NATIONAL QUALITY FORUM

Welcome to Today's Meeting!

- Housekeeping reminders:
  - Please **mute** yourself when **not** speaking
  - The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
  - We encourage you to keep your video on throughout the event
  - Feel free to use the chat feature to communicate with NQF staff

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at **MAPHealthEquity@qualityforum.org**

NATIONAL QUALITY FORUM
Driving measurable health improvements together

Measure Applications Partnership (MAP)

MAP Health Equity Advisory Group Orientation to the 2021-2022 Pre-Rulemaking Process Web Meeting

October 26, 2021

Funding provided by the Centers for Medicare & Medicaid Services, Task Order HHSM-500-T0003 Option Year 3.

Welcome, Introductions, and Review of Meeting Objectives

NATIONAL QUALITY FORUM

Agenda

- Welcome, Introductions, and Review of Meeting Objectives
- CMS Opening Remarks
- Overview of MAP and the Pre-Rulemaking Process
- Measure Set Review Pilot - New to 2021 Cycle
- Creation of Measures Under Consideration (MUC) List
- Setting-Specific Workgroups and Associated Federal Programs
- Role of the MAP Health Equity Advisory Group in the 2021-2022 Pre-Rulemaking Process
- Public and Member Comment
- Next Steps

NATIONAL QUALITY FORUM

MAP Health Equity Advisory Group Staff

Chelsea Lynch, MPH, MSN, RN, CIC
Director

Katie Berryman, MPAP, PMP,
Senior Project Manager

Ivory Harding, MS,
Manager

Amy Guo, MS,
Manager

Victoria Freire, MPH, CHES®,
Analyst

Joelencia LeFlore,
Coordinator

Health Equity Advisory Group Membership

Advisory Group Co-Chairs: Rebekah Angove, PhD / Laurie Zephyrin MD, MPH, MBA

Organizational Members (Voting)

- Aetna
- American Medical Association
- American Nurses Association
- American Society of Health-System Pharmacists
- America's Essential Hospitals
- Beth Israel Lahey Health
- Fenway Health
- IBM Watson Health
- National Committee for Quality Assurance
- National Health Law Program
- Patient Safety Action Network
- Planned Parenthood Federation of America
- The SCAN Foundation
- Vizient Inc.

Health Equity Advisory Group Membership (cont.)

Individual Subject Matter Experts (Voting)

- Emily Almeda-Lopez, MPP
- Susannah Bernheim, MD, MHS
- Damien Cabezas, MPH, MSW
- Mark Friedberg, MD, MPP
- Jeff Huebner, MD
- Gerald Nebeker, PhD, FAAIDD
- J. Nwando Olayiwola, MD, MPH, FAAFP
- Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM
- Cardinale Smith, MD, PhD
- Melony Sorbero, PhD, MPH
- Jason Suh, MD

Federal Government Liaisons (Nonvoting)

- Centers for Medicare & Medicaid Services (CMS)
- Health Resources & Services Administration (HRSA)
- CMS Office of Minority Health (OMH)
- Office of National Coordinator for Health Information Technology (ONC)
- Veterans Health Administration (VHA)

CMS Opening Remarks

Overview of MAP and the Pre-Rulemaking Process

Measure Applications Partnership (MAP) Overview

Statutory Authority

- The Affordable Care Act (ACA) requires the Department of Health and Human Services (HHS) to contract with a consensus-based entity (i.e., NQF) to **"convene multi-stakeholder groups to provide input on the selection of quality measures for public reporting, payment, and other programs"** (ACA Section 3014).
- The Social Security Act (SSA) establishes a pre-rulemaking process via a multi-stakeholder group input into selection of quality measures (SSA Section 1890A).
- This work is funded by the Centers for Medicare & Medicaid Services (CMS) under contract HHSM-500-T0003.

