Alternative Measures to Align with Meaningful Measures Initiatives

Right Measures for the Right Care of Heart Failure Patients

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DEPARTMENT OF MEDICINE

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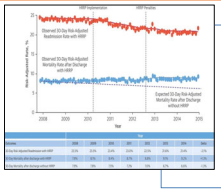
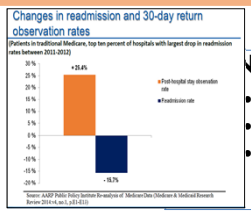
What do we know ?



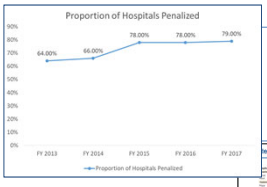
HFH and Mortality

- Mortality is a competing risk with HFH
- Reductions in HFH are not always associated with reduced mortality



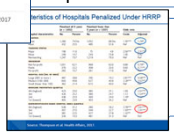
HFH by

- Observations
- Coding
- Defer admission>30d



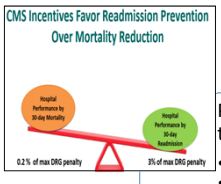
Penalized hospitals

- 79% pf hospitals penalized, % penalized increasing
- Teaching, large hospitals, treating low income/dual-eligible patients more likely to be penalized for readmissions



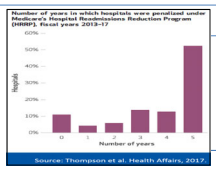
Risk adjustment inadequate for sick and high risk patients

Demographic, diagnostic variables such as race/ethnicity, SBP, HR, BMI, BUN, Creatinine, Na, BNP/NT-proBNP, LVEF, NYHA Class, Mechanical ventilation, Inotropic agent use, socioeconomic status



Penalties for HFH exceed that of mortality

- 528 M in revenue
- HRRP 3 % of max penalty , vs mortality 0.2 % of max penalty



Hospitals are persistently penalized

- all 5 years
- mostly safety net

ARRP Public Policy Institute Re-Analysis of Medicare Data (Medicare & Medicaid Research Review 2014;v4,no1, pE1-E13; Herrin et al., Health Services Research, 2015; Hu et al., Health Affairs, 2014; Glance, et al., Ann Surg., 20Volume 70, Issue 15, October 2017 16. Joynt and Jha, JAMA, 2013; Sheingold et al., Health Affairs, 2016; Gu et al., Health Serv Res., 2014., Thompson et al. Health Affairs, 2017, Fonarow et al. J of the Am Coll of Cardiol:70, Issue 15, October 2017

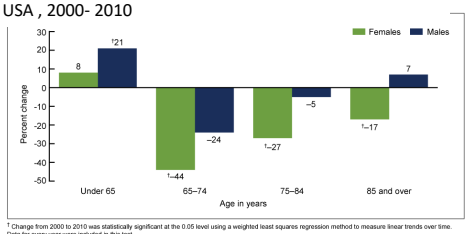
Financial Impact of the HRRP Penalties- National

Year	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Max penalty rate	1 %	2 %	3 %	3 %	3 %
% Hospitals penalized	64 %	66 %	78 %	78 %	79 %
Average hospital payment adjustment (all)	-0.27 %	-0.25 %	-0.49 %	-0.48 %	-0.58%
Average hospital payment adjustment (penalized hospitals)	-0.42%	-0.38%	-0.63%	-0.61%	-0.74%
CMS estimate of total penalties	$ 290 M	$ 227 M	$ 428 M	$ 420 M	$ 520 M

Source : Boccuti and Casillas, Kaiser Family Foundation Issue Brief 2017

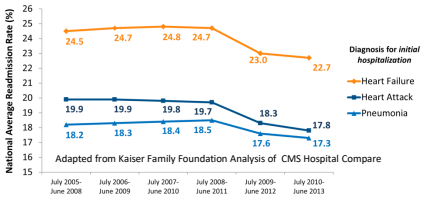
What is driving the change ?

