Submitted electronically via: ScorecardMeasures@Lewin.com

RE: Project Title: Home and Community Based Services Measures Development, Endorsement, Maintenance, and Alignment: Discharge from Inpatient Facilities to Home-Based Settings for Medicaid Participants

May 24, 2023

Dear Lewin Group,

LeadingAge appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Measures Management System (MMS) proposed quality measure: Discharge from Inpatient Facilities to Home-Based Settings for Medicaid Participants. We represent nearly 5,000 nonprofit, mission-driven aging services providers, including affordable senior housing, life plan communities, nursing homes, hospice, home health and home and community-based services. Alongside our members and 38 state partners, we appreciate the opportunity to provide comment and applaud goals associated with improving the Medicaid Program.

Upon review of the framing document, LeadingAge recommends that the Lewin Group and CMS revisit and clarify the following questions and issues.

This one measure cannot effectively meet the multiple established goals. The intent for the measure covers at least two different purposes -- Assist states in planning for HCBS and track discharge to community. This measure could assist in tracking discharge to community if the measure was better defined for that purpose. It will be less effective in helping states with HCBS planning given the proposed exclusions.

It is unclear how this metric is to be used in HCBS planning. How does knowledge of the number of Medicaid beneficiaries discharged from inpatient settings help states estimate Medicaid HCBS demand? Some of these individuals may receive Medicare home health care to assist with short-term activities of daily living (ADLs) needs, while others upon return to home may have ongoing ADL needs. Wouldn't states need also to account for Medicaid HCBS eligibility, which may be necessary to meet a robust care plan upon discharge to home? This is fundamental and would be required in state HCBS planning.

If the discharge to community metric were to be applied to individuals receiving HCBS, it could help determine the quality or effectiveness of HCBS in preventing rehospitalizations or need for other inpatient facility services. Data accumulated on HCBS effectiveness could be used in future in HCBS planning. As structured currently, the measure appears to judge the quality of the inpatient facilities to discharge to community without factoring availability of HCBS, affordable housing options or social determinant of health barriers.

We also seek clarification about whether this measure is being developed for inclusion in a Medicaid value-based payment program. If this is the case, the measure needs to be more clear on which entity is accountable for the discharge to community (e.g. hospital vs. SNF). Also, if the measure is to incentivize successful discharge to community, how would Medicaid financial incentives work for a Medicare-paid hospitalization? If the metrics are intended to be posted publicly, without proper education of the public, this metric could unfairly sway public opinion away from a particular hospital or affect stakeholder views of quality. This makes it even more

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important to ensure that the measure is risk adjusted or collected separately for 18-64 year olds vs. over 65 year old population.

The measure mingles discharges from acute and post-acute care. This fails to recognize that a person might discharge from a hospital but need post-acute care (PAC) prior to returning home. It has the potential to capture a person's discharge to community status once upon discharge from hospital to PAC and once upon discharge from the PAC.

It remains somewhat unclear to what settings the metric would apply. It seems that for the same individual a hospital could discharge a patient to a nursing home for brief rehabilitation following an inpatient stay. Subsequently, the nursing home completes an intensive rehab regimen, and discharges the individual home. The hospital would see a negative effect on the metric, while the nursing home would see a positive effect though the person receiving care had an optimal outcome. If we are striving towards outcome optimized care, we cannot misattribute discharges to 'home' as successful when stepping down service intensity may better serve the patient. Also, if this measure is meant to assist states in HCBS planning, it would potentially double count the need and therefore, create an inflated need for HCBS, if capturing data from both the hospital discharge and the PAC discharge.

It is difficult to advise on the measure inclusions and exclusions when there are many goals for the measure. For example, if the goal is just to determine how many individuals discharge back to their originating home, then every hospital admission and readmission is probably appropriate. If the goal is to determine HCBS demand, then this data should be tracked by individual.

We have concerns that the attempt of the proposal to apply broadly developed quality measures to a variety of inpatient settings is ill advised. For example, short-stay nursing homes certified by Medicare already have a community discharge measure[1] with specific exclusionary criteria. Should this proposal move forward for providers serving individuals covered by Medicaid, the metrics should be aligned across payers to limit confusion among the public.