NATIONAL QUALITY FORUM

The Role of MAP

- Inform the selection of performance measures to achieve:
  - Improvement
  - Transparency
  - Value for all
- Provide input to HHS on the selection of measures for:
  - Public reporting
  - Performance-based payment
  - Other federal programs
- Identify measure gaps for development, testing, and endorsement
- Encourage measurement alignment across public and private programs, settings, levels of analysis, and populations to:
  - Promote coordination of care delivery
  - Reduce data collection burden

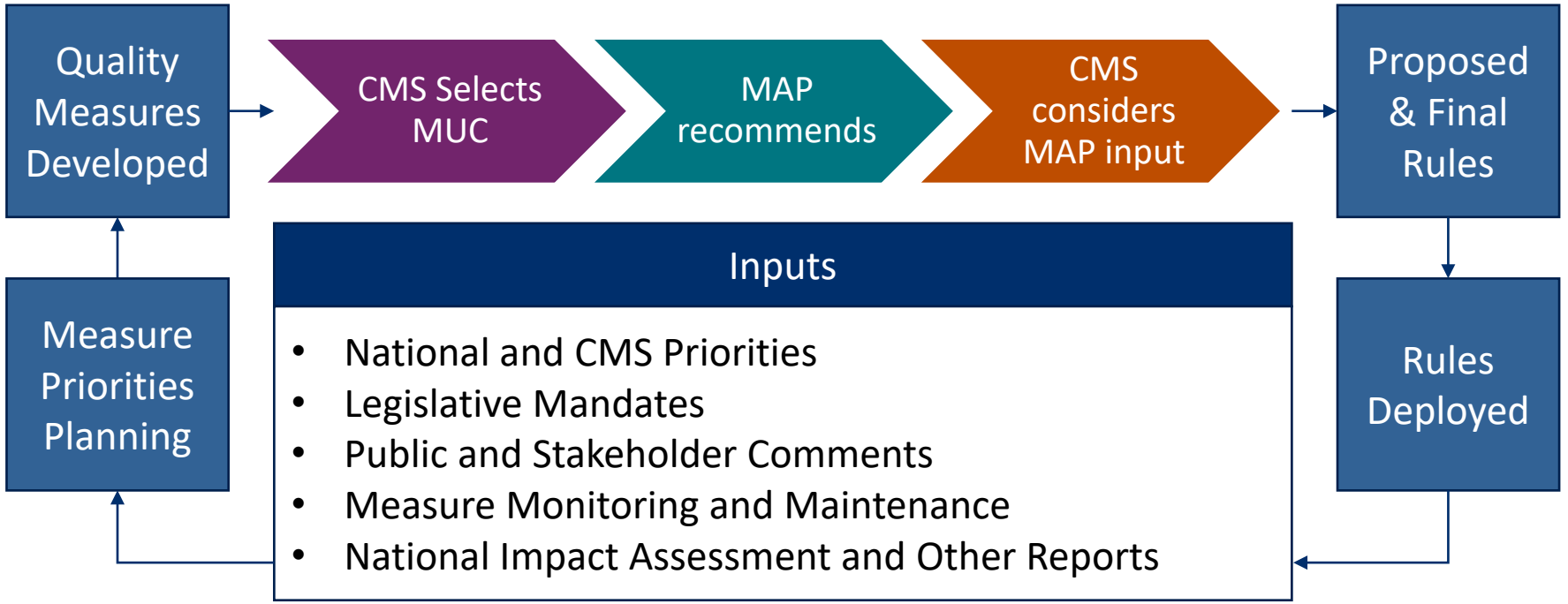
Rulemaking

Rulemaking refers to the process that government agencies, such as HHS, use to create regulations.

