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Driving measurable health improvements together

Measure Applications Partnership (MAP)

MAP Rural Health Workgroup Orientation to the 2020-2021 Pre-Rulemaking Process Web Meeting

September 18, 2020

Welcome, Introductions, and Review of Meeting Objectives

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Agenda

- Welcome, Introductions, and Review of Meeting Objectives
- CMS Opening Remarks
- Overview of MAP and the Pre-Rulemaking Process
- Creation of Measures Under Consideration (MUC) List
- Setting-Specific Workgroups and Associated Federal Programs
- Role of the MAP Rural Health Workgroup in the 2020-2021 Pre-Rulemaking Process
- Public and Member Comment
- Next Steps

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MAP Rural Health Workgroup Staff

- **Chelsea Lynch, MPH, MSN, RN, CIC,** Director
- **Nicolette Mehas, PharmD,** Director
- **Chris Dawson, MHA, CPHQ,** Manager
- **Carolee Lantigua, MPA,** Manager
- **Amy Guo, MS,** Analyst

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Rural Health Workgroup Membership

Workgroup Co-Chairs: Ira Moscovice, PhD; Aaron Garman, MD

Organizational Members (Voting)

- Alliant Health Solutions
- American Academy of Family Physicians
- American Academy of Physician Assistants
- American College of Emergency Physicians
- American Hospital Association
- American Society of Health-System Pharmacists
- Cardinal Innovations
- Geisinger Health
- Intermountain Healthcare
- Michigan Center for Rural Health
- Minnesota Community Measurement
- National Association of Rural Health Clinics
- National Rural Health Association
- National Rural Letter Carriers' Association
- RUPRI Center for Rural Health Policy Analysis
- Rural Wisconsin Health Cooperative
- Truven Health Analytics LLC/IBM Watson Health Company

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Rural Health Workgroup Membership

Individual Subject Matter Experts (Voting)

- Michael Fadden, MD
- John Gale, MS
- Curtis Lowery, MD
- Jessica Schumacher, PhD
- Ana Verzone, MS, APRN, FNP, CNM
- Holly Wolff, MHA

Federal Government Liaisons (Nonvoting)

- Federal Office of Rural Health Policy, Department of Health and Human Services (DHHS)/Health Resources and Services Administration (HRSA)
- Indian Health Services, Department of Health and Human Services (DHHS)
- Center for Medicare and Medicaid Innovation (CMMI), Centers for Medicare & Medicaid Services (CMS)

CMS Opening Remarks

Overview of MAP and the Pre-Rulemaking Process

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Measure Applications Partnership (MAP)

Statutory Authority

- The Affordable Care Act (ACA) requires the Department of Health and Human Services (HHS) to contract with the 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 multistakeholder 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.

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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

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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

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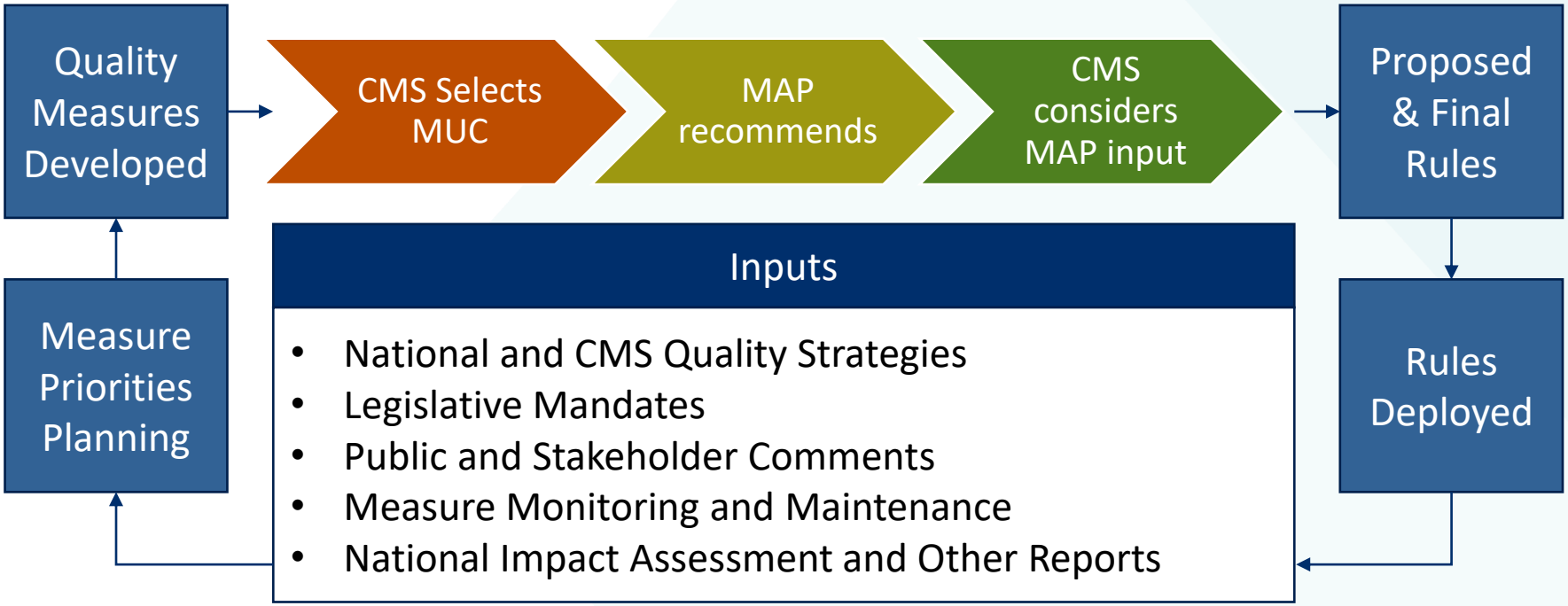
Pre-Rulemaking



