NATIONAL QUALITY FORUM

Measure Applications Partnership Pre-Rulemaking Web Meeting

Dual Eligible Beneficiaries Workgroup

January 10, 2017

Meeting Agenda

- Welcome and Review of Meeting Objectives
- MAP 2016-2017 Pre-Rulemaking Overview
- MAP Pre-Rulemaking In-Person Meeting Themes
- Discussion of Cross-Cutting and Recurring Themes
- Opportunity for Public Comment
- Summarize, Next Steps, and Adjourn

Meeting Objectives

- Review recommendations by other MAP workgroups during pre-rulemaking deliberations
- Consider strategic issues for federal measurement programs relevant to dual eligible beneficiaries
- Develop cross-cutting pre-rulemaking input from the MAP Dual Eligible Beneficiaries Workgroup to the Coordinating Committee

Introductions

Dual Eligible Beneficiaries Workgroup Membership

Workgroup Chairs: Jennie Chin Hansen, RN, MS, FAAN and Nancy Hanrahan, PhD, PN, FAAN

Organizational Members

AARP Public Policy Institute	Susan Reinhard, RN, PhD, FAAN
American Medical Directors Association	Gwendolen Buhr, MD, MHS, Med, CMD
American Occupational Therapy Association	Joy Hammel, PhD, OTR/L, FAOTA
Association for Community Affiliated Health Plans	Christine Aguiar
Centene Corporation	Michael Monson
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Easter Seals	Lisa Peters-Beumer, MPH
Homewatch CareGivers	Jennifer Ramona
iCare	Thomas H. Lutzow, PhD, MBA
Medicare Rights Center	Joe Baker, JD
National Association of Medicaid Directors	Alice Lind, BSN, MPH
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
New Jersey Hospital Association	Aline Holmes, DNP, MSN, RN
SNP Alliance	Richard Bringewatt

Dual Eligible Beneficiaries Workgroup Membership

Subject Matter Experts

Alison Cuellar, PhD
K. Charlie Lakin, PhD
Pamela Parker, MPA
Kimberly Rask, MD, PhD

Federal Government Members

Administration for Community Living	Eliza Bangit, JD
CMS Medicare Medicaid Coordination Office	Stacey Lytle, MPH
Office of the Assistant Secretary for Planning and Evaluation	DEB Potter, MS

MAP 2016-2017 Pre-Rulemaking

The Role of MAP

In pursuit of the National Quality Strategy, the MAP:

- Informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all
- Provides input to HHS during pre-rulemaking on the selection of performance measures for use in public reporting, performance-based payment, and other federal programs
- Identifies gaps for measure development, testing, and endorsement
- Engages in a feedback loop with HHS regarding the implementation of current program measure sets
- Encourages measurement alignment across public and private programs, settings, levels of analysis, and populations to:
  - *Promote coordination of care delivery*
  - *Reduce data collection burden*

What is the value of pre-rulemaking input?

- Facilitates multi-stakeholder dialogue that includes HHS representatives
- Allows for a consensus-building process among stakeholders in a transparent, open forum
- Proposed laws are “closer to the mark” because the main provisions related to performance measurement have already been vetted by the affected stakeholders
- Reduces the effort required by individual stakeholder groups to submit official comments on proposed rules

Role of the Dual Eligible Beneficiaries Workgroup in Pre-Rulemaking

Cross-Program and Cross-Setting Measurement Considerations for Complex Consumers

- Medicare-Medicaid dual eligible beneficiaries access all types of healthcare, therefore their care is measured in all of the programs reviewed during pre-rulemaking
- Members of the Duals Workgroup participate in the setting-specific workgroups as non-voting liaisons to share their perspectives
- The Dual Eligible Beneficiaries Workgroup meets to consider cross-program and cross-setting measurement issues relevant to complex consumers (e.g., care transitions, person-centered care)

MAP Dual Eligible Beneficiaries Workgroup Charge

- Consider the range of measurement issues relevant to consumers with complex medical and social needs, such as:
  - *Persistent gaps in available measures*
  - *Stratification and risk adjustment*
  - *Multiple chronic conditions*
  - *Shared accountability*