% Change in HF Hospitalization Rates by Age and Sex: USA , 2000- 2010



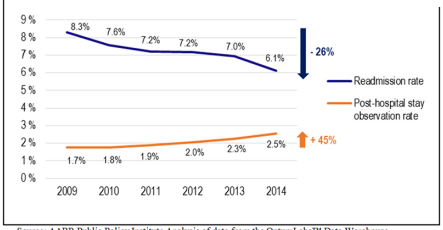
† Change from 2000 to 2010 was statistically significant at the 0.05 level using a weighted least squares regression method to measure linear trends over time. Data for every year were included in this test.
SOURCE: CDC/NCHS, National Hospital Discharge Survey, 2000–2010. Hall MJ et al NCHS Data Brief 108 October 2010

All CMS Core Metrics Related Hospitalizations are Improving since 2012



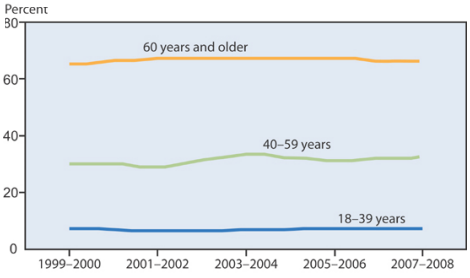
Adapted from Kaiser Family Foundation Analysis of CMS Hospital Compare

Readmission and Observation Rates for Privately Insured Patients (2009-2014)



Source: AARP Public Policy Institute Analysis of data from the OptumLabs™ Data Warehouse.

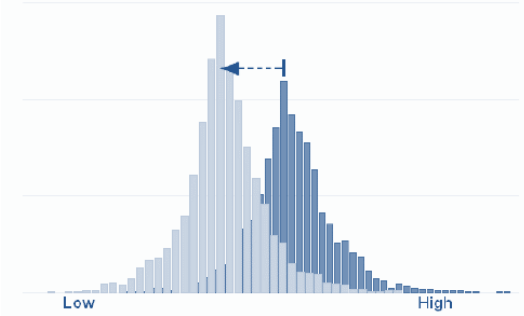
But not HTN (without penalties)



Adapted from the Centers for Disease Control and Prevention

Goals of HRRP

Reduce readmission rates (shifting of the curve)
Reduce variation of hospital performance (narrowing of the curve)



Readmission Rate

CMS Acute Care and Quality Programs, May 2015 National Provider Call,
adapted from Demiralp B. *Medicare's Hospital Readmissions Reduction Conference 2017*

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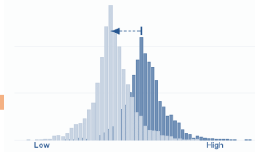
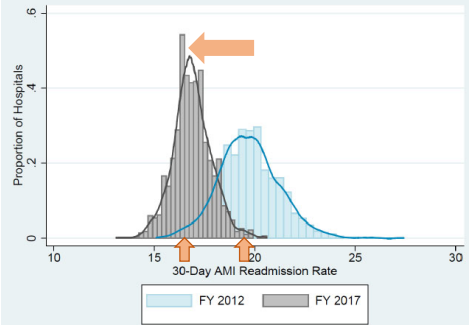
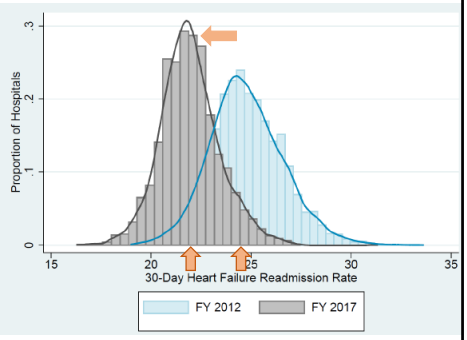


Reduce readmission rates (shifting of the curve)
Reduce variation of hospital performance (narrowing of the curve)





30 Day AMI Readmission Rate

30 Day HF Readmission Rate

reduction in heart failure readmissions smaller (~9%) than anticipated (~25%)

CMS Acute Care and Quality Programs, May 2015 National Provider Call, adapted from Demiralp B. *Medicare's Hospital Readmissions Reduction Conference 2017, analysis from hospitalcompare.gov*

Patient Centered vs *Other* Strategies

Patient Centered Strategies	Other Penalty Avoidance Strategies
• Optimize GDMT • Optimized care coordination • Right model of care for right patient • HF disease management program • HF clinics • Post discharge monitoring • Improved transitions of care • Multidisciplinary care teams • Early post d/c monitoring • Access to palliative care programs	• Upcoding competing dx • Block admissions within 30d of d/c • Observation Units • Placement in non-acute units (CNH, SNF, LTAC) • Hospice / Palliative Care • Reduced /limited care options for socially disadvantaged , high risk, frequently readmitted patients

How do we measure the right approach ?

