may differ significantly (Gage, et al, 2012). And identifying their complexity at time of hospital discharge would level the playing field to ensure the "same" patient is really being sent to lower cost PAC options when differences in outcomes are found. And using consistent quality metrics will allow the PAC providers to prove the value of their relative services.

The IMPACT Act set the platform for measuring value by standardizing language based on the clinical communities' expertise. The various QRPs and VBPs have moved the dial forward by giving providers the incentives to provide high-quality care within their various silos. You now have the tools to move the science forward and create high value, high performing systems of care for even the highest cost, most vulnerable beneficiaries – those discharged to PAC following hospital treatments.

These are complex issues. The healthcare markets are undergoing dramatic change in both the private and public payer programs. The redesign efforts are driving providers to be more

accountable for the patients they treat and not just the care they provide inside their doors. The opportunity to improve care, increase efficiencies without putting beneficiary access at risk, and improve the value of the healthcare provided under Medicare is tremendous.

Thank you for the invitation to speak today. I am happy to take any questions and can also be reached at my office at the George Washington University (bgage@gwu.edu).

References:

Gage, B., Morley, M., Smith, L., Ingber, M., Deutsch, A., Kline, T, Dever, J., Abbate, J., Miller, R., Lyda-McDonald, B., Kelleher, C., Garfinkel, D., and Manning, J. (2012, March). *Post-Acute Care Payment Reform Demonstration: Final Report, Volumes 1 – 4.* Prepared for Centers for Medicare & Medicaid Services.

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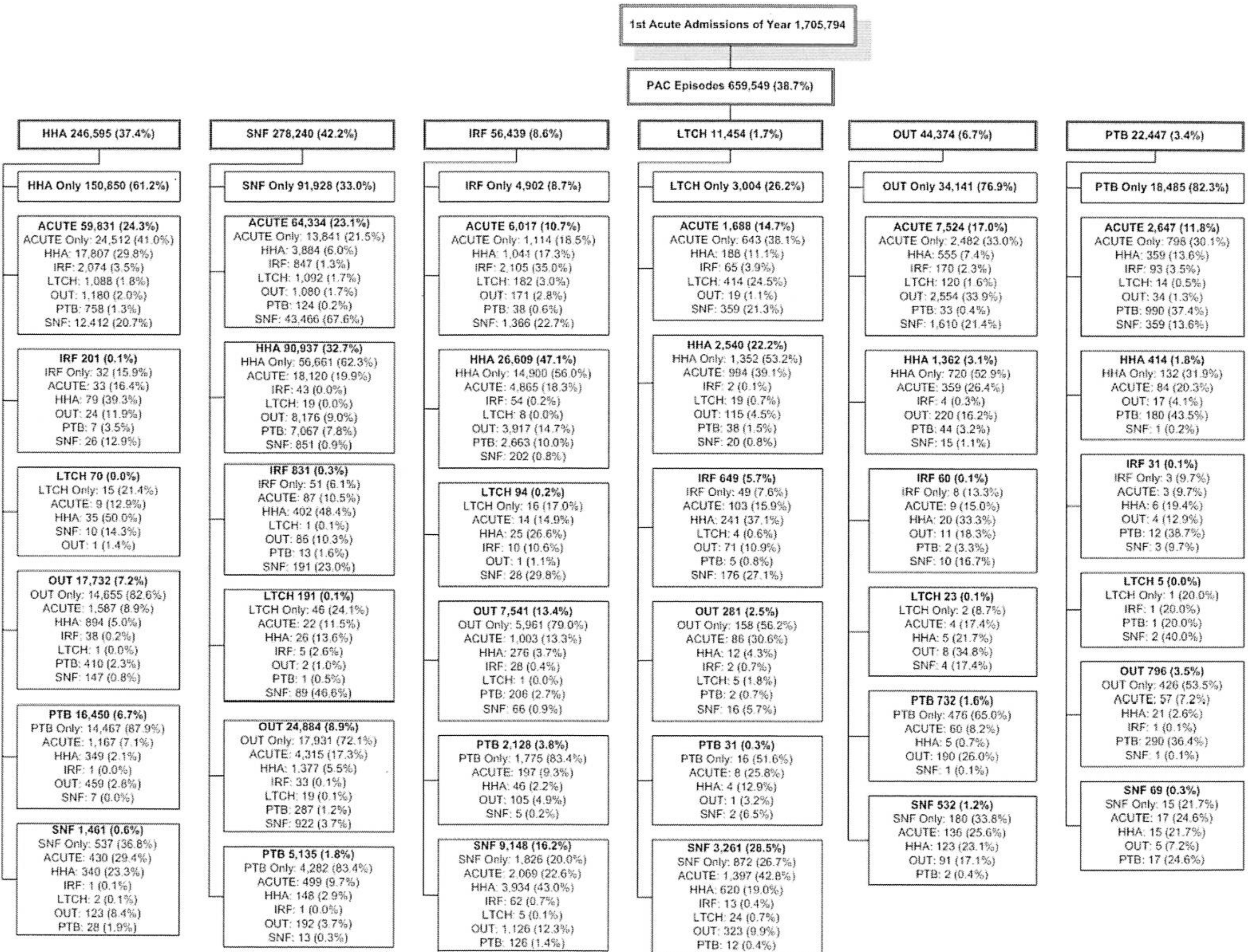
Exhibit 1:
Medicare Post-Acute Care Transitions Following Acute Hospital Discharge, 2008



Source: Post-Acute Care Payment Reform Demonstration Final Report, B. Gage, et al., March 2012, CMS Contract No. HHSM-500-2005-00029I