

MEASURE APPLICATIONS PARTNERSHIP

MAP 2016
Considerations for
Implementing Measures
in Federal Programs:
Post-Acute Care and
Long-Term Care

FINAL REPORT
FEBRUARY 15, 2016



NATIONAL
QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I, Task Order HHSM-500-T0018.

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GUIDANCE ON CROSS-CUTTING ISSUES

Summary

- Measures intended to promote alignment across post-acute and long-term care (PAC/LTC) settings should be tested in the appropriate setting(s) to ensure that specifications and measure intent reflect the specific patient population and acknowledge differences in outcome goals between settings.
- Measure concepts for PAC/LTC settings should reflect the impact of sociodemographic, socioeconomic, and psychosocial issues and encourage patient and family engagement.
- Measures under consideration (MUCs) are moving in the right direction to close gaps and address PAC/LTC core concepts; however, gaps remain in care coordination, transitions in care, and other areas that matter to patients and caregivers.

The Measure Applications Partnership (MAP) reviewed measures under consideration for six setting-specific federal programs addressing post-acute care (PAC) and long-term care (LTC):

- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)
- Home Health Quality Reporting Program (HH QRP)
- Hospice Quality Reporting Program (Hospice QRP)

MAP's pre-rulemaking recommendations for measures in these programs reflect the MAP Measure Selection Criteria, how well the measures address the identified program goals, and NQF's prior work to identify families of measures. MAP also drew upon its [Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement](#) as a guide to inform pre-rulemaking review of measures for the PAC/LTC programs. In the PAC/LTC coordination strategy, MAP defined high-leverage areas for performance measurement and identified 13 core measure concepts to address each of the high-leverage areas. The majority of MUCs continue to be early in development. MAP was provided with preliminary analysis and staff recommendations on MUCs for workgroup consideration. In some instances (SNF and Home Health), measure details were updated immediately prior to the meeting and updates

were described verbally during the PAC/LTC workgroup meeting.

In this year’s pre-rulemaking work, MAP revisited their PAC/LTC core concepts to ensure that they remain effective and meaningful in the rapidly changing work of post-acute and long-term care measurement. MAP made key revisions to the PAC/LTC core concepts. The MAP PAC/LTC Workgroup added quality of life as a highest-leverage area and identified symptom management, social determinants of health, autonomy and control, and access to lower levels of care. The workgroup stressed the need to move beyond concepts addressing processes to concepts that assess outcomes. For example, MAP updated the *establishment* of patient/family/caregiver goals to the *achievement* of patient/family/caregiver goals. Finally, the workgroup noted the need to make patients and their families partners in their own care and added education as a core concept to help ensure they have the tools they need.

Throughout the discussion of the individual measures across the six programs, MAP identified several overarching issues. These themes are explored below.

TABLE 1. PAC/LTC HIGHEST-LEVERAGE MEASUREMENT AREAS AND CORE MEASURE CONCEPTS

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	<ul style="list-style-type: none"> • Functional and cognitive status assessment • Mental health
Goal Attainment	<ul style="list-style-type: none"> • Achievement of patient/family/caregiver goals • Advanced care planning and treatment
Patient and Family Engagement	<ul style="list-style-type: none"> • Experience of care • Shared decisionmaking • Patient and family education
Care Coordination	<ul style="list-style-type: none"> • Effective transitions of care • Accurate transmission of information
Safety	<ul style="list-style-type: none"> • Falls • Pressure ulcers • Adverse drug events
Cost/Access	<ul style="list-style-type: none"> • Inappropriate medicine use • Infection rates • Avoidable admissions
Quality of Life	<ul style="list-style-type: none"> • Symptom Management • Social determinants of health • Autonomy and control • Access to lower levels of care

OVERARCHING THEMES

Implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act

The IMPACT Act was passed in September 2014 and requires PAC providers to report standardized patient assessment data as well as data on quality, resource use, and other measures. The standardized measures address several domains including functional status and changes in function, skin integrity and changes in skin integrity, medication reconciliation, incidence of major falls, and the accurate communication of health information and care preferences when a patient is transferred. Additionally, the IMPACT Act requires the implementation of measures to address resource use and efficiency such as total Medicare spending per beneficiary, discharge to community, and risk-adjusted hospitalization rates of potentially preventable admissions and readmissions. PAC programs affected by the IMPACT Act include the HH QRP, SNF QRP, IRF QRP, and LTCH QRP.