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

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Value of Pre-Rulemaking Input

- Facilitates multistakeholder 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

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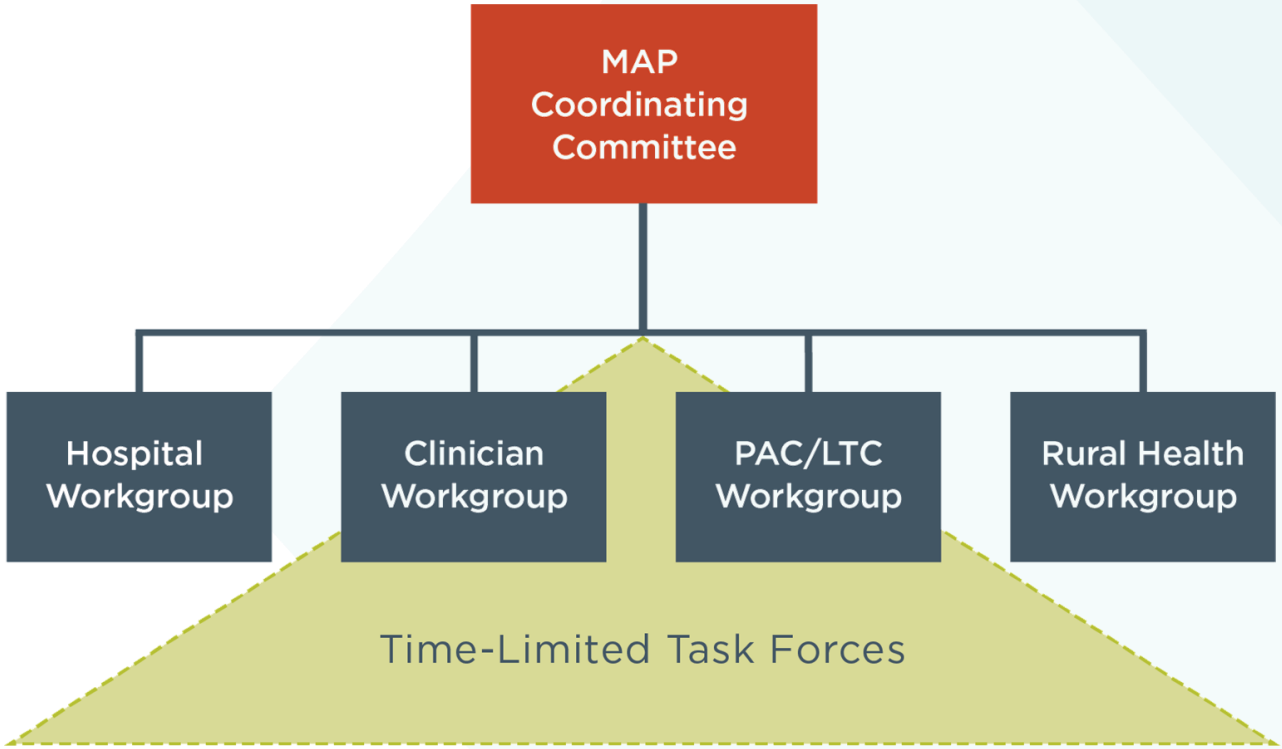
MAP Structure