We are concerned about some possible unintended consequences of the proposed measure definition. First, by counting discharges from the hospital in the discharge to community, it potentially encourages hospitals to forgo needed post-acute care (PAC) that allows individuals to rehabilitate and recover from their acute condition so they are able to return to and remain in their home. By measuring discharges from inpatient hospital stays, it encourages hospitals to send individuals home over receiving medically necessary care. For example, a stroke patient could conceivably return home but may benefit from therapies to restore function optimizing their ability to live independently[2]. Safe discharge to community-based homes should not be a measure of quality when discharge to rehab could optimize a patient's recovery and improve their functional and cognitive progress. Creating a quality measure that could disincentivize additional rehabilitation is not in the best interest of all patients. One way to remove this potential unintended consequence could be to look at discharges to community following a hospital stay 30 days after the proximal hospital stay. Typically, by this time, an individual would have completed their post-acute care. Alternatively, the measure might exclude hospital discharges for Medicaid beneficiaries requiring post-acute care from the numerator and denominator of the measure, as their discharge to community data will be captured following completion of the post-acute services.

[1] Accessed 5/16/23: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Measure-Specifications-for-FY17-SNF-QRP-Final-Rule.pdf

[2] Accessed 5/12/23: https://www.nih.gov/news-events/nih-research-matters/critical-time-window-rehabilitation-after-stroke

Another potential unintended consequence results from the measure's exclusion of observation stays. By excluding individuals on observation status, it potentially further incentivizes hospitals to not admit individuals for inpatient care. Observation stays are not counted toward the 3-day inpatient stay requirement for an individual to be eligible for skilled nursing facility care. However, individuals don't understand the difference between inpatient and observation status and so are often caught off guard when their SNF care is not covered following hospitalization. The proposed quality measure would also exclude these hospital stays. Under the proposed measure, the individual must first be admitted to a hospital before they can be discharged, therefore individuals on hospital observation stays would not be included in the "all discharges" metric. This could dangerously incentivize even higher rates of observation stay utilization by hospitals. This practice of keeping patients in hospitals on observation stays is costly to patients and the healthcare system and remains confusing for patients and their families.

We are of two minds regarding the inclusion of readmissions. If the goal of the measure is to assist states in determining HCBS need, then it might be preferable to count any hospitalization or inpatient facility care received within the measure window. However, if the goal is to determine successful discharges to the community, then it is appropriate to suggest that those who are readmitted to a hospital do not count as successful discharges. However, in this case, readmissions to inpatient facilities should only be counted as unsuccessful discharges to community when the readmission relates to the purpose of the initial inpatient stay. For example, an individual may initially be admitted to a hospital for a hip fracture, later receive SNF rehabilitative services and then return home only to be admitted two weeks later for congestive heart failure. While this hospital admission would be within the 30-day window, it would be unrelated to the prior hospitalization and as such, should not be counted. For this reason, we believe the proposed metric should be revised to only consider readmissions directly related to the initial inpatient stay as an unsuccessful discharge.

Similarly- would a person that is a 'frequent flyer' be included for each new admission? The term 'frequent flyer' or 'super utilizer' refers to a patient that regularly seeks emergency services or hospital care for chronic, recurring needs in lieu of primary care. If the metric were to exclude readmissions withing 30 days from discharge, would the same person be counted again if they are admitted for the same chronic condition 45 days later, then 45 days later again? CDC reports[3] that approximately 14% of Medicaid enrollees over 65 have diabetes. This is a condition commonly causing repeated hospitalizations if not managed properly.

The proposal excludes discharges for planned admissions from the denominator. While we don't think these planned admissions should be counted as unsuccessful discharges to community (i.e., a true readmission), we also think an argument could be made that one would want to ensure an individual is successfully discharged from a planned admission. For this reason, we would suggest that the definition of "successful" for the purposes of discharges, be amended to state "discharges to home not followed by an <u>unplanned</u> readmission to an inpatient facility…" and remove "planned admission to the inpatient facility" from the denominator exclusions. In many instances, these patients can be successfully discharged home with orders for outpatient or in-home rehabilitation. Additionally, these individuals that have had major surgery could acquire infections or other inpatient acquired adverse events that were the result of poor wound care or infection prevention practices.

The proposal explicitly notes that discharge to an assisted living provider would be a community discharge. Assisted living is not a federally regulated setting and therefore, the types of services it includes varies widely

[3] Accessed 5/16/23: https://www.cdc.gov/pcd/issues/2018/18_0148.htm#:~:text=Medicaid%20is%20especially%20important%20for,%2C%20had%20diabetes%20(4).

across states. There are many settings that would be considered assisted living in one state, but go by a different licensure, nomenclature or setting type in another state. For this reason, we encourage the measure developer to define "assisted living" (AL) by the types of services it provides to ensure consistency and comparability of data across states. For example, is it enough to offer daily meals, housekeeping services and transportation or must it provide support for activities of daily living and medication assistance? Perhaps both of these examples are types of ALs that CMS wishes to include but either way it would be helpful to clarify what is meant by AL.