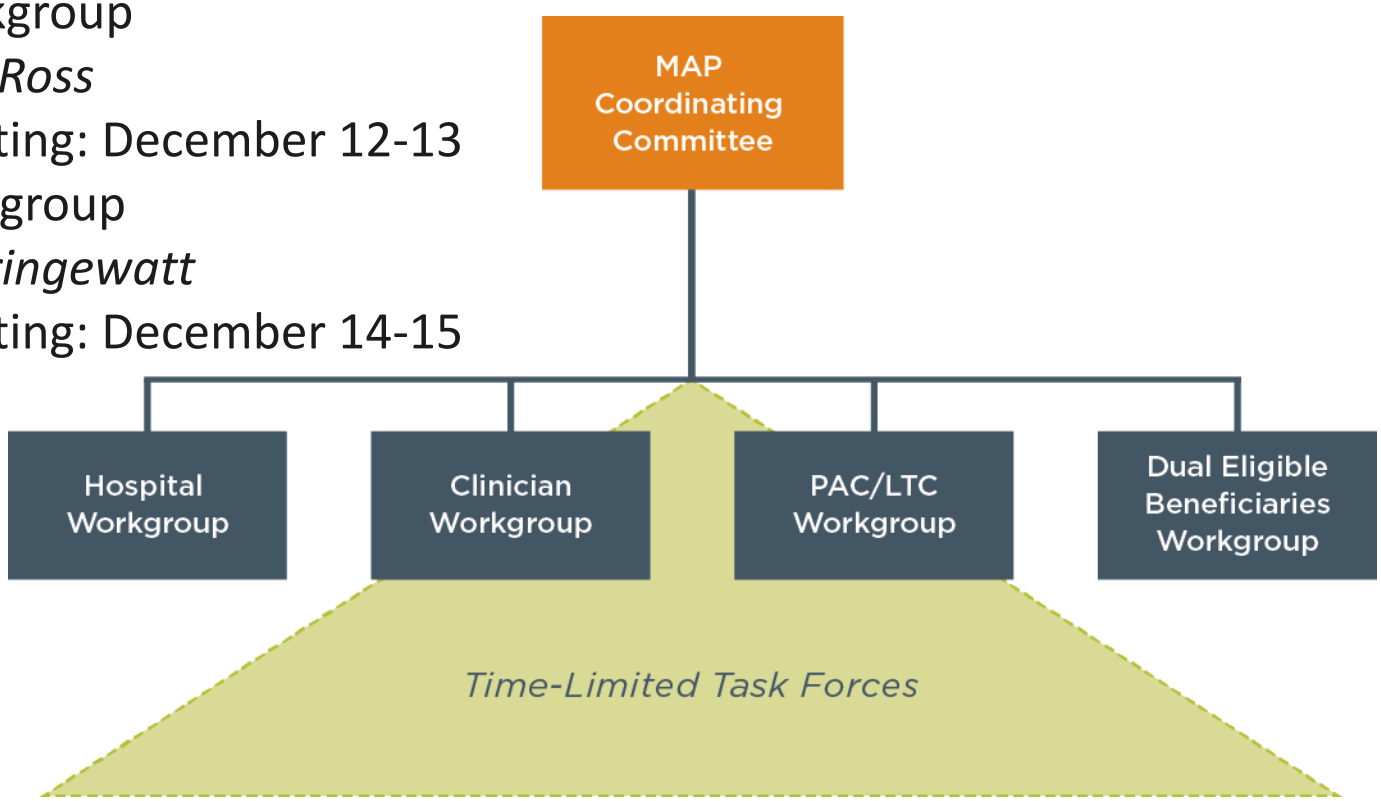
- Maintain a "family of measures" relevant to dual eligible beneficiaries to promote uptake and alignment of these measures across a variety of programs