HF Evaluation & Symptom Management

Guideline Directed Medical and Device Treatment

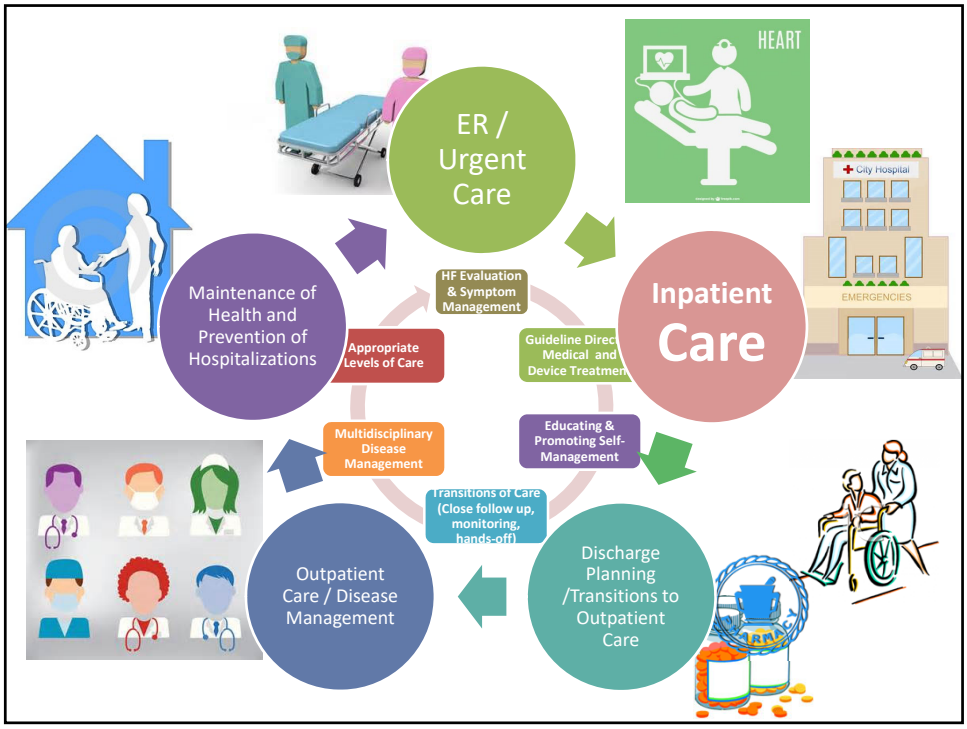
Educating & Promoting Self-Management

Transitions of Care (Close follow up, monitoring, hands-off)

Multidisciplinary Disease Management

Appropriate Levels of Care (Home Based Care, Palliative Care, Advanced Care such as VAD/Tx)

↓ Incident Admissions	↓ Readmissions	↓ Mortality	↑ QoL, Functional, Health Status