https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf

NATIONAL QUALITY FORUM

Pre-Rulemaking



https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rulemaking

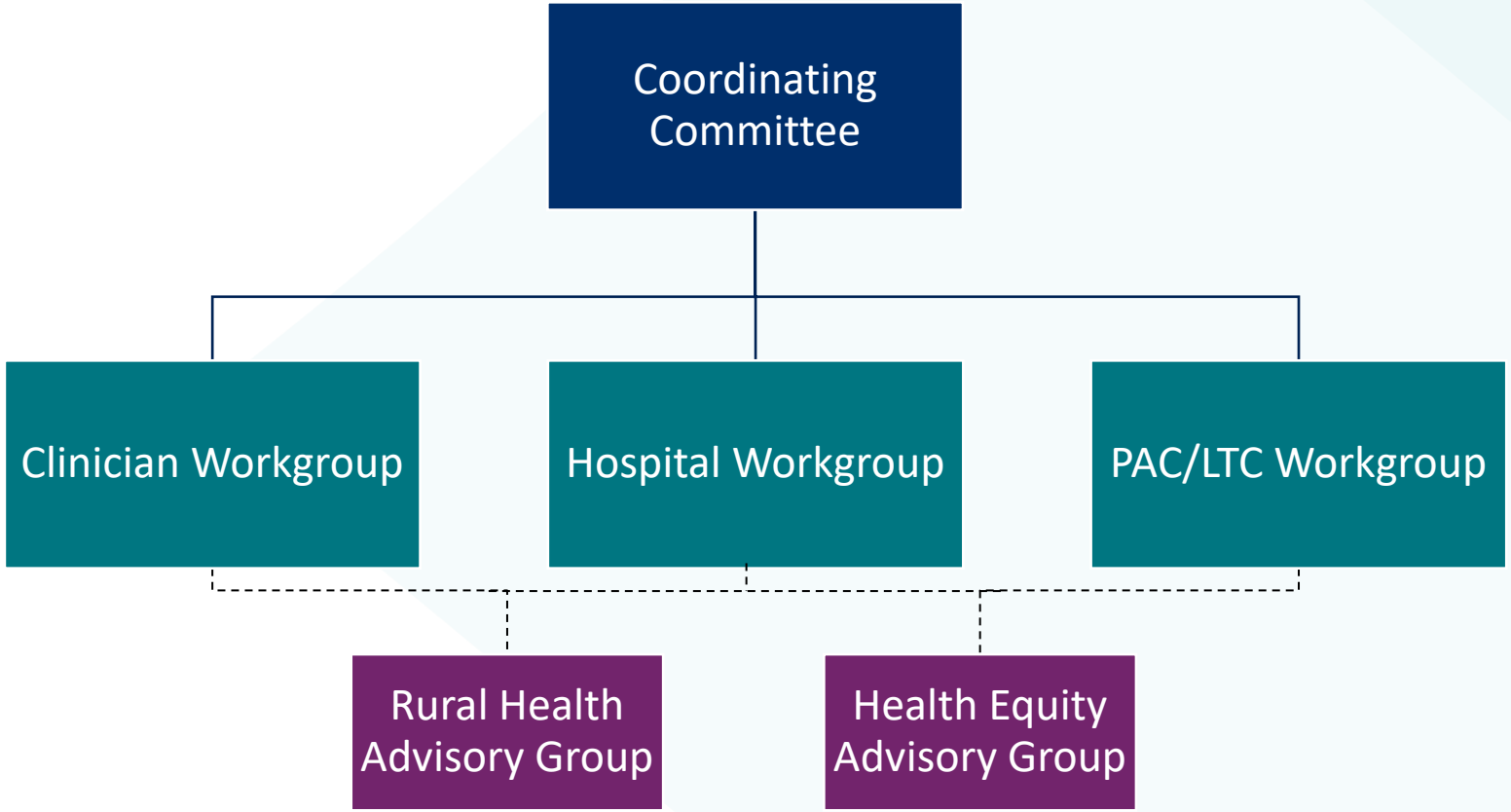
NATIONAL QUALITY FORUM

Value of Pre-Rulemaking Input

- Facilitates multi-stakeholder dialogue that includes HHS representatives
- Allows for a consensus-building process among stakeholders in a transparent and 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

NATIONAL QUALITY FORUM

MAP Structure



NATIONAL QUALITY FORUM

MAP Members

- **Organizational Representatives**
  - Constitute the majority of MAP members
  - Include those that are interested in or affected by the use of measures
  - Organizations designate their own representatives
- **Subject Matter Experts (SMEs)**
  - Serve as individual representatives bringing topic-specific knowledge to MAP deliberations
  - Chairs and co-chairs of MAP's workgroups, advisory groups, and task forces are considered subject matter experts
- **Federal Government Liaisons**
  - Serve as ex-officio, nonvoting members representing a federal agency