MAP Structure

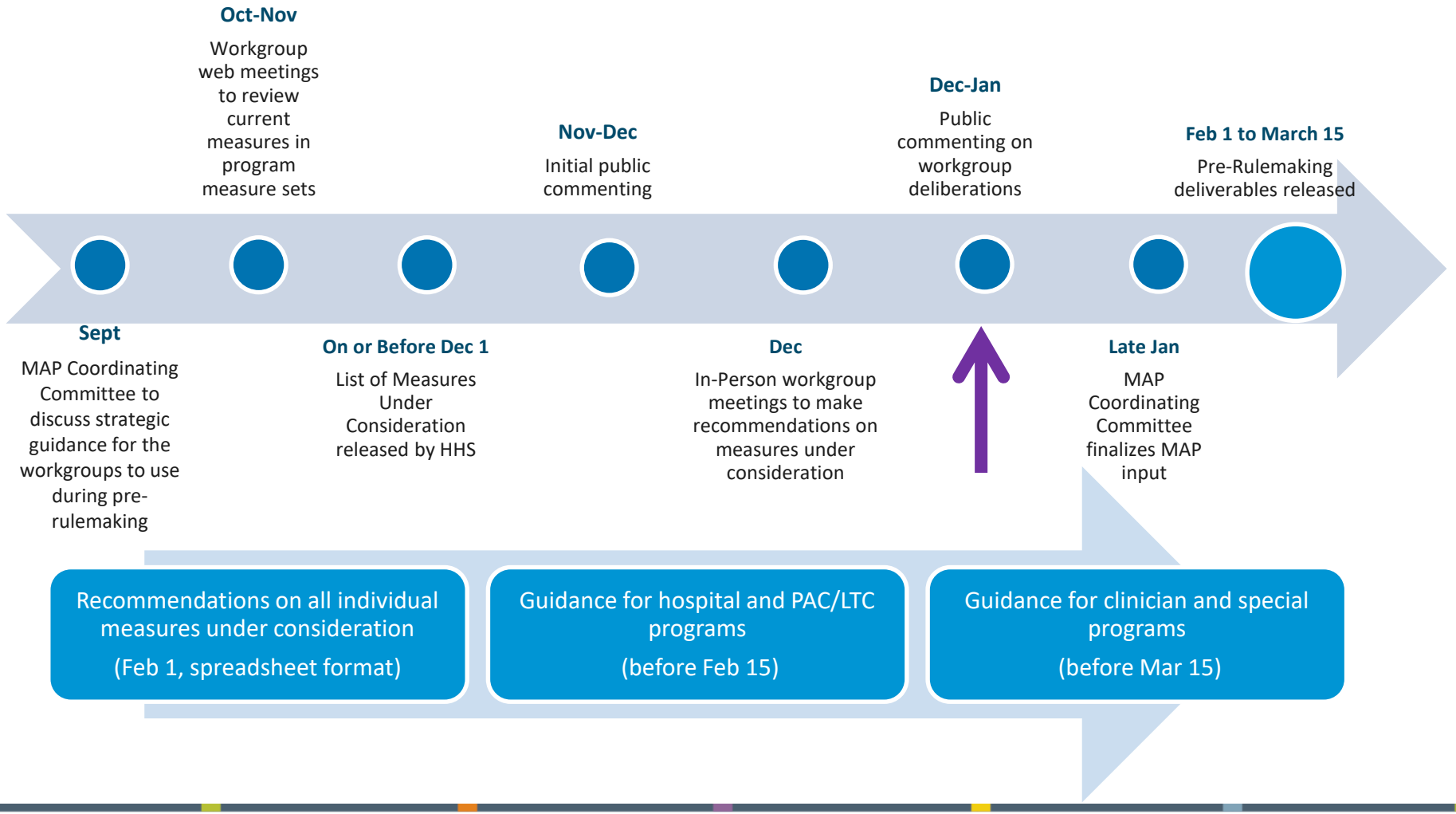
MAP Hospital Workgroup
- Liaison: *Aline Holmes*
- In-Person Meeting: December 8-9

MAP Clinician Workgroup
- Liaison: *Clarke Ross*
- In-Person Meeting: December 12-13

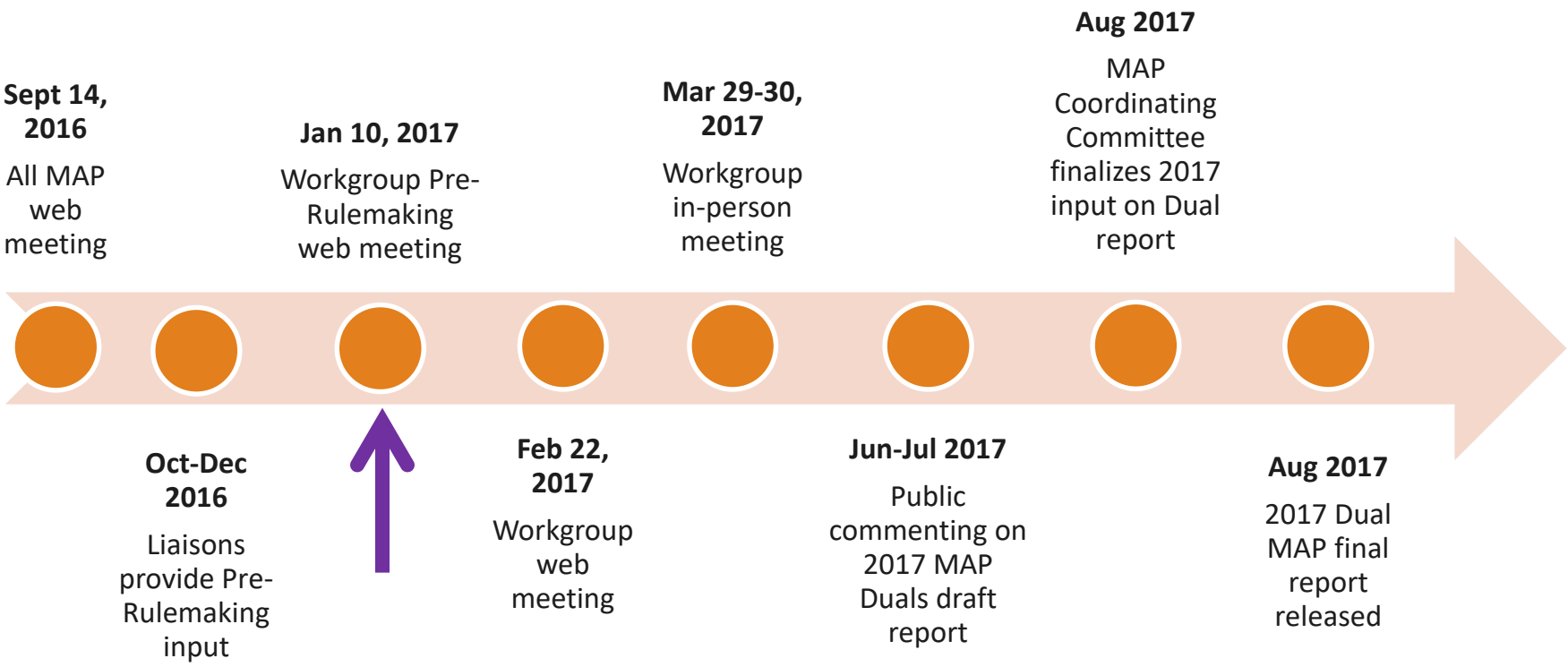
MAP PAC/LTC Workgroup
- Liaison: *Rich Bringewatt*
- In-Person Meeting: December 14-15