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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**
  - Serve as individual representatives bringing topic-specific knowledge to MAP deliberations
  - Chairs and co-chairs of MAP's Coordinating Committee, workgroups, and task forces are considered subject matter experts
- **Federal Government Liaisons**
  - Serve as ex-officio, nonvoting members representing a federal agency

Creation of the Measures Under Consideration (MUC) List

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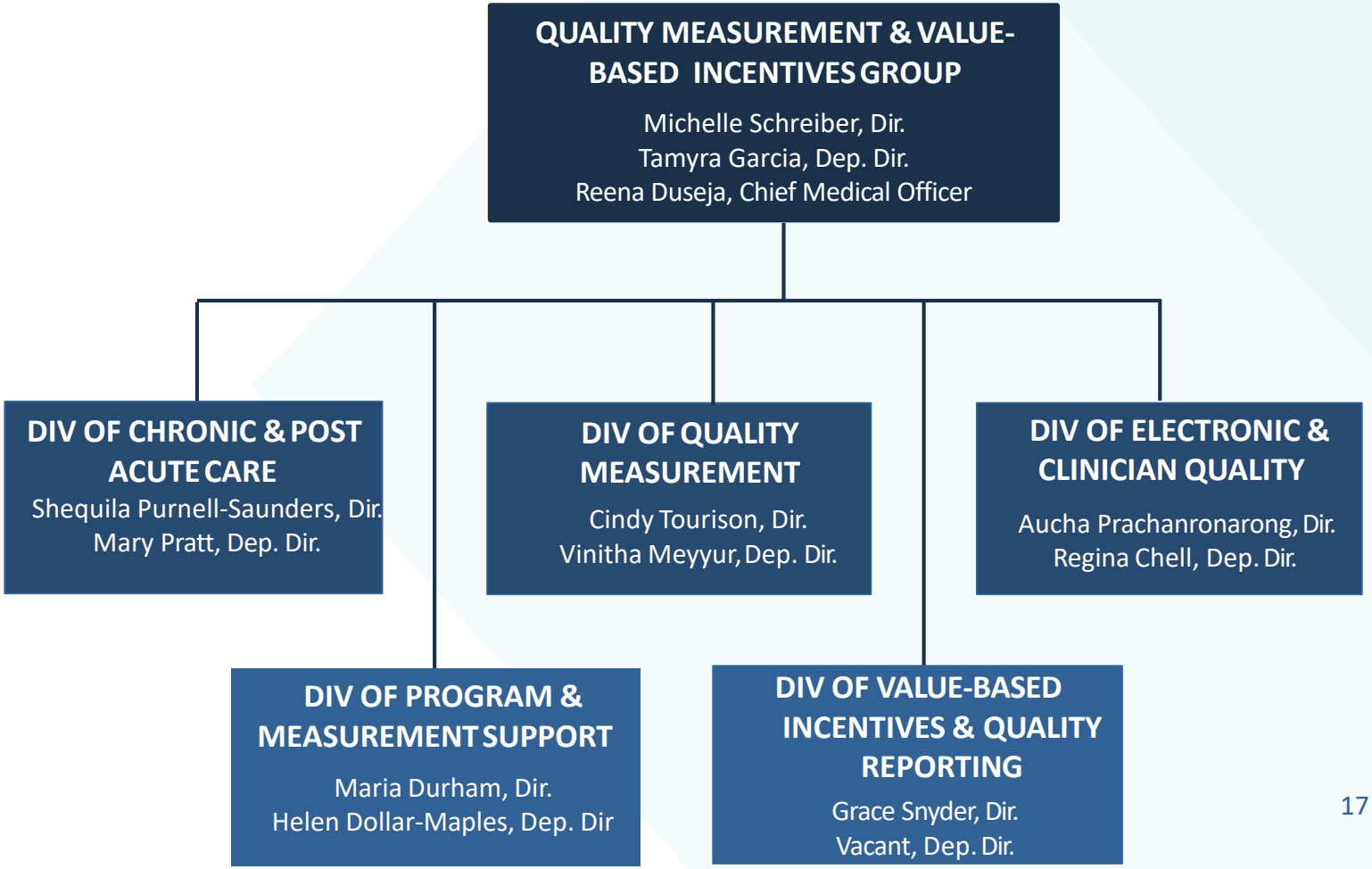
CMS' Center for Clinical Standards & Quality: Home to the Pre-Rulemaking Process



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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 multistakeholder 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 multistakeholder groups, which will be considered by HHS in the selection of quality and efficiency measures.

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Considerations for Selection of 2020 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.
- **Burden**
  - Consider amount of burden associated with the measure.