Measure Set Review – Pilot Process

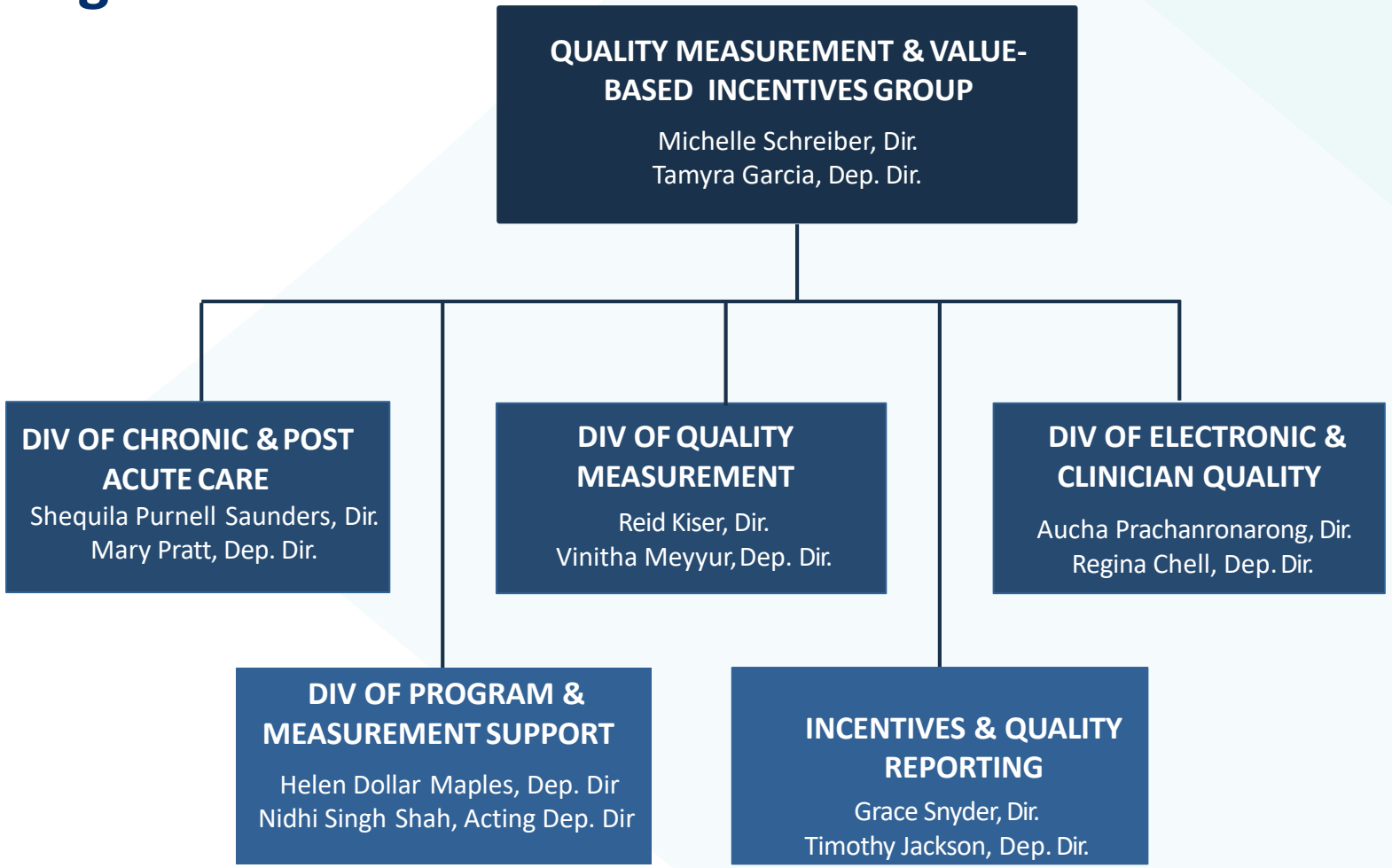
Measure Set Review Pilot – New to 2021

- In partnership with CMS, NQF developed a pilot process and measure review criteria (MRC) for federal quality programs covering the Clinician, Hospital and Post-Acute Care/Long-Term Care (PAC/LTC) settings
- For the 2021-2022 cycle, the MAP Coordinating Committee reviewed the pilot MSR and MRC
- The final report on measures will be submitted to CMS in October
- For the 2022-2023 cycle, MAP will fully implement the MSR to include input from all workgroups and advisory groups