MAP Approach to Pre-Rulemaking September 2016 – March 2017



Dual Eligible Beneficiaries Workgroup September 2016 – August 2017



MAP Family of Measures & Priority Gap Areas for Dual Eligible Beneficiaries

- The Family of Measures for Dual Eligible Beneficiaries:
  - *74 best-available measures to address the needs of the population and identify high-leverage opportunities for improvement in cares*

- Priority gap areas:
  - *Goal-directed, person-centered care planning & implementation*
  - *Shared decisionmaking*
  - *Systems to coordinate acute care, long-term services and supports, and nonmedical community resources*
  - *Beneficiary sense of control/autonomy/self-determination*
  - *Psychosocial needs*
  - *Community integration/inclusion and participation*
  - *Optimal functioning (e.g., improving when possible, maintaining, managing decline)*
  - *Home and community based services*
  - *Affordable and cost- effective care*

MAP Measure Selection Criteria

1	NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2	Program measure set adequately addresses each of the National Quality Strategy's three aims
3	Program measure set is responsive to specific program goals and requirements
4	Program measure set includes an appropriate mix of measure types
5	Program measure set enables measurement of person- and family-centered care and services
6	Program measure set includes considerations for healthcare disparities and cultural competency
7	Program measure set promotes parsimony and alignment

MAP Decision Categories

Decision Category	Evaluation Criteria
Support for Rulemaking	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	The measure is fully developed and tested and meets assessments 1-6. However, the measure should meet a condition (e.g., NQF endorsement) specified by MAP before it can be supported for implementation. MAP will provide a rationale that outlines the condition that must be met. Measures that are conditionally supported are not expected to be resubmitted to MAP.
Refine and Resubmit Prior to Rulemaking	The measure addresses a critical program objective but needs modifications before implementation. The measure meets assessments 1-3; however, it is not fully developed and tested OR there are opportunities for improvement under evaluation. MAP will provide a rationale to explain the suggested modifications.
Do Not Support for Rulemaking	The measure under consideration does not meet one or more of the assessments.

2016-2017 Summary of Recommendations for Measures Under Consideration

MAP Decision Category	Measures Under Consideration (n= 74)
Support for Rulemaking	20
Conditional Support for Rulemaking	14
Refine and Resubmit for Rulemaking	30
Do Not Support for Rulemaking	10

2016-2017 Pre-Rulemaking Cross-Cutting Themes Related to Dual Beneficiaries

- Importance of capturing the patient perspective through patient reported *outcome* measures
- Acknowledge various drivers of measurement
  - *Legislation and regulations*
  - *Clinical relevance*
  - *Patients' needs and perspectives*
- Importance of measures that are meaningful to providers *and* consumers
- Consider the level of effort involved with measurement:
  - *Patient – capturing information efficiently and sharing effectively*
  - *Provider – impact of data collection and reporting on workflow*