Measures implemented to meet the requirements of the IMPACT Act are mandated to go through the MAP pre-rulemaking process. Measures reviewed by MAP during this cycle addressed the following IMPACT Act measure domains:

- Medication reconciliation;
- Resource use measures, including total estimated Medicare spending per beneficiary;
- Discharge to community; and
- All-condition risk-adjusted potentially preventable hospital readmissions rates.

The IMPACT Act is an important step toward measurement alignment and shared accountability across the healthcare continuum, which MAP has emphasized over the past several years. MAP supports the alignment of measurement across

settings using standardized patient assessment data and acknowledges the importance of preventing duplicate efforts, maintaining data integrity, and reducing the burden of maintaining data on different scales. Both MAP and the public recognized the challenging timelines required to meet IMPACT Act requirements, but also had concerns about supporting measures with specifications that have not been fully defined, delineated, or tested. Overall, the MUCs introduced represent significant progress toward promoting quality in PAC settings, but there was some caution in considering the costs-per-beneficiary measures as indicators of quality. MAP recommended ensuring cost measures be tied to quality concepts and thus promote measuring “value” versus “cost” alone.

Public comments generally supported the MAP recommendations for the IMPACT Act MUCs and are summarized below for the IMPACT Act domains.

Medication Reconciliation. Commenters agreed about the importance of the Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care measure, but expressed concerns about key terms lacking clear definitions and administrative burden associated with the measure. Commenters encouraged robust testing of this measure and reconsideration before it is finalized and implemented in the respective PAC/LTC programs.

Medicare Spending Per Beneficiary – Post-Acute Care. For this measure, commenters agreed with the workgroup on the importance of balancing cost measures with quality and access, as spending alone is not an indicator of quality and efficiency. A concern raised was the potential for unintended consequences, particularly premature discharges. Commenters encouraged testing of this measure and reconsideration before it is

finalized. Specifically, commenters suggested reconsideration in three areas: (1) the inclusion and expansion of the risk adjustment methodology to ensure capture of sociodemographic and socioeconomic factors, (2) the consideration of episode cost differences between PAC settings and regionally within a setting, and (3) ensuring that reporting will be meaningful to patients.

Potentially Preventable 30-Day Post-Discharge Readmission. Commenters supported MAP's recommendation to "encourage continued development." One commenter noted a lack of evidence supporting 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. Other commenters expressed concerns with the potential overlap between readmission measures, the need for testing and validation of this measure, and the need for appropriate risk adjustment. Finally, concerns were raised about cross-setting comparisons of this measure in light of the different patient populations served by the various PAC/LTC settings. Commenters suggested the use of assessment data to capture patient distinctions appropriately.

Discharge to Community-Post Acute Care. Commenters generally supported MAP's recommendation to "encourage further development," but noted that while this measure addresses functional improvement, it does not address the practical value of the measurable improvement or the ability of a patient to return to the community. In addition, a commenter indicated that as specified, the measure does not reflect different discharge goals of the various PAC/LTC settings. Specifically, it was noted that for LTCH the discharge goal may not be to the community, but to a less intensive level of care. Several commenters strongly urged that the measure be appropriately risk adjusted, tested, and validated prior to implementation; in addition, they urged CMS to consider how to differentiate

the discharge-to-community measure from other readmission measures currently included in PAC/LTC programs.