Creation of the Measures Under Consideration (MUC) List

NATIONAL QUALITY FORUM

CMS' Center for Clinical Standards & Quality: Home to the Pre-Rulemaking Process



NATIONAL QUALITY FORUM

Statutory Authority: Pre-Rulemaking Process

- Under section 1890A of the Act and ACA 3014, HHS is required to establish a pre-rulemaking process under which a consensus-based entity (CBE) would convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures for use in certain CMS programs
- The list of quality and efficiency measures HHS is considering for selection is to be publicly published **no later than December 1** of each year. No later than **February 1** of each year, the CBE is to report the input of the multi-stakeholder groups, which will be considered by HHS in the selection of quality and efficiency measures

Considerations for Selection of 2021 MUC List Measures

- **Alignment with Meaningful Measures/Gap Areas**
  - Measures should be a high-priority quality issue or meet a statutory requirement
- **Measure Type**
  - Outcome measures are preferred
  - Patient Reported Outcomes (PRO)/Patient Reported Outcome Measures (PROM)/Patient Reported Outcome-Based Performance Measures (PRO-PM)
- **Burden**
  - Consider amount of burden associated with the measure

Considerations for Selection of 2021 MUC List Measures (continued)

- **Measures With Complete Specifications**
  - Ideally, measures should have endorsement; however, endorsement not necessary
- **Feasibility**
  - Digital quality measures (dQMs) and administrative claim measures help to determine burden and feasibility
- **Alignment**
  - Consider alignment of similar measures across CMS programs and with private payers while minimizing duplication of measures and measure concepts

NATIONAL QUALITY FORUM

2021 Pre-Rulemaking Timeline

January	• Submission period opens for new candidate measures
March-April	• MUC stakeholder education and outreach
May	• Measure submission period closes
July-August	• CMS programs review proposed MUC List
December	• MUC List release • MAP Workgroup and Advisory Group meetings
January	• MAP Coordinating Committee meeting • MAP recommendations published

Pre-Rulemaking Approach

The approach to the analysis and selection of measures is a two-step process:

- Evaluate MUCs for what they would add to the program measure set
- Identify and prioritize gaps for programs and settings

Setting-Specific Workgroups/Advisory Groups and Associated Federal Programs

MAP Coordinating Committee Charge

- Provide input to HHS on the coordination of performance measurement strategies across public sector programs, across settings of care, and across public and private payers;
- Set the strategic direction for the MAP; and
- Give direction to and ensure alignment among the MAP setting-specific and advisory workgroups.
  - Hospital Workgroup
  - Post Acute Care-Long Term Care (PAC-LTC) Workgroup
  - Clinician Workgroup
  - Rural Health Advisory Group
  - Health Equity Advisory Group

MAP Hospital Workgroup Charge

MAP Hospital Workgroup reviews measures considered for:

- Hospital Inpatient Quality Reporting Program (Hospital IQR Program)
- Medicare Promoting Interoperability Program for Hospitals
- Hospital Value-Based Purchasing Program (VBP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital-Acquired Condition Payment Reduction Program (HACRP)
- Hospital Outpatient Quality Reporting Program (Hospital OQR Program)
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Ambulatory Surgical Center Quality Reporting Program (ASCQR)
- PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
- End-Stage Renal Disease Quality Improvement Program (ESRD QIP)

Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

Hospital Value-Based Purchasing Program (VBP)

- **Program Type:** Pay for Performance
- **Incentive Structure:** The amount equal to 2% of base operating diagnosis-related group (DRG) is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments.
- **Program Goal:** Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards.