ER / Urgent Care
Inpatient Care
Discharge Planning /Transitions to Outpatient Care
Outpatient Care / Disease Management
Maintenance of Health and Prevention of Hospitalizations
HF Evaluation & Symptom Management
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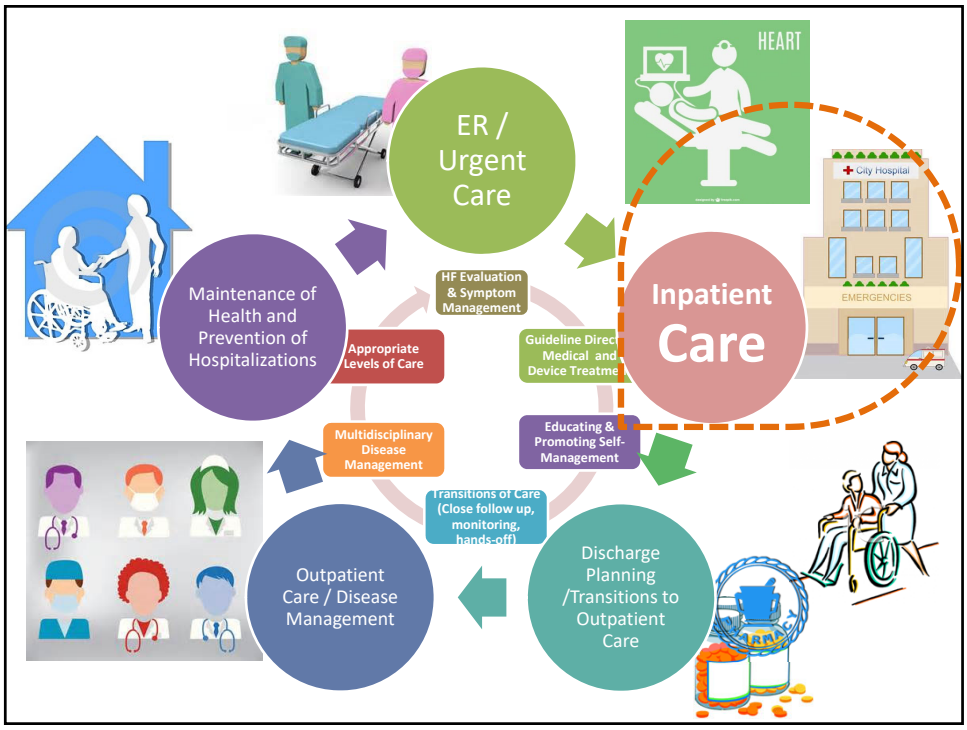
Appropriate Levels of Care
HEART
City Hospital
EMERGENCIES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Alternative Patient Centered Measures

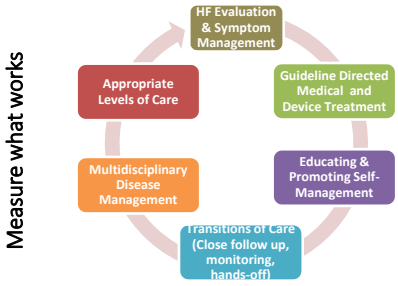
- **Composite** measure of risk adjusted **30 day mortality / readmission**
- Days **alive and outside hospital** over **12 months**
- Days alive, **functional** and outside hospital over 12 months
- Complementary : **Patient health status** and other patient reported outcome measures (PROMS)
- **Prevention: Index HF** admission rates and incident HF rates
- **Excess days in acute care** (EDAC) (ER, obs, UC) after hospitalization for heart failure

❖ Different measures according to stages of disease or different patient phenotypes / goals

Alternative Process Measures

Measurement of development of optimal care delivery models such as

- Establishment of HF clinics, telehealth , utilization of care coordination, and effective communication
- Disease management programs, care transition



Regulatory Changes/ Different Incentivization

- **Right value proposition for penalties/incentives:**
  - Incentivize right care delivery **with the right amount of emphasis**; than focus *largely* on penalties for regulatory performance that may not be associated with quality
  - If penalty obligatory, shouldn't penalties 30 day risk adjusted mortality > those for 30 day readmission rates ?
- Compare hospital performance to a fixed readmission target or prior performance instead of comparing to national average
- **Appropriate risk adjustment models**: demographic, diagnostic variables such as race/ethnicity, SBP, HR, BMI, BUN, Creatinine, Na, NPs, LVEF, NYHA Class, mechanical ventilation, inotropic agent use, socioeconomic

Alternative Legislative Approaches

Have we reached the limits of what hospitals can accomplish in reducing readmissions?

- **Are other value-based models** (e.g., ACOs, bundled payments) more effective in improving value of care ?
- **Legislative Change:** Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program

Existing Implementation Drivers of Care

Payment incentive and penalty programs

- Hospital Acquired Conditions Reduction Program (HAC)
- Hospital Inpatient Quality Reporting (HIQR)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-based Purchasing (HVBP)
- Medicare Shared Savings Program (MSSP)
- Merit-based Incentive Payment System (MIPS)

Proposed Additional Drivers of Care

New Models of Care Delivery and Payment Approaches

- **Existing Model:** HF -**inpatient clinical episode -** payment tied to performance on quality measures
- **Alternative payment models (APMs)**
  - Bundled Payments for Care Improvement-Advanced (BPCI Advanced).
  - Quality Payment Program (QPP)
- **New Model:** HF Disease Management -effective care delivery models that can reduce mortality and/or readmissions.