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Considerations for Selection of 2020 MUC List Measures (continued)

- **Measures With Complete Specifications**
  - Ideally, measures should have endorsement; however, endorsement is not absolutely necessary.
- **Feasibility**
  - Measures should be able to be feasibly implemented by CMS.
- **Alignment**
  - Consider alignment of similar measures across CMS programs and with private payers while minimizing duplication of measures and measure concepts.

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2020 Pre-Rulemaking Timeline

January	• Submissions open for new candidate measure
April	• MUC stakeholder education and outreach
July	• Measure submissions closed
August	• Federal stakeholders meeting • Clearance process began for proposed MUC List
December	• MUC List release • MAP Workgroup meetings
January	• MAP Coordinating Committee meeting • MAP recommendations published

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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 and Associated Federal Programs

MAP Coordinating Committee Charge

- Advise 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 Workgroup

MAP Hospital Workgroup Charge

MAP Hospital Workgroup reviews measures considered for:

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

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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.

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Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals and Critical Access 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 between electronic health records (EHRs) and CMS data collection.

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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.

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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%.
- **Program Goal:** Reduce excess readmissions in acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), which includes more than three-quarters of all hospitals and encourage hospitals to improve communication and care coordination efforts to better engage patients and caregivers, with respect to post-discharge planning.

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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.

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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.

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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.

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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.

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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.

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End-Stage Renal Disease Quality 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

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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 proposed 2020 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.

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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
    - » Also includes Alternative Payment Model (APM) Scoring Standard where MIPS eligible clinicians 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.

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Part C and D Star Ratings

- **Program Type:** Quality Payment Program and Public Reporting
- **Incentive Structure:**
  - Medicare Advantage: Public reporting and quality bonus payments
  - 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) 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 provides reviews measures considered for:

- Home Health Quality Reporting Program (HHQRP)
- 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 (HHQRP)

- **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.

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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).

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Hospice Quality Reporting Program (HQRP)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospices that fail to submit quality data will have their annual payment update reduced by 2%.
- **Program Goal:** Addressing pain and symptom management for hospice patients and meeting their patient-centered goals, while remaining primarily in the home environment.

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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.

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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 toward rewarding better value, outcomes, and innovations instead of merely volume.
  - Linking payments to performance on a single readmission measure.

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Protecting Access to Medicare Act (PAMA)

- The Protecting Access to Medicare Act (PAMA) of 2014 authorized the SNF VBP Program.
- The SNF VBP Program awards incentive payments to SNFs per the quality of care provided to Medicare beneficiaries.
  - The SNF VBP Program measures quality of care with a single all-cause hospital readmission measure, as mandated by PAMA.
  - 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.

Role of the MAP Rural Health Workgroup in the 2020-2021 Pre-Rulemaking Process

MAP Rural Health Workgroup Charge

- To provide timely input on measurement issues to other MAP workgroups and committees and to provide rural perspectives on the selection of quality measures in MAP
- To help address priority rural health issues, including the challenge of low case-volume

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Rural Health Workgroup Review of MUCs

- **Step 1.** NQF staff describes the program which the measure is being proposed
- **Step 2.** The lead discussant will summarize the measure and proffer initial thoughts about inclusion of the measure into the program
- **Step 3.** Workgroup discusses the measure regarding:
  - Relative priority/utility in terms of access, cost, or quality issues encountered by rural residents
  - Data collection and/or reporting challenges for rural providers
  - Methodological problems of calculating performance measures for small rural facilities
  - Potential unintended consequences of inclusion in specific programs

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Rural Health Workgroup Review of MUCs

- **Step 4.** Workgroup votes on agreement that the measure is suitable for use with rural providers within the specific program of interest
  - Vote Range is 1-5, where higher reflects more agreement regarding suitability for the program
- **Step 5.** Workgroup discusses gap areas in measurement relevant to rural residents/providers for the specific program

Rural Health Workgroup Input Provided to the Setting-Specific Workgroups

Rural Health Workgroup feedback will be provided to the setting-specific Workgroups through the following mechanisms:

- Measure discussion guide:
  - A qualitative summary of Rural Health Workgroup's discussion of the MUCs
  - Voting results that quantify the Rural Health Workgroup's perception of suitability of the MUCs for various programs
    - Average vote and vote counts
- Attendance of Rural Health Workgroup liaisons at setting-specific Workgroup pre-rulemaking meetings in December

Public and Member Comment

Next Steps

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2020-2021 Pre-Rulemaking Timeline

