



March 18, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Slavitt,

On behalf of post-acute care (PAC) consumer and provider advocates, we appreciate your continued leadership in working to preserve the Medicare Trust Fund by promoting innovations in the delivery and payment of PAC services. We are strong supporters of the principles and objectives of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, and remain committed to working with you to ensure that it is implemented to achieve these objectives.

The IMPACT Act established a detailed process to collect critically important data and analyze and synthesize them across PAC settings. The thoughtful analysis of these data and appropriate stakeholder engagement in developing meaningful quality and resource use measures could provide the foundation for significant changes to post-acute quality and payment policies aligned with the triple aims of the National Quality Strategy of better care, smarter spending, and healthier people.

We have serious collective concerns, however, about the implementation process. Since enactment, the Centers for Medicare and Medicaid Services (CMS) has had a compressed timeframe in which to

implement IMPACT Act provisions due to statutory timelines. The unusually hurried pace of the extensive measure development process could create unintended consequences and serious risks to beneficiary safety and access to care. We have a few examples of these concerns and recommendations to address these issues.

First, the Medicare Spending per Beneficiary for Post-Acute Care (MSPB-PAC) measure is currently scheduled to be applied far earlier than is prudent. CMS stated that the measure development process may require up to two years.¹ The measure, however, though only initiated in summer 2015, has a specified application date of October 1, 2016 for inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs) and skilled nursing facilities (SNFs), and January 1, 2017 for home health agencies (HHAs). Furthermore, as seen in the chart below there is insufficient measure specification information available to permit a thoughtful review of the proposed measure, and little or no opportunity for CMS and its contracted measure developers to adequately review the submitted stakeholder feedback prior to the submission to the National Quality Forum (NQF) for review. This opaque process raises questions regarding the consideration given to providers and lacks adequate opportunity for public input, likely leading to the development of flawed quality and resource use measures.

Measure Development Timeline Example – MSPB-PAC Measure
Mid-September – CMS request for technical expert panel (TEP) nominations to react to the MSPB-PAC measure development work to date
October 2 – TEP panelist nomination deadline
October 9-15 – TEP panelist acceptance notifications
October 27 – Some (not all) TEP panelists receive 175-page TEP packet (which did not include fully specified measure information)
October 29-30 – 1.5 day face-to-face TEP meeting
November 18 – TEP panelists receive 5+ page questionnaire of 30 questions requesting feedback on how to develop and specify the measure
November 25 – Due date for TEP panelists to respond to questionnaire
November 27 – CMS issues a list of Measures Under Consideration (MUC) to the NQF Measure Application Partnership (MAP) to comply with Section 1890(a)(2) of the Social Security Act for public comment ² . The list includes 30 measures for IRF, LTCH, SNF, and HH (which we again note did not include fully specified MSPB-PAC measure information)
December 7 – Due date to submit public comments to National Quality Forum (NQF) for MAP endorsement consideration
December 14-15 – NQF MAP PAC/LTC workgroup in-person meeting to consider the MUC list and public comments
January 13 – CMS issues incomplete Draft Specifications titled <i>Medicare Spending Per Beneficiary – Post-Acute Care (MSPB-PAC) Resource Use Measures, Provided for Public Comment</i> and posts a call for sub-regulatory public comment through their measure development contractor with a January 27 close date
January 26-27 – NQF MAP meets and issues final recommendations on PAC IMPACT Act related measures (including MSPB-PAC). Decision on all was to “Encourage further development” rather than endorsement as the measures were considered “early stage” and not “fully developed” with the MAP citing concerns about burden, unintended consequences, et al.
January 27 – On the last day of the Draft MSPB-PAC measure specifications comment period, CMS extends comment period for two days until January 29
February 1 – Three days after the close of the Draft MSPB-PAC measure specifications comment period, CMS again reopens comment period until February 5
February 5 - Draft MSPB-PAC measure specifications comment period closes

The hurried process behind the development of the MSPB-PAC measure demonstrates broader concerns applying to other IMPACT Act measures in development, including discharge to community and readmissions. Unreasonable sub-regulatory seven- and fourteen-day comment period timelines further exacerbate these issues. While CMS has occasionally extended the comment periods, such last-minute extensions would be unnecessary and less disruptive if reasonable and realistic comment periods and implementation timelines were initially provided.

¹ CMS MLN Connects National Provider Call. *The IMPACT Act of 2014 and Data Standardization*. October 21, 2015. <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-10-21-Post-Acute-Care-Presentation.pdf>

² CMS. *List of Measures under Consideration for December 1, 2015*. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/2015-Measures-Under-Consideration-List.pdf>

In addition, we have numerous concerns about the proposed specifications of several other IMPACT Act measures, particularly whether they have been adequately vetted for cross-setting application. Such outcomes measures require time for thoughtful deliberation and testing prior to implementation for quality and payment purposes. Some examples of identified concerns include:

- Measures developed, tested, validated, and endorsed by NQF for the patient population characteristics within one PAC setting (e.g., mobility and self-care) may not be appropriate for the patient population in another PAC setting. Testing, validating, and potentially modifying the measure (e.g., risk-adjustment methodology) so that adequate cross-setting comparisons can be made are necessary steps to insure these measures fairly and accurately compare care across settings. Additionally, the risk adjustment method identified for each measure will have tremendous impact on the reported results and should itself be subject to review and comment.
- Some proposed measures, such as discharge to community, do not adequately address regional variations in Medicare fee-for-service (FFS) versus Medicare Advantage (MA) enrollment and may not reflect a true provider performance profile.
- Several proposed measure specifications are based on outdated ICD-9 diagnosis codes. These were replaced by ICD-10 codes on October 1, 2015 with no conversion system currently provided to translate such specifications.
- The independent and non-aligned development of clinical outcome and resource use measures may result in conflicting patient care performance metrics that, if not fully vetted and mitigated, may result in beneficiary harm or could reduce access to care for beneficiaries with certain characteristics.