Key Issues for Post-Acute Care and Long-Term Care Programs

PAC/LTC Workgroup - Background

- Expanding requirements since 2005, starting with CAHPS for home health settings
- Implementation of pay for reporting in 2010
  - *Expansion across PAC settings continues - since a lot of the data collection started in 2016*
- IMPACT Act of 2014 instituted required reporting of:
  - *Standard patient assessment data*
  - *Data on quality measures in five domains*
  - *Data on resource use and other measures*
  - *Measurement of new topics, including discharge to community and potentially preventable conditions*

PAC/LTC Highest-Leverage Measurement Areas and Core Measure Concepts

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts	
Function	• Functional and cognitive status assessment	• Mental health
Goal Attainment	• Achievement of patient/ family/caregiver goals	• Advanced care planning and treatment
Patient and Family Engagement	• Experience of care • Shared decision-making	• Patient and family education
Care Coordination	• Effective transitions of care	• Accurate transmission of information
Safety	• Falls • Adverse drug events	• Pressure ulcers
Cost/Access	• Inappropriate medicine use • Infection rates	• Avoidable admissions
Quality of Life	• Symptom Management • Social determinants of health	• Autonomy and control • Access to lower levels of care

Current Program Measures by MAP PAC/LTC Core Concepts

PAC/LTC Core Concepts	IRF QRP	LTCH QRP	HH QRP	SNF QRP
Falls	■	■	■	■
Functional and Cognitive Status Assessment	■	■	■	■
Inappropriate Medicine Use		■		■
Infection Rates	■	■	■	
Pressure Ulcers	■	■	■	■
Shared Decision-Making				
Effective Transitions of Care	■		■	■
Mental Health			■	
Achievement of Patient/family/caregiver Goals				
Advance Care Planning and Treatment				
Experience of Care				
Adverse Drug Events	■	■	■	■
Avoidable Admissions	■	■	■	■
Patient and Family Education			■	
Accurate Transitions of Information			■	
Symptom Management			■	
Social Determinants of Health				
Autonomy and Control			■	
Access to Lower Levels of Care				

Current Program Measures by IMPACT Act Domains

IMPACT Act Domains	IRF QRP	LTCH QRP	HH QRP	SNF QRP
Skin integrity and changes in skin integrity	■	■	■	■
Functional status, cognitive function, and changes in function and cognitive function	■	■		■
Medication reconciliation	■	■		■
Incidence of major falls	■	■		■
Transfer of health information and care preferences when an individual transitions	■	■	■	■
Resource use measures, including total estimated Medicare spending per beneficiary	■	■		■
Discharge to community	■	■		■
All-condition risk-adjusted potentially preventable hospital readmissions rates	■	■		■

PAC/LTC Workgroup Programs

- Skilled Nursing Facility Quality Reporting Program
- Home Health Quality Reporting Program
- Inpatient Rehabilitation Facility Quality Reporting Program
- Long-Term Care Hospital Quality Reporting Program
- Hospice Quality Reporting Program
- Skilled Nursing Facility Value-based Purchasing Program

Measures Under Consideration

Program	# of Measures
Skilled Nursing Facility Quality Reporting Program	3
Home Health Quality Reporting Program	5
Inpatient Rehabilitation Facility Quality Reporting Program	3
Long-Term Care Hospital Quality Reporting Program	3
Hospice Quality Reporting Program	8
Skilled Nursing Facility Value-based Purchasing Program	0

Relevant Themes from the PAC/LTC Workgroup

- Standardization of measures
  - *Example: standardizing the denominator across all settings*
- Data Sharing & Transfer of Information
  - *Interoperability*
  - *Harmonization of measures*
  - *Shared accountability across settings and beyond PAC/LTC*
- PROMIS Tool
  - *Opportunity to promote patient and family engagement*
  - *Potential to allow patients/caregivers to tailor assessment based on what is important to them*
- Risk Adjustment
  - *Use of duals status as an risk adjustment or stratification variable*