January	• Submissions open for new candidate measure
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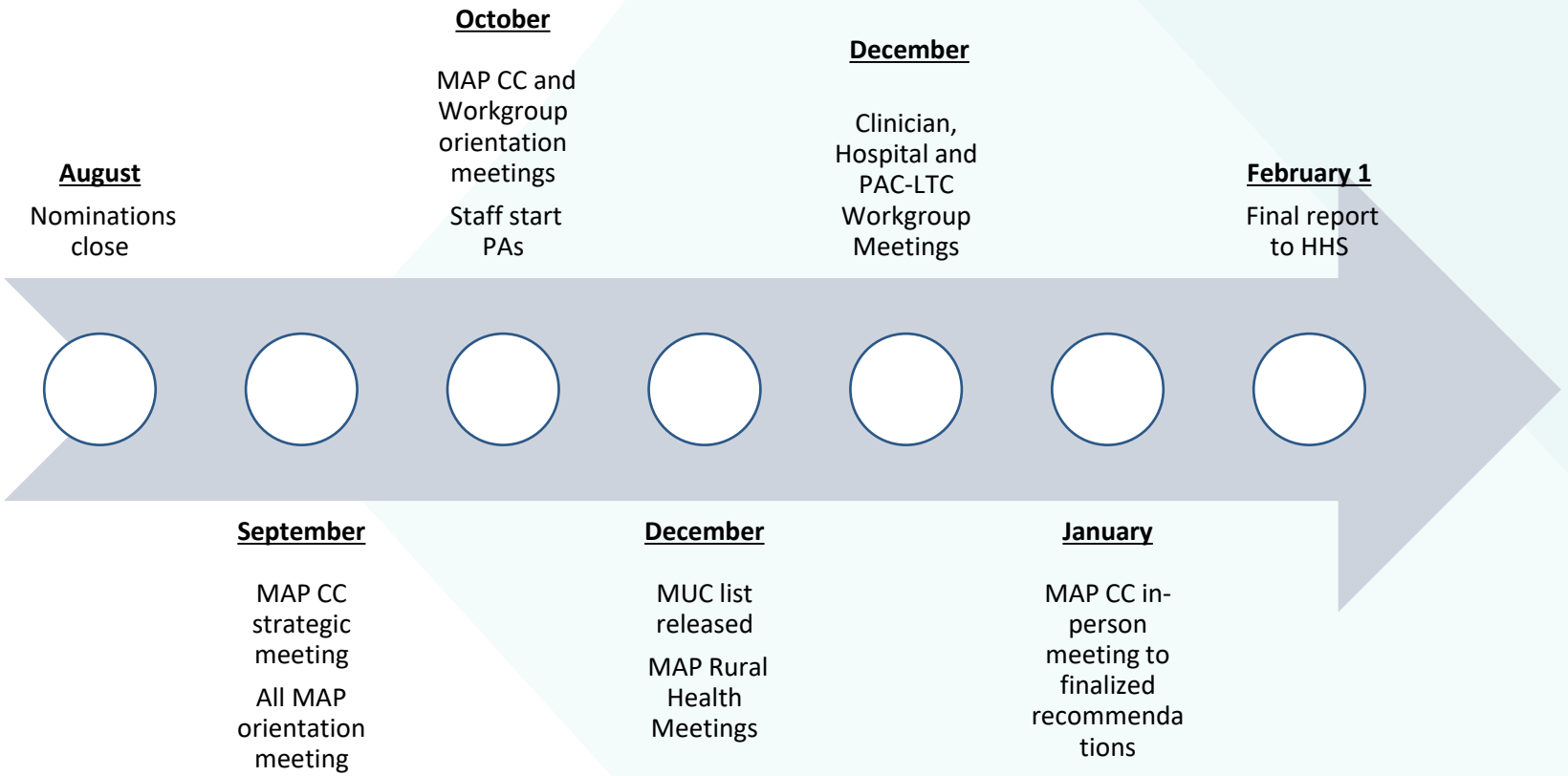
Timeline of MAP Activities



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Timeline of Upcoming Activities

- **Release of the MUC List** – by December 1
- **Public Comment Period 1** – Timing based on MUC List release
- **Rural Workgroup Web Meetings**
  - December 4th, 7th, 9th
- **Virtual Forums**
  - PAC/LTC, Hospital, Clinician Workgroup – **December 17**
  - Coordinating Committee – **January 19**
- **Public Comment Period 2** – December 28, 2020 – January 13, 2021

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Resources

- CMS Measurement Needs and Priorities Document: https://www.cms.gov/files/document/cms-measurement-priorities-and-needs.pdf
- Pre-Rulemaking URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html
- MAP Member Guidebook: http://share.qualityforum.org/Projects/MAP%20Rural%20Health/CommitteeDocuments/MAP%20Member%20Guidebook%202020.pdf

THANK YOU.

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