Hospital Readmissions Reduction Program (HRRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** Medicare fee-for-service (FFS) base operating diagnosis-related group (DRG) payment rates are reduced for hospitals with excess readmissions. The maximum payment reduction is 3.0%.
- **Program Goal:** Reduce excess readmissions in acute care hospitals and encourage hospitals to improve communication and care coordination to better engage patients and caregivers with post-discharge planning.

Hospital-Acquired Condition Reduction Program (HACRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.
- **Program Goal:** Encourage hospitals to reduce hospital-acquired conditions (HACs) through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

Hospital Outpatient Quality Reporting Program (HOQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not report data on required measures receive a 2.0% reduction in annual payment update.
- **Program Goal:** Provide consumers with quality-of-care information to make more informed decisions about healthcare options, and establish a system for collecting and providing quality data to hospitals providing outpatient services such as emergency department visits, outpatient surgery, and radiology services.

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Inpatient psychiatric facilities (IPFs) that do not submit data on all required measures receive a 2.0% reduction in annual payment update.
- **Program Goal:** Provide consumers with quality-of-care information to make more informed decisions about healthcare options, and encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware of and reporting on best practices.

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Ambulatory surgical centers (ASCs) that do not participate or fail to meet program requirements receive 2.0% reduction in annual payment update.
- **Program Goal:** Promote higher quality, more efficient healthcare for Medicare beneficiaries through measurement, and allow consumers to find and compare the quality of care given at ASCs to inform decisions on where to get care.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

- **Program Type:** Quality Reporting Program
- **Incentive Structure:** PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare.
- **Program Goal:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program, and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices.

End-Stage Renal Disease Quality Improvement Program (ESRD QIP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** As of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions will be on a sliding scale, which could amount to a maximum of 2.0% per year.
- **Program Goal:** Improve the quality of dialysis care and produce better outcomes for beneficiaries.

MAP Clinician Workgroup Charge

MAP Clinician Workgroup reviews measures considered for:

- Merit-based Incentive Payment System (MIPS)
- Medicare Shared Savings Program (SSP)
- Medicare Parts C & D Star Ratings

NATIONAL QUALITY FORUM

Merit-based Incentive Payment System (MIPS)

- **Program Type:** Quality Payment Program
- **Incentive Structure:**
  - Pay-for-performance
  - There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight.
  - The MIPS performance categories and finalized 2021 weights:
    - Quality (40%)
    - Promoting Interoperability (25%)
    - Improvement Activities (15%)
    - Cost (20%)
    - The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.
- **Program Goals:**
  - Improve quality of patient care and outcomes for Medicare FFS.
  - Reward clinicians for innovative patient care.
  - Drive fundamental movement toward value in healthcare.

NATIONAL QUALITY FORUM

Medicare Shared Savings Program (SSP)

- **Program Type:** Mandated by section 3022 of the ACA
- **Incentive Structure:**
  - Pay-for-performance
  - Voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an Accountable Care Organization (ACO) to give coordinated, high-quality care to their Medicare beneficiaries.
    - CMS assess ACO performance annually based on quality and financial performance to determine share savings and losses
    - ACOs reports MIPS measures on behalf of clinicians and are scored under MIPS Alternative Payment Model (APM) Scoring Standard.
    - Eligible clinicians in Advanced APMS may qualify for the 5% APM incentive payment
- **Program Goals:**
  - Promote accountability for a patient population.
  - Coordinate items and services for Medicare FFS beneficiaries.
  - Encourage investment in high quality and efficient services.

Part C and D Star Ratings

- **Program Type:** Quality Payment Program and Public Reporting
- **Incentive Structure:**
  - Medicare Advantage: Public reporting and quality bonus payments (QBP)
  - Stand-alone Prescription Drug Plans: Public reporting
- **Program Goal:**
  - Provide information about plan quality and performance indicators to beneficiaries to help them make informed plan choices
  - Incentivize high performing plans (Part C)

The April 2018 final rule (CMS-4282-F) initially codified the methodology for the Part C and Part D Star Ratings

MAP Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup Charge

MAP PAC/LTC Workgroup reviews measures considered for:

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

Home Health Quality Reporting Program (HH QRP)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Home health agencies (HHAs) that do not submit data will have their annual HH market basket percentage increase reduced by 2%.
- **Program Information:** Alignment with the mission of the National Academy of Medicine (NAM) which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness.

