Alliance Comments on CMS Measures Under Consideration (2015)

MUC ID	Measure Title	Alliance Comments
MUC15-235	Improvement in Dyspnea in Patients with a Primary Diagnosis of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and/or Asthma	The Alliance is supportive of this measure, but is concerned about overlap with existing measures and the absence of measures involving stabilization of function. At present, there is a home health compare measure for improvement in dyspnea for all home health patients. This will provide more specific measurement for CHF, asthma and COPD patients. This measure will capture a subset of the patients included in the existing improvement in dyspnea measure. The Alliance is concerned about the overlap in the measures and these measures raise the issue of whether some measures will be retired where new measures are becoming more focused on subsets of patients. The growing number of overlapping measures has the potential to be confusing for the general public and even those who are using the measures as payers and policy-makers. The ideal is a streamlined, meaningful measure set and the Alliance encourages CMS to make this a goal. In addition, the Alliance continues to be concerned about the exclusive focus of measurement on improvement, to the exclusion of measurement of stabilization. Many home health patients have multiple chronic conditions and two or more ADL limitations. For some, stabilization of function is a legitimate goal of treatment. The Alliance believes this is an important measure gap that must be addressed in the future. Finally, the Alliance urges testing of this measure and reconsideration before it is finalized. Testing and validation should be no less than six months with an opportunity to modify the measure prior to finalizing it. A similar approach was used for many of the OASIS-based measures that CMS uses for home health agencies.
MUC15 - 207	Falls risk composite process	The Alliance supports this measure, but is concerned about the overlap of this measure with

	measure	other existing measures. Currently, there are several home health measures relating to falls risk. A measure on multi-risk fall risk assessment conducted for all patients who can ambulate is in Home Health Compare. Two other measures relating to falls (relating to having the care plan reflect the falls risk assessment, and implementation of the care plan) also appear in the home health CASPER reports. This measure appears to combine aspects of the three existing measures into a single composite process measure. As such, it will capture a subset of the patients included in the existing falls-related process measures. The Alliance is concerned about the overlap in the measures. The question is whether some measures will be retired as appropriate. The growing number of overlapping measures has the potential to be confusing for the general public and even those who are using the measures as payers and policy-makers. The ideal is a streamlined, meaningful measure set and the Alliance encourages CMS to make this a goal. Finally, the Alliance urges testing of this measure and reconsideration before it is finalized. Testing and validation should be no less than six months with an opportunity to modify the measure prior to finalizing it. A similar approach was used for many of the OASIS-based measures that CMS uses for home health agencies.
MUC15 - 1127	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Home Health Quality Reporting Program (Required under the IMPACT Act)	The Alliance supports the use of this measure, but is concerned about the lack of clarity involving the definition of key terms and administrative burden associated with the measure, and the need for adequate testing before such a measure is applied broadly. The Alliance is concerned that there are not clear definitions for the term “potential clinically significant” medication issues, as well as for what constitutes “significant drug interactions,” and “significant side effects,” “any potential adverse

		effects." Greater clarity is also needed to understand what constitutes ineffective drug therapy. Moreover, the Alliance is concerned about burden associated with this measure. The follow up time with the physician or physician designee must be clearly defined, but also adaptive to the risk and urgency of follow-up with a physician. We are also concerned about whether agencies will be penalized if physicians are not responsive to home health agency follow-up. Unfortunately, physicians often are not conscientious about follow up with home health agencies that are reaching out regarding their patients. Finally, the Alliance urges testing of this measure and reconsideration before it is finalized. Testing and validation should be no less than six months with an opportunity to modify the measure prior to finalizing it. A similar approach was used for many of the OASIS-based measures that CMS uses for home health agencies.
MUC15 - 1134	Medicare Spending Per Beneficiary-Post Acute Care (PAC) Home Health Quality Reporting Program (Required under the IMPACT Act)	The Alliance appreciates the importance of developing measures to better understand Medicare cost and resource use. However, when viewed in isolation, the Alliance is concerned that cost information alone is a confusing measure because it does not necessarily correlate with quality of care. The Alliance believes that spending alone is not an indicator of quality, nor is it an indicator of efficiency. The measure will be most useful when paired with quality outcome measures. If outcome measures are not linked to this cost measure, there may be an incentive for providers not to refer patients for reasonable and necessary services, including post-acute care services that can be used to reduce rehospitalization rates and improve patient experience. Ensuring that adequate quality outcome measures are coupled with measures of the cost of care is critical to discouraging underuse. Moreover, there is a need for the development of measures of patient access to care. Reforms that