Shared Accountability Across the Care Continuum

The IMPACT Act requires the implementation of measures to address risk-adjusted hospitalization rates of potentially preventable admissions and readmissions. The IMPACT Act also requires the implementation of measures focused on discharge to community from the various PAC settings. The inclusion of both types of measures (e.g., admission, readmission, and discharge to community) in the PAC/LTC programs raises issues of shared accountability across the care continuum. MAP raised questions about the importance of incentivizing creative and improved connections in post-acute and long-term care with hospital care. In its guidance on the selection of avoidable readmission measures, MAP stressed the need to promote shared accountability, engage patients and caregivers as partners, ensure effective care transitions, and communicate effectively across transitions. In addition, the importance of recognizing the uniqueness and variability of care provided by the home health industry was highlighted. During this cycle of pre-rulemaking, MAP stressed the importance of hospitals and PAC/LTC settings working together to reduce avoidable admissions and readmissions and recognizing that discharge-to-community measures require further development to ensure that they are defined appropriately for each setting and that they achieve intended results.

MAP reiterated the importance of successful care transitions and noted the need for engagement by all providers in the care planning process. MAP noted that partnerships between hospitals and PAC/LTC providers are critical to successful transitions. As part of a successful transition of care, MAP has repeatedly noted the need for improved discharge planning, and to go beyond planning to the actual transition of

care and meeting goals defined collaboratively between providers, patients, and caregivers. MAP recognized the need for better data sharing and interoperability of data to facilitate discharge planning and transitions of care. MAP hopes that the requirement for standardized data elements will help improve the discharge planning process and the successful exchange of information between acute-care hospitals and PAC/LTC providers.

Public comments supported MAP feedback to CMS on the cross-setting measures and further encouraged developers to consider differences

in payment methods, patient goals, and patient population diagnoses and severity, in both the calculation of standardized and expected ratios and in reporting and comparisons across settings. Public comments raised concerns about duplication of readmission measures and the potential for double penalties where this duplication exists. A number of commenters suggested greater scrutiny be paid to the definitions and to coding for the potentially preventable conditions specified in measures, and encouraged rigorous testing of the reliability and validity of the measures to accomplish this.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

Inpatient Rehabilitation Facility Quality Reporting Program

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is a pay-for-reporting and public reporting program established under the Affordable Care Act (ACA). This program addresses the rehabilitation needs of individuals, including improved functional status and return to the community post discharge. This program specifically applies to all IRF settings that receive the IRF prospective payment system (PPS) including IRF hospitals, IRF units that are co-located with affiliated acute-care facilities, and IRF units affiliated with critical care access hospitals (CAH). Data sources for quality measures include Medicare Fee for Service Claims, Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN) data, and the IRF-Patient Assessment Instrument records. As of 2014, failure to submit quality data results in a 2 percent reduction rate in the annual applicable IRF-PPS payment update. The data must also be made publicly available, with IRF providers having opportunity to review the data prior to their release.

In addition to the IMPACT Act domains, the Centers for Medicare & Medicaid Services (CMS) had identified four high-priority domains and subdomains for future measure consideration to improve the IRF QRP and promote the National Quality Strategy (NQS). These high-priority areas included:

- making care safer by reducing the rate of hospital-acquired infections and conditions (e.g., catheter-associated urinary tract infections, clostridium difficile, and methicillin-resistant staphylococcus aureus);

- patient and family engagement with a primary focus on restoring functional status as well as measuring patient and caregiver experiences of care;
- making care affordable by assessing medical costs based on PAC episodes of care; and
- communication and care coordination.

During this rulemaking cycle, the focus on measurement for IRF programs was the integration of IMPACT Act requirements into the IRF QRP. In addition, CMS brought forward a measure that assesses potentially preventable within-stay readmission rates. Overarching considerations raised by MAP included encouraging CMS to ensure that attribution is appropriate to the level of care that most strongly affects both the discharge decision and admission to the IRF.

Public comments received on the MUCs that address IMPACT Act requirements are noted above. In addition, comments were received on the Potentially Preventable Within Stay Readmission for Inpatient Rehabilitation Facilities measure. Many of the comment themes were similar in that concerns were raised about duplication of readmission measures, review of coding and definitions for “potentially preventable” conditions, risk adjustment methodology, and the need for empirical testing prior to finalization of specifications and implementation of the measure.