Relevant Themes from the PAC/LTC Workgroup

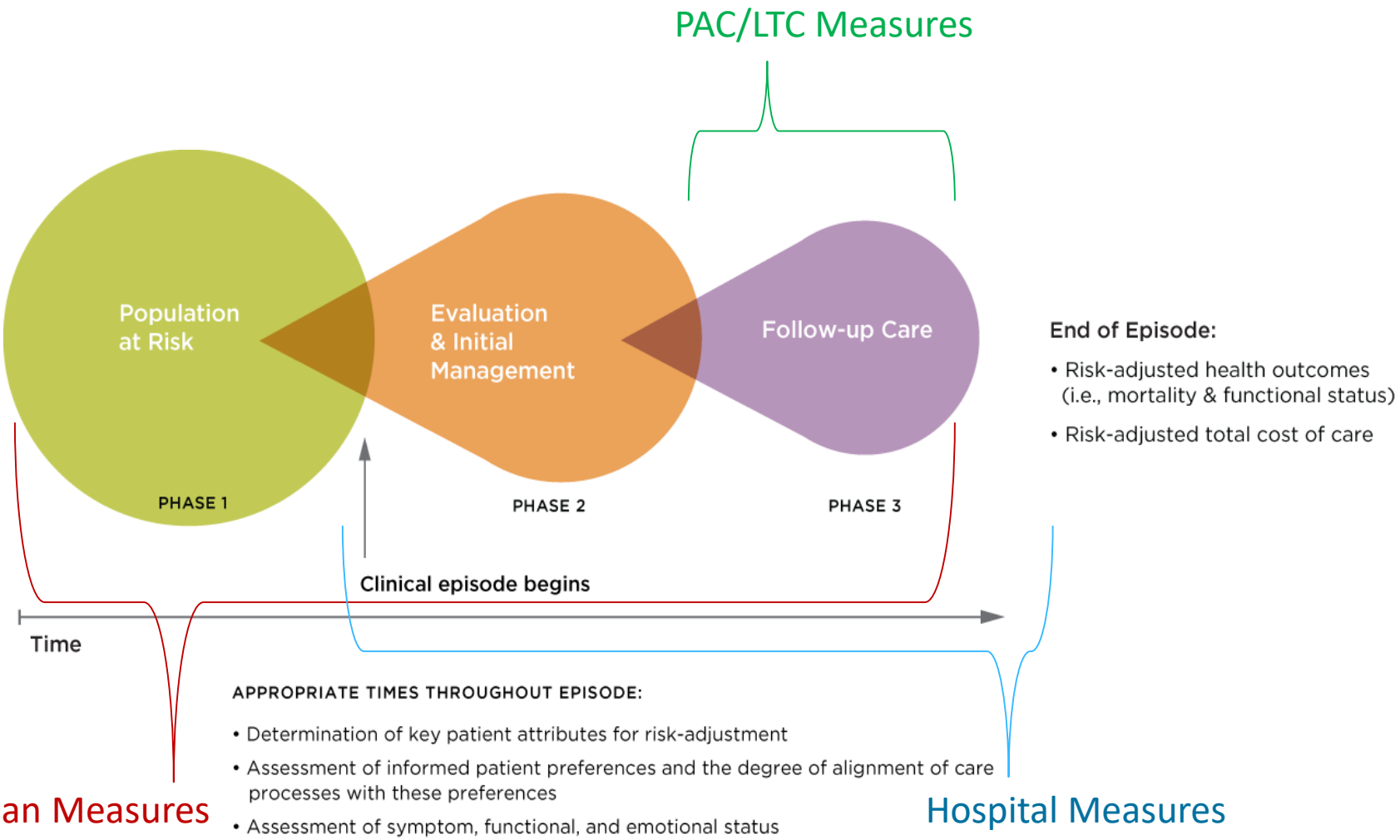
- Providers/Institution
  - *Effort related to reporting requirements at various settings of care*
  - *Importance of understanding patient populations based on their setting of care*
  - *Multiple provider types involved in an episode of care*
- Importance of Sociodemographic Status (SDS)
- Holistic approach to reporting and thereby alignment of incentives across providers.

