MAP Rural Health Technical Expert Panel Conference Call #1

Karen Johnson
Suzanne Theberge
Kirsten Reed
Ameera Chaudhry

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Welcome

Agenda

- Introductions
- Background and Context
- TEP Objectives and Activities
- Considering Implications for Healthcare Performance Measurement
- Overview of CMS Quality Improvement Programs
- Low Case-Volume Recommendations to Date
- TEP Questions & Discussion
- NQF Member and Public Comment
- Project Timeline and Next Steps
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Project Team

Karen Johnson, Senior Director

Suzanne Theberge, Senior Project Manager

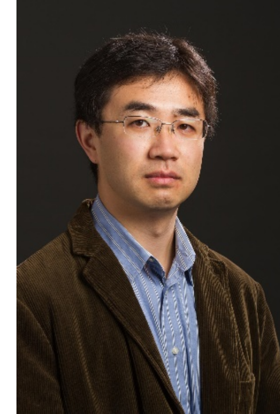
Kirsten Reed, Project Manager

Ameera Chaudhry, Project Analyst

Technical Expert Panel Members

Mariel Finucane, PhD

Jeffrey Geppert, EdM, JD



Shuangge (Steven) Ma, PhD

Jessica Schumacher, PhD

Alan Zaslavsky, PhD

Background and Context

NQF's 2015 Rural Health Project
Purpose and Objectives

- To provide multistakeholder information and guidance on performance measurement issues and challenges for rural providers
  - *Make recommendations regarding measures appropriate for use in CMS pay-for-performance programs for rural hospitals and clinicians*
  - *Make recommendations to help mitigate measurement challenges for rural providers, including the low case-volume challenge*
  - *Identify measurement gaps for rural hospitals and clinicians*

NQF's 2015 Rural Health Project

Key Issues Regarding Measurement of Rural Providers

- Geographic isolation
  - *Limited provider availability*
  - *Limited IT capabilities*
  - *Transportation difficulties*
- Small practice size
  - *Limited time, staff, and/or finances for QI*
  - *Multiple and disparate staff responsibilities across facilities*
- Heterogeneity
  - *Heterogeneity in settings and patient population*
  - *Implications for adjustment, reliability, and use of measures*
- Low case-volume
  - *Insufficient volume to achieve reliable and valid measurement*
  - *Limited set of available healthcare services may limit applicability of measures*

NQF's 2015 Rural Health Project

- Overarching Recommendation
  - *Make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers, but allow a phased approach for full participation across program types and explicitly address low case-volume*

- Some Supporting Recommendations
  - *Select measures that are relevant for rural providers*
  - *Use a core set of measures, along with a menu of optional measures*
  - *Create a Rural Measure Applications Partnership (MAP) workgroup*
  - *Fund development of rural-relevant measures*
  - *Develop/modify measures to explicitly address low case-volume*
  - *Ensure that component measures within composites are appropriate for rural (low-volume) providers*

Measure Applications Partnership (MAP)

Statutory Authority

The Affordable Care Act (ACA) requires 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).

MAP Rural Health Workgroup

Key Activities for 2017-2018

- Assemble MAP Rural Health Workgroup
- Identify a core set of the best available rural-relevant measures
- Identify gaps in measurement and provide recommendations on alignment and coordination of measurement efforts
- Make recommendations regarding measuring and improving access to care for the rural population

MAP Rural Health Workgroup
Key Activities for 2018-2019

- Share August 2018 report and recommendations with MAP Hospital, Clinician, and PAC/LTC Workgroups
- Provide feedback on clinician-specific measures included on the 2018 Measures Under Consideration (MUC) list
- Convene a Technical Expert Panel (TEP) to provide feedback and recommendations to address the low case-volume challenge faced by many rural providers

TEP Objectives and Activities

TEP Objectives

- Develop recommendations on approaches for calculating healthcare performance measures when case-volume is low
  - *Consider exemptions for reporting requirements in various CMS programs*
  - *Consider heterogeneity of residents and providers in rural areas*
  - *Recommendations should include approaches that are actionable for measure developers*
- Assist NQF in drafting a report that describes the TEP's discussion and recommendations