Long-Term Care Hospital Quality Reporting Program

The Long-Term Care Hospital Quality Reporting Program (LTCH QRP) is a pay-for-reporting and public reporting program established under the ACA and aims to provide extended medical care to individuals with clinically complex conditions

(e.g., multiple, acute, or chronic conditions needing hospital level care for periods of greater than 25 days). This program specifically applies to all LTCH facilities under this Medicare program. As a provision of this program, LTCH providers are required to submit quality reporting data from sources such as Medicare FFS Claims, CDC NHSN data submissions, and the LTCH Continuity Assessment Record and Evaluation Data Sets (LCDS). Beginning in fiscal year 2014, failure to report quality data results in a 2 percent reduction in the annual PPS increase factor. The data must be made publicly available with LTCHs having the opportunity to review the data prior to their release.

In addition to the IMPACT Act domains, CMS identified four high-priority domains for future measure consideration to improve the LTCH QRP and align with the NQS. These domains include:

- effective prevention and treatment;
- patient and family engagement with a primary focus on functional outcomes and patients' experiences of care;
- making care affordable by assessing medical costs based on PAC episodes of care; and
- communication and care coordination.

Many of these previously identified domains align with measures under consideration to meet IMPACT Act requirements. In addition to IMPACT Act focused measures, MAP reviewed measures in development assessing ventilator weaning, compliance with spontaneous breathing trials, and antipsychotic medication use in the LTCH setting. MAP urged CMS to consider the implications of the inclusion or exclusion of patients with bipolar disorder in any of the measures of antipsychotic use and suggested further thought on how duration of exposure to antipsychotic medications could impact the measure specifications. MAP recognized CMS work on addressing the gaps in ventilator support and encouraged continued development of these measures.

Public comments received on the MUCs that address IMPACT Act requirements are noted above. Public comments received on the measures of antipsychotic use, compliance with spontaneous breathing trial, and ventilator weaning supported MAP's recommendations. One commenter noted the importance of the Compliance with Spontaneous Breathing Trial measure due to continued variation in the field.

Skilled Nursing Facility Quality Reporting Program

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) is a pay-for-reporting and public reporting program established under section 1899B of the IMPACT Act. This program requires all facilities that submit data under the SNF PPS to participate in the SNF QRP with the exception of units affiliated with critical access hospitals. SNFs are required to submit quality data to CMS through sources including Medicare FFS Claims and the Minimum Data Set (MDS) assessment data. As of fiscal year 2018, SNFs that fail to report quality data will receive a 2 percent reduction in their annual payment updates.

CMS identified four high-priority domains for future measure consideration for the SNF setting. These domains include:

- patient and family engagement with a focus on assessing functional status and functional decline for SNF residents;
- making care safer;
- making care affordable by assessing medical costs based on PAC episodes of care; and
- communication and care coordination.

Assessing patient care transitions and re-hospitalizations as well as infrastructure and processes for care coordination continue to be important areas for measure development in the SNF QRP. MAP had the opportunity to provide input on measures under development that are intended to close gaps in the identified

high-priority domains as well as those submitted to meet IMPACT Act requirements. The measures considered included functional status measures aimed at assessing improvement in mobility and self-care during the SNF stay, functional status measures that assess discharge scores for mobility and self-care, antipsychotic medication utilization, pain assessment, and influenza vaccination administration. Each of these measures, in addition to those in development to meet IMPACT Act requirements, promotes alignment across programs as well as addresses high-priority domains. MAP encouraged further development of these concepts.