		are aimed at improving efficient, cost-effective delivery of care are needed, as are measures that will help to encourage efficiency. However, patient access should not be compromised as a means to lower cost. Unfortunately, this measure alone cannot be used to assess whether patients have access to quality care. The Alliance is not aware of any measures at present that would address access to care. We would support development of such measures. Finally, the Alliance urges testing of this measure and reconsideration before it is finalized. Testing and validation should be no less than six months with an opportunity to modify the measure prior to finalizing it. A similar approach was used for many of the OASIS-based measures that CMS uses for home health agencies.
MUC15 - 234	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Home Health Quality Reporting Program (Required under the IMPACT Act)	The Alliance is concerned about the evidence used to support this measure. The evidence regarding post-acute care potentially preventable readmissions is limited (see p. 5 of the measure specifications document that CMS shared on its website). The diagnosis codes identified as potentially preventable in the measure specifications are based on the ambulatory care sensitive conditions that the Agency for Healthcare Research and Quality (AHRQ) has developed. AHRQ's list identifies conditions for which hospitalizations should be preventable if such conditions are well managed in ambulatory care settings. However, the list is not specifically targeted at conditions for which readmissions should be preventable. In other words, it is not clear whether after a hospitalization such conditions are ones for which readmissions should be considered preventable. Hospitalization significantly changes the condition of a patient and may in itself make the patient more likely to experience health risks that make the patient more likely to be readmitted. We are concerned that there is little evidence regarding the ability to prevent a subsequent post-acute care readmission for the ambulatory care sensitive conditions that are the basis of the list of

		diagnosis codes in the measure specifications. The Alliance recommends close analysis of the evidence base for this measure, and that modifications be made accordingly. In addition, patients that have used other post-acute care settings before using home health care tend to have higher severity and are more likely to be at risk for readmission. The measure as described in the specifications would not distinguish among patients that have been to only one post-acute care setting (home health) or three or more different post-acute care settings. The Alliance recommends considering this factor in the risk adjustment for the measure. In addition, the Alliance urges testing of this measure and reconsideration before it is finalized. Both this measure and the discharge to community measure are based on risk-adjusted estimates. Testing and validating this measure will be critical. Testing and validation should be no less than six months with an opportunity to modify the measure prior to finalizing it. A similar approach was used for many of the OASIS-based measures that CMS uses for home health agencies. If finalized, the potentially preventable readmission measure will be the third measure for home health care that involves readmissions. There is already a measure for acute care hospitalization (during the 60-day home health episode), as well as a measure for readmissions from home health care within 30 days of discharge from the acute care hospital. There is overlap among these multiple measures that each capture readmissions. The Alliance recommends that CMS provide context for how it anticipates using or applying each measure. Increasingly, there are different applications for measures and it is unclear as yet how CMS plans to use each one. The Alliance's full comments on this measure's specifications can be found at: http://ahhqi.org/images/uploads/Alliance_Comm

		ents_on_Potentially_Preventable_Readmissions_111615.pdf
MUC15 - 523	Discharge to Community-Post Acute Care (PAC) Home Health Quality Reporting Program (Required under the IMPACT Act)	The Alliance supports the development of this measure, but has concerns that it articulated to the measure development contractors in recent comments. Most significantly, the discharge to community measure is structured as a single measure, but the target populations are not standardized among the various settings. Specifically, the target population for the home health setting is all Medicare fee-for-service persons admitted to home health care. An acute care discharge in the 30 days preceding the start of the home health episode is not required; by contrast, for the SNF, IRF and LTCH settings, the target population is only those who were admitted within 30 days of discharge from an acute care hospital. As a result, for home health settings, the discharge to community measure is not solely a post-acute care measure. Further, as drafted in the specifications, the measure as applied to home health care would be a unique home health measure that is inconsistent with the intent of the IMPACT Act to standardize patient assessment data in post-acute care. If the intent of the IMPACT Act is to be able to compare patient outcomes and characteristics across post-acute care settings, the unique target population for home health care will confound the ability to achieve the goals of the IMPACT Act. The Alliance recommends that the target population for home health match that of the other settings so that only those admitted to home health within 30 days of discharge from an acute care hospital are included in the target population. The Alliance's full comments on this measure can be found at: http://ahhqi.org/images/uploads/Alliance_Comments_on_Discharge_to_Comm_112315.pdf. In addition, the Alliance notes that for the other settings' (SNF, IRF and LTCH) discharge to community measures, both to home health and

		discharge home (without home health) are considered a discharge to community. The Alliance urges stratification that will enable identification of those discharged to home health and those sent to home without home health care. This will enable improved analysis of provider performance and practice in bundled payment arrangements such as the comprehensive care for joint replacement model. The Alliance urges testing of this measure and reconsideration before it is finalized. Both this measure and the potentially preventable readmission measure are based on risk-adjusted estimates. Testing and validation should be no less than six months with an opportunity to modify the measure prior to finalizing it. A similar approach was used for many of the OASIS-based measures that CMS uses for home health agencies.