TEP Activities

Panel participation includes:

- Four 2-3 hour conference calls
- Review of meeting materials prior to conference calls
- Assistance in drafting a report summarizing the TEP's recommendations
- Assistance in reviewing public comments and revising draft report as needed

Low Case-Volume and Implications for Healthcare Performance Measurement

(Healthcare) Performance Measurement

- Measures used for quantifying the performance of different aspects of the healthcare system
- Goal is to improve the quality of healthcare received by patients (and ultimately health)
- Categories of performance measures
  - *Quality*
  - *Resource use/cost*
  - *Access*
  - *Efficiency (combination of quality and resource use)*

(Healthcare) Performance Measurement

- Types of performance measures
  - *Structure*
  - *Process*
  - *Outcome*
    - Intermediate clinical outcomes, use of services (used as proxies for outcomes), patient-reported outcomes (e.g., experience, function, quality of life, symptoms, behaviors)
- Other groupings of performance measures
  - *Composite*
  - *Instrument-based*
  - *eCQMs*

(Healthcare) Performance Measurement

- Level of Analysis
  - *Individuals*
  - *Groups*
  - *Facilities*
  - *Health Plans*
  - *Populations*

- Data sources and care settings

Scientific Acceptability of Measure Properties

- Reliability
  - *Consistency/repeatability of data elements used in measurement*
  - *Precision of measure results*
    - » Way to quantify how well one can confidently distinguish the performance of one provider from another
      - *Signal to noise: Variability in measured performance that can be explained by real differences in performance (signal) compared to variability in measure performance that is due to measurement error*
      - *Provides information about risk of misclassification*

- Validity
  - *Accuracy of data elements used in measurement*
  - *Correctness of conclusions derived from measure results*

Discussion Questions

- What do we mean by low case-volume?
  - *Some of these? All of these? Other?*

  - *Few patients meet measure denominator*
  - *Few patients meet measure numerator*
  - *Program reporting requirements*
  - *Some services not provided at all*
    - This is different from low case-volume, but may exacerbate problems, based on program design?

Discussion Questions

- How does low case-volume impact reliability?
  - *At the data element level?*
  - *At the score level?*
- How does low case-volume impact validity?
  - *At the data element level?*
  - *At the score level?*
- Of these, which are the most important to focus on, vis-à-vis low case-volume?
- What other things should we be thinking about? (e.g., level of analysis, rare events, etc.)?

Overview of CMS Quality Improvement Programs

Hospital and Acute Care Facility Program

- Pay-for-Reporting Programs
  - *Hospital Inpatient Quality Reporting Program (IQR) and Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals (CAHs)*
  - *Hospital Outpatient Quality Reporting (OQR) Program*
  - *Ambulatory Surgical Center Quality Reporting (ASCQR) Program*
  - *Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)*
  - *PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)*

- Public Reporting Program
  - *Hospital Compare*

- Pay-for-Performance Programs
  - *Hospital Value-Based Purchasing (VBP) Program*
  - *Hospital-Acquired Condition (HAC) Reduction Program*
  - *Hospital Readmissions Reduction Program*
  - *End-Stage Renal Disease Quality Incentive Program (ESRD QIP)*

Clinician Programs

- Reporting and Payment Program
  - *Merit-based Incentive Payment System (MIPS)*
    - MIPS combined:
      - *Physician Value-Based Payment Modifier*
      - *Physician Quality Reporting System (PQRS)*
      - *Medicare and Medicaid EHR Incentive Program for Eligible Professionals (EPs)*
      - *Physician Compare*
- Public Reporting Program
  - *Physician Compare*
- Alternative Payment Models (selected)
  - *Medicare Shared Savings Program (MSSP)*
  - *Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)*
  - *Comprehensive ESRD Care (CEC)*
  - *Comprehensive Primary Care Plus (CPC+)*
  - *Updated Medicare Accountable Care Organization (ACO) Track 1+ Model*
  - *Next Generation ACO Model*
  - *Oncology Care Model (OCM)*
  - *Comprehensive Care for Joint Replacement (CJR) Payment Model*