CMS Meaningful Measures Initiative

Framework links high priority measurements with individual programs or initiatives across the agency. Whether the measures finalized within a program:

- Align with CMS strategic goals while also reducing burden
- Are targeted to outcomes that are most meaningful to patients, families, clinicians, hospitals
- Provide a holistic picture of how the programs and associated measures drive improvements around better health through improved outcomes, cost savings, healthy communities.

19 measurement areas across 6 quality priorities on which measurements intended to focus

1. Making Care Safer by Reducing Harm
Healthcare Associated Infections
Preventable Healthcare Harm
2. Strengthen Person and Family Engagement as Partners in Their Care
Care is Personalized and Aligned with Patient's Goals
End of Life Care According to Preferences
Patients Experience with Care
Patient Reported Functional Outcomes
3. Promote Effective Communication and Coordination of Care
Medication Management
Admissions and Readmissions to Hospitals
Transfer of Health Information and Interoperability

4. Promote Prevention and Treatment of Chronic Disease
Preventive care
Management of Chronic Conditions
Prevention, Treatment, and Management of Mental Health
Prevention and Treatment of Opioid and Substance Use
Risk Adjusted Mortality
5. Work with Communities to Promote Best Practices of Healthy Living
Equity of Care
Community Engagement
6. Make Care Affordable
Appropriate Use of Healthcare
Patient Focused Episode of Care
Risk Adjusted Total Cost of Care

Health Care Delivery Implementers Accountable Stakeholders

Who is able to do what ?

Accountable Care Organization / Systems of Care

CMS MM

1. Making Care Safer by Reducing Harm	Metric
Healthcare Associated Infections	
Preventable Healthcare Harm	
2. Strengthen Person and Family Engagement as Partners	
Care is Personalized and Aligned with Patient's Goals	
End of Life Care According to Preferences	
Patients Experience with Care Patient Reported Functional Outcomes	
3. Promote Effective Communication and Coordination of Care	
Medication Management	**Medication Reconciliation Post-D/C (MIPS, MSSP)**
Admissions and Readmissions to Hospitals	**ACO 37: All-Cause Unplanned Admissions for Patients with Heart Failure (MSSP)**
Transfer of Health Information and Interoperability	
4. Promote Effective Prevention and Treatment of Chr.Disease	
Preventive care	
Management of Chronic Conditions	
Prevention, Treatment, and Management of Mental Health	
Prevention and Treatment of Opioid and Substance Use Disorders	
Risk Adjusted Mortality	
5. Work with Communities to Promote Best Practices of Healthy	
Equity of Care	
Community Engagement	
6. Make Care Affordable	
Appropriate Use of Healthcare	
Patient Focused Episode of Care	

ACO / System of Care

:

- Medication Management
- Admissions and Readmissions to Hospitals

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Hospital/Inpatient

1. Making Care Safer by Reducing Harm	Metric
Healthcare Associated Infections	
Preventable Healthcare Harm	
2. Strengthen Person and Family Engagement as Partners	
Care is Personalized and Aligned with Patient's Goals	
End of Life Care According to Preferences	
Patients Experience with Care	
Pt Reported Functional Outcomes	
3. Promote Effective Communication and Coordination of Care	
Medication Management	
Admissions and Readmissions to Hospitals	▪ **Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following HFH (HVBP)** ▪ **Excess Days in Acute Care after Hospitalization for HF (HIQR)**
Transfer of Health Information and Interoperability	

CMS MM

Hospital/Inpatient

4. Promote Effective Prevention and Treatment of Chr.Disease	
Preventive care	
Management of Chronic Conditions	
Prevention, Treatment, and Mgmt Mental Health	
Prevention and Treatment of Opioid and Substance Use	
Risk Adjusted Mortality	▪ **Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following HFH (HVBP)**
5. Work with Communities to Promote Best Practices of Healthy Living	
Equity of Care	
Community Engagement	
6. Make Care Affordable	
Appropriate Use of Healthcare	
Patient Focused Episode of Care	▪ **Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of- Care For Heart Failure (HF) (HIQR)**
Risk Adjusted Total Cost of Care	

CMS MM

Hospital / Inpatient

- Admissions and Readmissions to Hospitals
- Risk Adjusted Mortality
- Patient Focus Episode of Care