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** IRFs that fail to submit data will have their applicable IRF Prospective Payment System (PPS) payment update reduced by 2%.
- **Program Goal:** Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

- **Program Type**: Pay for reporting and public reporting
- **Incentive Structure**: Long-term care hospitals (LTCHs) that fail to submit data will have their applicable annual payment update (APU) reduced by 2%.
- **Program Goal:** Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).

Hospice Quality Reporting Program (HQRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** Starting in FY 2024 (CY 2022 data), hospices that fail to submit quality data will have their annual payment update (APU) reduced by 4%; prior to FY 2024, the APU payment penalty was 2%.
- **Program Goal:** Addressing pain and symptom management for hospice patients and meeting their patient-centered goals, while remaining primarily in the home environment.

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** Skilled nursing facilities (SNFs) that do not submit the required quality data will have their annual payment update reduced by 2%.
- **Program Goals:** Increase transparency so that patients are able to make informed choices.

NATIONAL QUALITY FORUM

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Program Type:** Value-Based Purchasing
- **Incentive Structure:** The SNF VBP Program awards incentive payments to SNFs based on a single all-cause readmission measure (SNF 30-Day All-Cause Readmission Measure; NQF #2510), as mandated by Protecting Access to Medicare Act (PAMA) of 2014. SNFs' performance period risk-standardized readmission rates are compared to their own past performance to calculate an improvement score and the National SNF performance during the baseline period to calculate an achievement score. The higher of the achievement and improvement scores becomes the SNF's performance score.
- SNFs with less than 25 eligible stays during the baseline period will not receive an improvement score. These SNFs will be scored on achievement only. SNFs with less than 25 eligible stays during the performance period will be "held harmless".
- **Program Goal:** Transforming how care is paid for, moving increasingly towards rewarding better value, outcomes, and innovations instead of merely volume, and linking payments to performance on a single readmission measure.

Protecting Access to Medicare Act (PAMA) and The Consolidated Appropriations Act of 2021

- The Protecting Access to Medicare Act (PAMA) of 2014 authorized the SNF VBP Program.
- Per PAMA, the all-cause measure will be replaced as soon as practicable with a potentially preventable readmission measure.
- CMS withholds 2% of SNF Medicare FFS payments to fund the Program, and 60% of these withheld funds are redistributed to SNFs in the form of incentive payments.
- The SNF VBP Program began awarding incentive payments to SNFs on October 1, 2018.
- The Consolidated Appropriations Act of 2021 allows the Secretary to apply up to 9 additional measures, which may include measures focusing on functional status, patient safety, care coordination, or patient experience for payments for services furnished on or after October 1, 2023.

Role of the MAP Health Equity Advisory Group in the 2021-2022 Pre-Rulemaking Process

MAP Health Equity Advisory Group Charge

- Provide input on MUCs with a lens to measurement issues impacting health disparities and the over 1,000 United States critical access hospitals
- Provide input on MUCs with the goal to reduce health differences closely linked with social, economic, or environmental disadvantages

NATIONAL QUALITY FORUM

Health Equity Advisory Group Review of MUCs

- **Step 1.** NQF staff describes the program in which the measure is being proposed
- **Step 2.** The lead discussant will summarize the measure and offer initial thoughts about inclusion of the measure into the program
- **Step 3.** Advisory Group discusses each measure and provides feedback on:
  - Relative priority in terms of advancing health equity for all
  - Data collection and/or reporting challenges regarding health disparities
  - Methodological problems of calculating performance measures adjusting for health disparities
  - Potential unintended consequences related to health disparities if the measure is included in specific programs