Workgroup Discussion

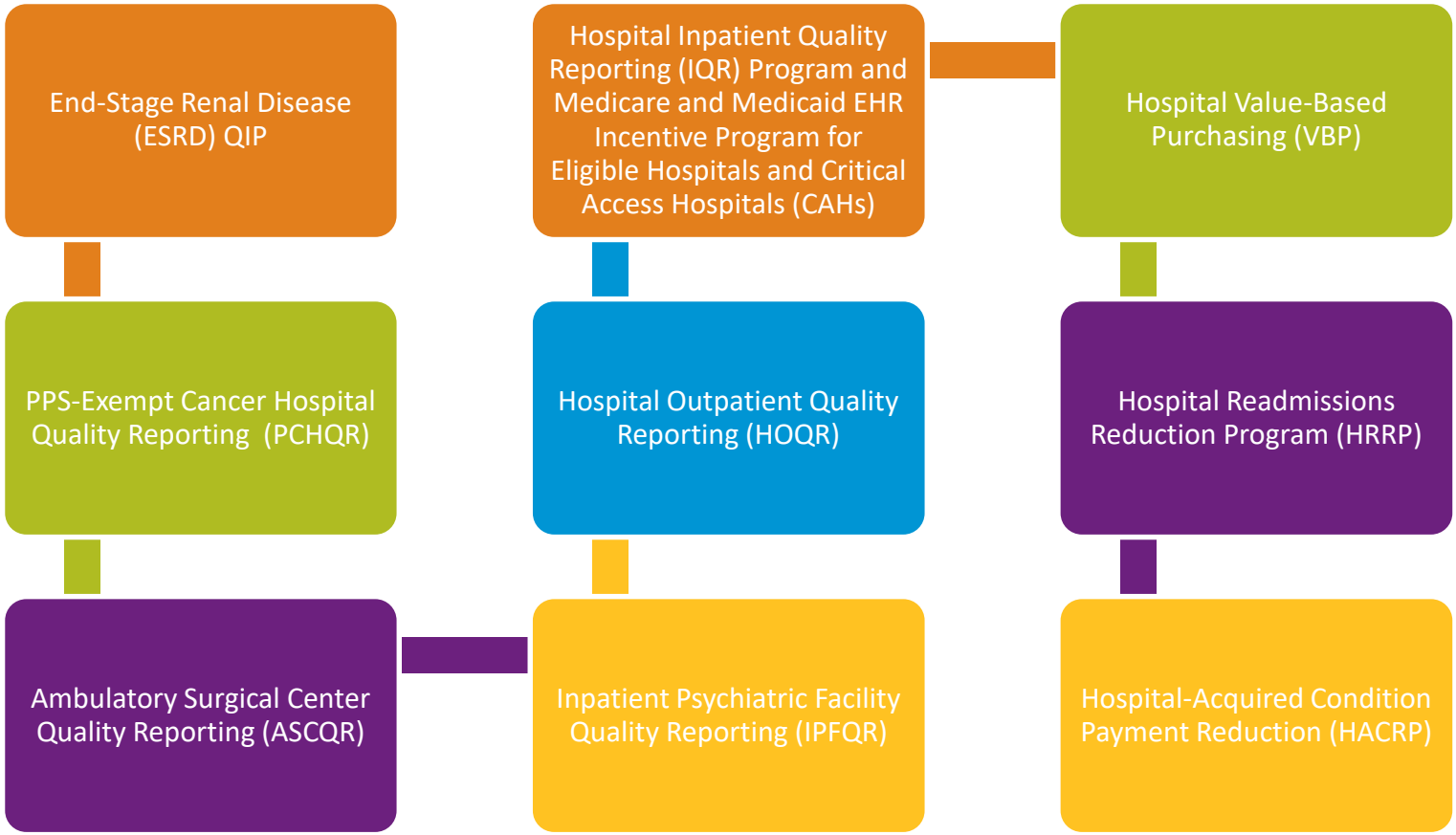
- Thoughts from PAC/LTC Liaison: Richard Bringewatt
- Discuss how the PAC/LTC measure sets or the measures under consideration address goal-directed, person-centered care planning & implementation.
- Discuss strategies to foster shared responsibility across providers in different settings of care.

Key Issues for Hospital Programs

Hospital Workgroup - Background



Programs Considered by Hospital Workgroup



Measures Under Consideration

Program	# of Measures
End Stage Renal Disease Quality Incentive Payment	3
PPS-Exempt Cancer Hospital Quality Reporting	5
Ambulatory Surgical Center Quality Reporting	3
Inpatient Psychiatric Facility Quality Reporting	3
Hospital Outpatient Quality Reporting	3
Hospital Inpatient Quality Reporting (IQR)/ Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	15
Hospital Value-Based Purchasing	1
Hospital Readmissions Reduction Program	0
Hospital Acquired Condition Reduction Program	0

Hospital Workgroup Meeting Themes

- Move to High-Value Measures

Future measure development is needed including appropriate use, care transitions, and patient-reported outcomes.

- Need for measures across programs that evaluate the appropriate use of health interventions and testing
- Appropriate prescribing practices
- Measures assessing care transitions
- Measures based on patient reported outcomes (PRO-PMs)

Hospital Workgroup Meeting Themes

- **Balance Measurement Burden with Opportunity for Improvement**
  - *Measure sets should balance the effort required for data collection and reporting and potential to improve quality of care and patient outcomes*
    - » Need for measures that:
      - *Are parsimonious*
      - *Drive improvement and address unwarranted variation among providers*
      - *Don't require undue reporting effort by patients*
    - » Suggested removal of measures that:
      - *Are topped out*
      - *Have unintended consequences*
      - *Have lost NQF endorsement*
      - *Are no longer aligned with the current evidence or the program's goals*

Workgroup Discussion

- Thoughts from Hospital Liaison: Aline Holmes
- Discuss how the hospital measure sets or the measures under consideration address goal-directed, person-centered care planning & implementation.
- Discuss strategies for the Coordinating Committee to consider in fostering the development of quality measures that address the incorporation of the patient's preferences and goals into the patient's plan of care.