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Physician/Ambulatory

CMS MM

1. Making Care Safer by Reducing Harm	Metric
Healthcare Associated Infections	
Preventable Healthcare Harm	
2. Strengthen Person and Family Engagement as Partners	
Care is Personalized and Aligned with Patient's Goals	▪ **Care Plan (MIPS)** ▪ **Heart Failure: Patient Self Care Education (MIPS QCDR)**
End of Life Care According to Preferences	
Patients Experience with Care	
Patient Reported Functional Outcomes	▪ **Functional Status Assessment for Congestive Heart Failure (MIPS)**
3. Promote Effective Communication and Coordination of Care	
Medication Management	▪ **Medication Reconciliation Post-Discharge (MIPS, MSSP)**
Admissions and Readmissions to Hospitals	
Transfer of Health Information and Interoperability	

Physician/Ambulatory

CMS MM

4. Promote Effective Prevention and Treatment of Chronic Disease	
Preventive care	▪ **Preventive Care and Screening: BMI Screening and Follow-up Plan (MIPS)** ▪ **Preventive Care and Screening: Screening for High BP and F/U Documented (MIPS)** ▪ **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (MIPS)** ▪ **Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (MIPS)**
Management of Chronic Conditions	▪ **HF : ACEI or ARB for LVSD (MIPS)** ▪ **HF: β-blocker Therapy for LVSD (MIPS)** ▪ **HRS-3: ICD Complications Rate (MIPS)**
Prevention, Treatment, and Management of Mental Health	▪ **Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions (MIPS)**
Prevention and Treatment of Opioid and Substance Use Disorders	
Risk Adjusted Mortality	
5. Work with Communities to Promote Best Practices of Healthy Living	
Equity of Care	
Community Engagement	

Physician / Ambulatory

- Care is Personalized and Aligned with Patient's Goals
- Patient Reported Functional Outcomes
- Medication Management
- Risk Adjusted Mortality
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health

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MIPS- Improvement Activities (IAs)

Merit-based Incentive Payment System - complementary to performance measures included in the Quality category

Expanded Practice Access

- IA_EPA_1: Provide 24/7 Access to MIPS Eligible /Groups Who Have Real-Time Access to Patient's Medical Record
- IA_EPA_2: **Use of telehealth services** that expand practice access

Population Management

- IA_PM_11: **Regular Review Practices in Place on Targeted Patient Population Needs**
- IA_PM_13: **Chronic Care and Preventative Care Management for Empaneled Patients**
- IA_PM_14: **Implementation of methodologies for improvements in longitudinal care**
- IA_PM_15: **Implementation of episodic care management practice improvements management for high risk patients**
- IA_PM_16: **Implementation of medication management practice improvements**

Care Coordination

- IA_CC_9: **Implementation of practices/processes for developing regular individual care plans**
- IA_CC_10: **Care transition documentation practice improvements**
- IA_CC_14: **Practice Improvements that Engage Community Resources to Support Patient Health Goals**
- IA_CC_17: **Patient Navigator Program**

Beneficiary Engagement

- IA_BE_1: **Use of certified EHR to capture patient reported outcomes**
- IA_BE_4: **Engagement of patients** through implementation of improvements in patient portal
- IA_BE_15: **Engagement of Patients, Family, and Caregivers in Developing a Plan of Care**
- IA_BE_19: Use **group visits** for common chronic conditions (e.g., diabetes)
- IA_BE_20: **Implementation of condition-specific chronic disease self-management support programs**

Patient Safety and Practice Assessment

- IA_PSPA_16: Use **decision support/standardized treatment protocols** to manage workflow to meet patient needs.
- IA_PSPA_19: Implementation **of formal quality improvement methods, practice changes, or other practice improvement processes**

Achieving Health Equity

- **IA_AHE_3: Promote Use of Patient-Reported Outcome Tools**

Alternative Approaches- Summary

- Alternative Patient Centered Measures:
  - Combined Mortality & HFH,
  - with Health Status and PROM
- Alternative Process Measures:
  - Disease Management ,
  - Care Coordination, HF Clinics
- Alternative Regulatory / Policy Approaches to Penalties / Incentives
  - with emphasis on care and quality rather than predominantly cost
- Enhance Utilization of
  - Alternative payment models
  - Meaningful Measures for HF