NATIONAL QUALITY FORUM

Health Equity Advisory Group Review of MUCs Continued

- **Step 4.** Advisory Group takes a poll on the potential impact on health disparities if the measure is included within a specific program
  - Range is 1-5, from negative impact (increasing disparities) to positive impact (reducing disparities)
- **Step 5.** Advisory Group discusses gap areas in measurement relevant to health disparities and critical access hospitals

Health Equity Advisory Group Input Provided to the Setting-Specific Workgroups

Health Equity Advisory Group feedback will be provided to the setting-specific Workgroups through the following mechanisms:

- Preliminary analyses (PAs):
  - A qualitative summary of Health Equity Advisory Group's discussion of the MUCs
  - Polling results that quantify the Health Equity Advisory Group's perception of the potential impact on health disparities if the MUCs are included in specific programs
    - » Average polling results
- Health Equity Advisory Group discussion will be summarized at the setting-specific Workgroup pre-rulemaking meetings in December

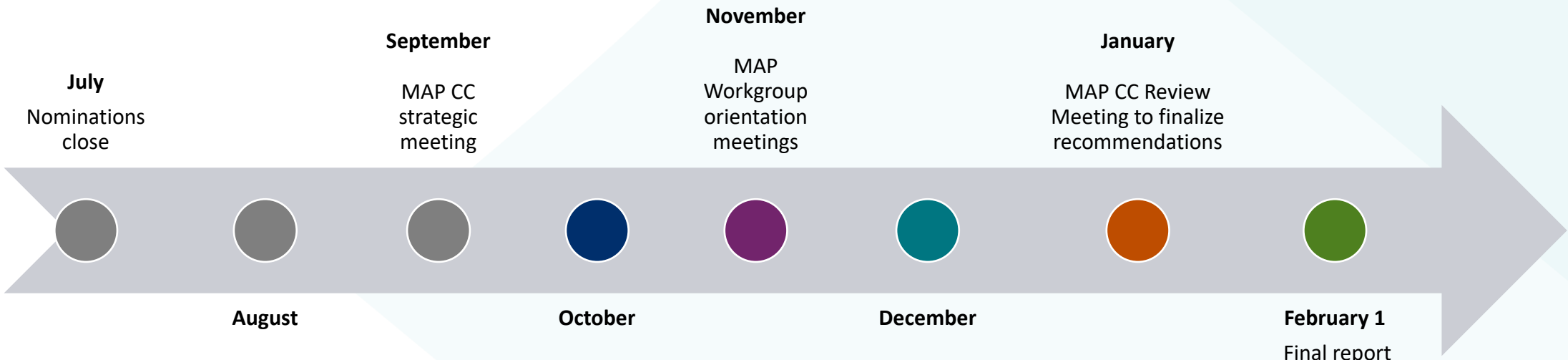
Questions?

Public and Member Comment

Next Steps

NATIONAL QUALITY FORUM

Timeline of MAP Activities



NATIONAL QUALITY FORUM

Timeline of Upcoming Activities

- **Release of the MUC List** – by December 1
- **Public Comment Period 1** – Timing based on MUC List release
- **Advisory Group Review Meetings**
  - Rural Health Advisory Group – **December 8**
  - Health Equity Advisory Group – **December 9**
- **Workgroup Review Meetings**
  - Clinician Workgroup – **December 14**
  - Hospital Workgroup – **December 15**
  - Post-Acute/Long-Term Care (PAC/LTC) Workgroup – **December 16**
  - Coordinating Committee – **January 19, 2022**
- **Public Comment Period 2** – December 30, 2021 – January 13, 2022

Resources

- **CMS' Measurement Needs and Priorities Document:**
  - 2021 Needs and Priorities (PDF)
- **CMS' Pre-Rulemaking Overview:**
  - Pre-Rulemaking Webpage
- **MAP Member Guidebook:**
  - All MAP members will receive a copy of the 2021 MAP Member Guidebook via email

Health Equity Project Team Inbox – MAPHealthEquity@qualityforum.org

THANK YOU.

NATIONAL QUALITY FORUM

https://www.qualityforum.org