Public comments received on the MUCs that address IMPACT Act requirements are noted above. Public comments received on the measures not included on the IMPACT Act-focused consent calendars were mixed in their support or opposition to the MUCs, as proposed. Commenters expressed concern with the functional status measures and specifically called for testing in SNFs, as opposed to the IRF adaptations. While commenters supported MAP's recommendation to encourage continued development, they noted a difference with that recommendation and recommending use in programs prior to full testing and finalization of risk adjustment. A commenter suggested the MAP should have an opportunity to review all endorsed measures for a specific topic area and not just those identified on the MUC list. Commenters supported MAP's recommendations for the antipsychotic medication utilization and influenza vaccination measures, but perhaps more strongly, in that they supported inclusion in the SNF QRP and not just further development. Comments on the self-reported pain measure were split with some support received, but also a concern raised that the subjectivity of patient report of pain does not measure quality of care, but only if pain is present. A more appropriate measure would address if pain is or is not effectively managed.

Skilled Nursing Facility Value-Based Purchasing Program

The Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP) was established under the Protecting Access to Medicare Act (PAMA) of 2014. Under the program, the SNF VBP per diem rate will be reduced by 2 percent or incentive payments will be applied to facilities based upon the readmission measure performance. The legislation mandates CMS to specify two time-limited measures:

- An SNF all-cause, all-condition hospital readmission measure, or any successor to such a measure, no later than October 1, 2015;
- A resource measure to reflect an all-condition, risk-adjusted potentially preventable hospital readmission rate for SNFs no later than October 1, 2016. This resource measure is meant to replace the all-cause, all-condition readmission measure as soon as it is feasible to do so.

CMS previously identified the sole priority domain for future measure consideration as the specification of a readmission measure. CMS lacks the authority to implement additional measures to the program at this time. As such, MAP considered the Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measures, as required by PAMA. There was support for the importance of this measure, and it was noted that readmission for the SNF setting is not an occasional occurrence.

Public comments generally supported MAP's recommendation to "encourage continued development" of the Skilled Nursing Facility 30-Day Potentially Preventable Readmission measure. Commenters expressed concerns with the specifications and the challenge for MAP to make a recommendation on a measure that is not fully tested or specified.

Home Health Quality Reporting Program

The Home Health Quality Reporting Program (HH QRP) is a pay-for-reporting and public reporting program established in accordance with Section 1885 of the Social Security Act and aims to improve the quality of care provided to HH patients. The incentive structure is designed to require all HH agencies (HHA) to submit quality data from the Outcome and Assessment Information Set (OASIS) and Medicare FFS Claims. HHAs that do not comply with this incentive structure are subject to a 2 percent reduction in the annual PPS increase factor. This data is made publicly available through the Home Health Compare website to provide national ratings on the quality of HHAs.

The HH QRP is more mature compared to programs for other PAC settings and thus incorporates more measures. While gaps in measurement continue, ensuring a parsimonious group of measures that addresses burden to providers is important to CMS and was encouraged by MAP. While measures continue to be developed for home health, there is greater attention to retiring topped out measures and exploring opportunities to implement composite measures that use existing data sources. The CMS high-priority domains for future measure consideration to improve the HH QRP and align with the NQS include:

- patient and family engagement with a focus on the quality of care in home health settings as well as functional status for home health patients;
- making care safer since CMS identified individuals in home-based settings as high risk for major injury due to falls, new or worsened pressure ulcers, and pain and functional decline;
- making care affordable by assessing medical costs based on PAC episodes of care; and
- communication and care coordination.

Assessing patient care transitions and re-hospitalizations as well as infrastructure and processes for care coordination are important areas for measure development. Many of these previously identified priority domains align with the IMPACT Act and were included in the MAP deliberations for this rulemaking cycle. In addition, measures assessing risk of falls and improvement with dyspnea have been advancing through the development cycle for inclusion in future program iterations. Overall support for these emerging measures was received from MAP, as well as encouragement for continuing to move toward parsimony in the QRP measure set.

Commenters supported of MAP's recommendation to "encourage continued development" of the Falls Risk Composite measure. Several commenters noted the overlap of this measure with existing falls-related process measures, and that the growing number of measures could confuse stakeholders and the general public. Commenters encouraged CMS to explore how this measure might be aligned with existing falls measures developed in other settings. Commenters encouraged testing of this measure and reconsideration before it is finalized.