Key Issues for Clinician Programs

Medicare Shared Savings Program (MSSP) - Background

- Authorized by Section 3022 of the Affordable Care Act
- Participation in an Accountable Care Organization (ACO) creates incentives for health care providers to work together voluntarily to coordinate care and improve quality for their patient population.
- ACOs submit an application to join the Shared Savings Program and, if accepted, voluntarily enter a 3-year agreement with CMS
- ACOs may earn shared savings, if generated, by meeting program requirements and the quality performance standard
  - *As currently proposed, Shared Savings Program quality reporting requirements align with the MIPS quality category.*
- Beneficiaries are assigned to an ACO based on utilization of primary care services provided by professionals participating in the ACO

Merit-based Incentive Payment System (MIPS) - Background

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA):

- Sunsets Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBPM), and Electronic Health Record (EHR) Incentive Programs in 2018
- Authorizes MIPS program beginning 2019 - consolidates existing clinician quality and incentive programs
- One of two tracks in the Quality Payment Program (QPP) policy designed to reform Medicare Part B payments. Individual clinicians self-select quality measures to submit to CMS. A clinician who participates in an Advanced Alternate Payment Model (Advanced APM) is excluded from MIPS.

Programs Considered by the Clinician Workgroup

- Medicare Shared Savings Program (MSSP)
- Merit-Based Incentive Payment System (MIPS)

Measures Under Consideration

Program	# of Measures
Medicare Shared Savings Program (MSSP)	1
Merit-Based Incentive Payment System (MIPS)	18

Clinician Workgroup Meeting Themes

- Population health level measurement
  - *Aligning incentives and measures across providers and settings*
  - *Duals-specific population health level measurement – variations with sub-populations*
  - *Issues related to demographics, locality specific disease prevalence/burden, education, and medical catchment area*
- Composite Measures
  - *Risk adjustment*
  - *Consider advantages and disadvantages of measures with an expectation of 100% compliance vs combined scores on a composite of measures*
  - *Consider translating individual measures to composite measures*
    - » Provides a more holistic view of care across teams and settings

Clinician Workgroup Meeting Themes

- PROMIS & Patient-Reported Outcome Performance Measures
  - *Potential Uses of PRO-PMs:*
    - » Assess how teams function in terms of consistency and message to patient
    - » Assess shared decision making and how often patient goals are solicited
  - *Patient involvement and team accountability*
  - *Consider the use of the term "person" instead of "patient"*
  - *Attribution model, defined as a set of rules to define the accountable unit for a patient's healthcare outcomes**

*National Quality Forum (NQF). Attribution: Principles and Approaches. Washington, DC: NQF; 2016. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=84236. Last accessed January 2017.

Workgroup Discussion

- Thoughts from Clinician Liaison: Clarke Ross
- Discuss how the clinician measure sets or the measures under consideration address the issue of goal-directed, person-centered care planning & implementation.
- Discuss strategies to incorporate PROs into care processes and how physicians can empower patients and include them as equal partners in care decisions.

Cross-Cutting Themes

2016-2017 Pre-Rulemaking Cross-Cutting Themes Related to Dual Beneficiaries

- Importance of capturing the patient perspective through patient reported *outcome* measures
- Acknowledge various drivers of measurement
  - *Legislation and regulations*
  - *Clinical relevance*
  - *Patients' needs and perspectives*
- Importance of measures that are meaningful to providers *and* consumers
- Consider the level of effort involved with measurement:
  - *Patient – capturing information efficiently and sharing effectively*
  - *Provider – impact of data collection and reporting on workflow*

Workgroup Discussion of Cross-Cutting Themes

- Recap of workgroup discussion themes
- Recommended steps for advancing key issues in measurement for annual pre-rulemaking process
- Additional recommendations to the Coordinating Committee

Opportunity for Public Comment

Summarize, Next Steps, and Adjourn

Next Steps

- Coordinating Committee 2-Day In-Person Meeting
  - *January 24 – 25, 2017 (Optional for Workgroup members)*
- Dual Eligible Beneficiaries Workgroup Web Meeting #2
  - *Wednesday, February 22, 2017 2:30-4:30PM ET*
- Dual Eligible Beneficiaries Workgroup In-Person Meeting
  - *Wednesday, March 29 and Thursday, March 30, 2017*

Contact Us!

Project webpage:

- http://www.qualityforum.org/MAP
- General information
- Current and archived reports
- Register and attend meetings, access materials and recordings of past meetings

Project staff:

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Thank You for Participating!