Post-Acute Care/Long-Term Care (PAC/LTC) Programs

- Pay-for-Reporting Programs
  - *Skilled Nursing Facility Quality Reporting Program (SNF QRP)*
  - *Long-Term Care Hospital Quality Reporting Program (LTCH QRP)*
  - *Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)*
  - *Home Health Quality Reporting Program (HH QRP)*
  - *Hospice Quality Reporting Program (HQRP)*
- Public Reporting Program
  - *Nursing Home Compare*
  - *Home Health Compare*
  - *Hospice Compare*
- Pay-for-Performance Program
  - *Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)*
  - *Home Health Value-Based Purchasing (HHVBP) Model*
    - Implemented in nine states (AZ, FL, IA, MA, MD, NE, NC, TN, WA)

Program Structures for Payment – Two Exemplars

- Hospital Value-Based Purchasing (VBP) Program
  - *Hospitals receive two scores on each measure and dimension: one for achievement (i.e., performance compared to other hospitals) and one for improvement (current vs. previous performance). CMS uses a threshold (50th percentile) and benchmark (mean of the top decile) to determine how many points to award for the Achievement and Improvement scores. CMS will use the greater of these on each measure and dimension to calculate the hospital's overall total performance.*
- Hospital-Acquired Condition (HAC) Reduction Program
  - *Total HAC Score composed of two domains to identify the worst-performing quartile of hospitals*

Low Case-Volume Recommendations to Date

Potential Solutions Identified in 2015 Report

- Select measures (particularly for P4P programs) that are broadly applicable to large numbers of patients (e.g., screening measures)
- Pool data across several years (e.g., using three years of data rather than just one year)
- Aggregate data from multiple providers (e.g., combining data within regions or networks)
- Combine inpatient and outpatient data for similar measures
- Develop composite measures that expand the number of patients captured by measurement

Potential Solutions Identified in 2015 Report (continued)

- Present confidence intervals, numerator counts, and denominator counts
- Use indicators that do not have a denominator* (e.g., number of infections per month; time since last adverse event)
- Stratify providers so that performance results are compared only among similar groups (i.e., comparing "like to like")
- Consider measures that reflect the wellness of the community (i.e., population-based measures)

*This approach can be used for internal quality improvement efforts when patient populations/conditions are stable but typically would not be appropriate when comparing to other providers.

Potential Solutions Identified in 2015 Report (continued)

- Reconsider exclusions for existing measures
- Consider measures constructed using continuous variables
- Consider ratio measures
- Employ sophisticated statistical approaches such as hierarchical modeling

Continuing the Dialogue: Additional Recommendations

Discussion Questions

- What additional approaches can you recommend (particularly more sophisticated statistical approaches)?
  - Bayesian shrinkage (is this applied at the development stage)?
  - Non-parametric approaches?
  - Regularization methods (e.g., lasso estimators)?
  - Others?

- How are the above related or different?
- To what types of measures would they apply?

Discussion Questions

- How would rural heterogeneity (of residents, providers) impact these methods?
  - *Or impact other recommendations?*
- Would exemptions for reporting requirements matter?
  - *If so, how?*
- Does program structure for payment matter? (e.g., payment reduced if don’t meet a certain score; top 25% get penalized; etc.)
- How do we make our recommendations actionable for measure developers?

Discussion Questions

- How should we categorize any additional recommendations?
  - *e.g., measure development, measure implementation, measure selection*
    - Are these out of scope for a short project, and if so, what should we focus on first and what might be reasonable for next steps?

NQF Member and Public Comment

Next Steps & Project Timeline

Project Timeline

- **TEP Call #2** *Continue Discussion*: November 13, 2018
- **TEP Call #3** *Finalize Recommendations*: November 30, 2018
- Write Draft Report: December 3 – January 4
- NQF Member and Public Comment Period: January 18-February 8, 2019
- **TEP Call #4** *Discuss and Adjudicate Comments Received*: February 27, 2019
- Finalize Report: March, 2019
- Final Report Complete: March 29, 2019

Next Steps

- Review Materials
- Prep for November 13 call

Project Contact Info

- Email: MapRural@qualityforum.org
- NQF phone: 202-783-1300
- Project page: http://www.qualityforum.org/MAP_Rural_Health_Workgroup.aspx

Adjourn