Several commenters supported MAP's recommendation "do not encourage continued development" of the Improvement in Dyspnea in Patients with a Primary Diagnosis of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and/or Asthma measure. One commenter urged MAP to instead recommend "encourage continued development." Commenters were split on whether or not the measure should be limited to the specific diagnoses of congestive heart failure, chronic obstructive pulmonary disease, and/or asthma. Concerns raised included overlap with existing measures and the absence of measures involving stabilization of function. One commenter agreed with the workgroup that dyspnea is an important quality issue for that population but noted that improvement might not be possible for some patients near the end of life.

Hospice Quality Reporting Program

The Hospice Quality Reporting Program (HQRP) is a pay-for-reporting and public reporting program established in accordance with section 1814(i) of the Social Security Act and amended by section 3004 of the Affordable Care Act. The HQRP applies to all hospices, regardless of setting. Under the program, hospice providers are required to submit quality data from proposed sources such as the Hospice Item Set and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaire through which future HQRP measures can be developed. Failure to submit quality data will result in a 2 percent reduction to hospices' annual payment update.

CMS previously identified three high-priority domains for future measure consideration with the overall goal of developing symptom management outcome measures. The dearth of tested and endorsed outcome measures for hospices across domains of care was noted as a major gap area and a central aspect of care. CMS also identified communication and care coordination as a high priority with a special focus on the responsiveness to patient and family preferences for care. The second high-priority domain is patient and family engagement, addressing the needs of individuals and their families to assess the level of quality provided by the hospice setting. The third high-priority domain is making care safe through timeliness and responsiveness of care. CMS noted the responsiveness of a hospice initiation of treatment once a patient has elected hospice benefits as an important indicator of quality. In order to start addressing these measurement gaps, measures under development include a measure focusing on hospice visits when death is imminent and a composite process measure. The measures were well received by MAP with the recognition that testing is continuing. MAP stressed that an important aspect in assessing quality in hospice care is determining if visits and care provided are

meaningful to both the patient and the caregiver.

Commenters generally supported MAP's recommendation to "encourage continued development" of the Hospice Visits When Death is Imminent measure, though several concerns with the specifications were expressed. The measure was originally presented as one measure; however, new information was presented to the workgroup during its deliberations. CMS explained that based on pilot results and feedback from the TEP and Caregiver Workgroup in September and October 2015, this measure is specified as a set of two measures, instead of one measure. Several commenters requested greater clarity on the definition of "visits" and had concerns with exclusions. Commenters also noted that physician assistants are included in the measure, but at this time CMS does not recognize physician assistants in hospice care, and that greater clarity is needed so that hospices are not misled into thinking that physician assistant visits are allowed in the last 7 days of life. Another concern was that the measure includes nurse practitioners, but many hospices do not employ nurse practitioners. Several commenters stated that hospices do not currently collect and report all the visit data that is included in the measure. Although some is captured on the Medicare hospice claims, not all visit types for this measure can be captured consistently across hospices. If this measure were implemented, it could create a burden for those programs which lack the capability and infrastructure to collect and report the visit data. Lastly, several commenters noted that visits are an important service to patients at the end of life, but the number of visits doesn't always reflect quality of care.

Commenters generally supported MAP's recommendation to "encourage continued development" of the Hospice and Palliative Care Composite process measure and agreed that this measure should be balanced with patient-centered care that is relevant to the patient. Commenters who did not support the recommendation expressed concerns with the exclusions.

Commenters noted that eliminating the less than 7 day length of stay exclusion could be problematic because of the high proportion of hospice patients with a length of stay of less than 7 days. Although hospices will be incentivized to collect data on all of the measures in the composite, the data collection may not be appropriate for patients and families in situations where the patient is in crisis and/or close to death on admission. Commenters expressed that quality care means that the hospice team must focus on identifying and meeting the needs of the patient and family, and without the 7 day exclusion, data collection could potentially become the priority ahead of the needs of the patients and families.