This has created confusion and reporting burdens not foreseen by the law and its implementation timeline. CMS has yet to update the setting-specific PAC assessment instruments with common cross-setting measure data items, as required in statute, prior to proposing measures that would use such items. Illustratively, while new IMPACT Act mandated mobility and self-care items were introduced through rulemaking into existing PAC assessment instruments, some of these items are not aligned across settings. In some cases, existing PAC assessment items addressing the same functional domains were not concurrently eliminated, meaning that the same PAC assessment now contains parallel mobility and self-care items, but with differing definitions, scales, and purposes.

To address the above concerns, we request your consideration of the following principles:

- **Fully Specified Measures.** The IMPACT Act requires that data on patient assessment, quality measures, and resource use be standardized and interoperable by using common standards and definitions. We encourage the collection of necessary information for measure development purposes through the identified PAC assessment instruments and other sources. Before any use of a cross-setting outcome measure for quality reporting or payment purposes, however, a measure should be subject to endorsement by a consensus-based entity, and only after fully specified and tested measures have been presented.
- **Validated Measures.** Existing measures that have been endorsed for patient characteristics used in one PAC setting may not provide adequate risk-adjustment for those present in another PAC setting. Failure to validate a cross-setting measure could have unintended consequences on patient care and access, particularly in settings where the adjustments do not adequately identify

meaningful patient characteristic differences. Any proposed cross-setting outcome measure should be validated within and across each PAC setting and endorsed by a consensus-based entity prior to use for quality reporting or payment purposes.

- **Aligned Measures.** Measures not only serve as benchmarks for quality and cost efficiency purposes, they can also be used as a framework to build clinical redesign processes. Measures that do not align with one another across settings, however, could incentivize care choices favoring the improvement of one patient characteristic or clinical pathway to the detriment of another potentially more appropriate option. Before any new cross-setting outcome measure is implemented, the measure specifications must be fully evaluated for potential care delivery incentive conflicts. In particular, resource use measures in isolation can dis-incentivize care and should not be used unless they include clinical and functional items, or otherwise align with other quality measures within and across settings.

Legislative Recommendations:

As a collective, we offer the following details that we believe would improve upon the very important foundation of the IMPACT Act:

- **NQF Endorsement:** The Secretary shall have PAC measures endorsed by NQF before they can be used for payment, public reporting of quality and resource use, and in Five Star (or similar) Rating Systems.
 - In instances where there is no NQF-endorsed PAC measure, the Secretary shall obtain said endorsement within 18 months of proposing to use the measure.
- **Defining Assessment Tool and Data Elements:** The Secretary shall inform the public of the measure's assessment tool and data elements prior to implementation in addition to existing IMPACT Act requirements of informing the public of the measure's numerator, denominator, exclusions, and any other aspects the Secretary deems necessary.
- **Study on Applicability of Quality Measures to all Individuals, Regardless of Payer:** The Secretary shall examine and provide a report to Congress on the practicality and benefits of extending the quality measure population to reflect the care provided to all patients by a provider.

Administrative Recommendations:

Short of legislative changes to the implementation timeline, Congress should encourage the Agency to make the following accommodations:

- **Prospective Schedule.** CMS should provide advance notice in the form of an anticipated timeline for developing all measures required under IMPACT Act rather than release draft measures in different places with limited announcements and no advanced notice.
- **Adequate Opportunity for Comment.** CMS should afford the public a minimum of 30 days to submit comments on proposed measures (including comments submitted to measure development contractors). Shorter time periods, irrespective of last-minute extensions, do not afford the public sufficient time to review and respond to proposed measures and their draft specifications.
- **Instill Greater Transparency.** By allowing its contractors to operate the public comment process, CMS is able to sidestep basic assurances typically afforded to the interested public. In addition to minimum durations for comment periods, CMS should require that all submitted comments be available for public review. While this is standard practice for notice-and-comment

rulemaking, the IMPACT Act measurement development process is a “black box” in which stakeholders are not privy to each other’s comments and the Agency is not required to attend to or otherwise acknowledge any comments received. In addition, we urge CMS to use publicly available data sets to test and validate the measures before they are released and make the results of testing available prior to the comment period. If CMS uses data that are not publicly available, such as the PAC-PRD data, we urge CMS to make those data available as soon as possible to permit external review of measure performance.

We appreciate your consideration of our concerns and proposed principles, which we believe necessitates adjustments to the implementation timeline and oversight of measure development. We look forward to working with you, your staff, and affected stakeholders in ensuring that the IMPACT Act is implemented to achieve its desired objectives.

Sincerely,

American Academy of Physical Medicine and Rehabilitation
American Health Care Association
American Medical Rehabilitation Providers Association
LeadingAge
National Association for Home Care & Hospice
National Association for the Support of Long Term Care
National Association of Long Term Hospitals
National Center for Assisted Living
Partnership for Quality Home Healthcare
Visiting Nurse Associations of America