What data source(s) will be used to calculate this measure? The framing document indicates that claims data will be used but it is not clear if this is Medicaid or Medicare claims data or both. For dual eligible, the hospital stay would be covered by Medicare as would the corresponding SNF stay and therefore, would not be captured through Medicaid claims data review. In addition, it is not clear if the data will include only fee-for-service claims or also managed care claims data. Some states have all-payer databases that might allow for an all-payer claims data review but many don't. In states with heavy enrollment in Medicare and Medicaid managed care plans, use of only FFS data will provide incomplete data and a skewed view of discharge practice patterns. Nationally, Medicare Advantage penetration has reached 50% so limiting quality measures to a FFS only population leaves out 50% or more of the population depending upon the geography. It also make it more challenging to compare results across states.

In addition, we seek further clarification regarding which Medicaid eligible individuals are included in this metric. Is it someone who is fully eligible for Medicaid, or do qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMB), and qualified individuals (QI) also count?

As you consider the data sources, we ask you to balance the importance of the data collection with the administrative burden it may place on providers. Claims data poses no burden unless providers must report this information for Medicaid beneficiaries enrolled in managed care. Alternatively, would these requirements fall on managed care organizations (MCOs) – both Medicaid and Medicare Advantage? If MCOs are intended to assist with this, what about states that remain in fee for service (FFS) for their Medicaid programs, or individuals within a FFS window during Medicaid eligibility determination? In either instance, how is data integrity assured?

The measure covers disparate populations and does not appear to risk adjust. Because the measure proposes to include all Medicaid beneficiaries over the age of 18, the data received from the measure is muddied. The needs of these different age cohorts impacts their ability to return home. A 22-year-old car accident patient may be able to return home with the support of parent caregivers in their home and outpatient physical therapy. On the other hand, an 85-year-old widow with multiple chronic conditions who has no family caregiver support may need skilled care in a SNF to return to a level of function that allows her to return to her home independently.

Data from Kaiser Family Foundation indicates that more than 60% of dually eligible individuals report one or more chronic condition. In addition, Medicaid beneficiaries are generally more clinically complex, have limited income and assets, and often have other social determinants of health that pose barriers to their outcomes and ability to safely return home. Each of these factors in isolation can complicate safe and successful discharge, including availability of a home, a safe and clean home, or tools and resources to manage chronic conditions. Chronic conditions include diagnoses like diabetes. Proper management of diabetes can require self-injection of refrigerated insulin. From this alone, an individual must have adequate vision to read their blood sugar levels and draw appropriate insulin doses. They must have stable electricity to maintain refrigeration for their medication. Understandably, limited income, lack of comprehensive vision coverage, along with other possible challenges like mobility or access to healthy food could make diabetes management very difficult. Discharge to home for this individual may not be appropriate for either a hospital or a nursing home.

Another consideration is whether those Medicaid beneficiaries who already reside in long-stay nursing homes should be excluded from the denominator. The proposed definition suggests that a return to home does not include long-stay nursing home even when this is the person's residence and from where, they originated. Again, if the goal is to determine need for HCBS services in the community then it would make sense to exclude this population from the denominator. This may be what is meant in the exclusions as "length of stay in institution post discharge" though it is not clear as written.

Conclusion

LeadingAge is perennially supportive of outcome measures and in particular, measures that seek to ensure people can return to wherever they call home, when appropriate. We are concerned about implementing the measure as written due to the measure's lack of clarity, purpose, and direction. Further refinements are needed before this measure is implemented. To truly assist states in determining HCBS need, we believe an additional measure is needed that looks at the reason one is or is not discharged to the community. The measure, as proposed, presents an incomplete picture as it fails to capture: 1) the reason one does or does not return to the community; and 2) all hospital readmission/admission data (no Medicare Advantage or Special Needs Plan data). Further, it fails to clearly define which inpatient care settings will be attributed with a successful discharge and whether affected providers' rates will be impacted by this performance.

Without adequate definition of the goal of the measure, it is difficult to ensure this is the best metric for this purpose. We need to know why we need this information, what problem we are trying to solve before we can identify an appropriate measure for the purpose and an adequate definition of the measure. As we question initially, is there a problem with Medicaid eligible individuals with safe and appropriate housing not being discharged to their homes? If this data exists, has it been analyzed to demonstrate both safe and appropriate housing availability? Do the patient characteristics demonstrate that safe and suitable discharge to home with or without services will optimize their recovery from their hospitalization? It is possible that references to COVID-19 in the metric framework were overly distracting, though we have concerns that this mention is the foundational genesis for the metric. If that is the case, we feel the metric is attempting to solve a problem that was not related to inpatient facilities, but the limited understanding of an emergent pathogen.

Thank you for your time and consideration of our comments. LeadingAge would be privileged to remain a resource as work continues on this measure/project.

Sincerely,

Georgia Goodman
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LeadingAge