APPENDIX A: Program Summaries

Inpatient Rehabilitation Facility Quality Reporting Program

Program Type

Pay for Reporting

Incentive Structure

The IRF QRP was established under the Affordable Care Act. Beginning in FY 2014, IRFs that fail to submit data will be subject to a 2 percentage point reduction of the applicable IRF Prospective Payment System (PPS) payment update.

Program Goals

Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.

CMS identified the following four domains as high-priority for future measure consideration:

- Patient and family engagement: restoring functional status and experience of patients and caregivers
- Making care safer: risk for injury due to falls, new or worsened pressure ulcers, infections (e.g., CAUTI, C. Diff. and MRSA)
- Making care affordable: efficiency-based measures
- Communication and care coordination: transitions and re-hospitalizations and medication reconciliation

Long-Term Care Hospital Quality Reporting Program

Program Type

Pay for Reporting

Incentive Structure

The LTCH QRP was established under the Affordable Care Act. Beginning in FY 2014, LTCHs that fail to submit data will be subject to a 2 percentage point reduction of the applicable Prospective Payment System (PPS) increase factor.

Program Goals

Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for periods of greater than 25 days).

CMS identified the following four domains as high-priority for future measure consideration:

- Patient and family engagement: functional outcomes
- Effective prevention and treatment: ventilator use, ventilator-associated event and ventilator weaning rate, and mental health status
- Making care affordable: efficiency-based measures
- Communication/care coordination: transitions and re-hospitalizations and medication reconciliation

Skilled Nursing Facility Quality Reporting Program

Program Type

Pay for Reporting

Incentive Structure

The IMPACT Act added Section 1899 B to the Social Security Act establishing the SNF QRP. Beginning in FY 2018, providers [SNFs] that do not submit required quality reporting data to CMS will have their annual update reduced by 2 percentage points.

Program Goals

CMS identified the following four domains as high-priority for future measure consideration:

- Patient and family engagement: functional status and functional decline
- Making care safer: major injury due to falls
- New or worsened pressure ulcers making care affordable: efficiency-based measures
- Communication and care coordination: transitions and re-hospitalizations
- Medication reconciliation

Skilled Nursing Facility Value-Based Purchasing Program

Program Type

Pay for Performance

Incentive Structure

Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) authorizes establishing a SNF VBP Program beginning with FY 2019 under which value-based incentive payments are made to SNFs in a fiscal year based on performance.

CMS identified the following domain as high-priority for future measure consideration:

- The PAMA legislation mandates that CMS specify:
 - An SNF all-cause, all-condition hospital readmission measure by no later than October 1, 2015
 - A resource use measure that reflects resource use by measuring all-condition, risk-adjusted potentially preventable hospital readmission rates for SNFs by no later than October 1, 2016 (This measure will replace the all-cause, all-condition measure)

Home Health Quality Reporting Program

Program Type

Pay for Reporting

Incentive Structure

The HH QRP was established in accordance with section 1895 of the Social Security Act. Home health agencies (HHAs) that do not submit data receive a 2 percentage point reduction in their annual HH market basket percentage increase.

Program Goals

Alignment with the mission of the IOM which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness.

CMS identified the following four domains as high-priority for future measure consideration:

- Patient and family engagement: care preferences; functional status and functional decline
- Making care safer: major injury due to falls and new or worsened pressure ulcers
- Making care affordable: efficiency-based measures
- Communication and care coordination: transitions and re-hospitalizations and medication reconciliation

Hospice Quality Reporting Program

Program Type

Pay for Reporting

Incentive Structure

The Hospice QRP was established under the Affordable Care Act. Beginning in FY 2014, hospices that fail to submit quality data will be subject to a 2 percentage point reduction to their annual payment update.

Program Goals

Make the hospice patient as physically and emotionally comfortable as possible, with minimal disruption to normal activities, while remaining primarily in the home environment.

CMS identified the following three domains as high-priority for future measure consideration:

- Overall goal: symptom management outcome measures
- Patient and family engagement: goal attainment
- Making care safer: timeliness/responsiveness of care
- Communication and care coordination: alignment of care coordination measures

APPENDIX B: MAP PAC/LTC Roster and NQF Staff

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