NATIONAL QUALITY FORUM

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Measure Applications Partnership 2020 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care

FINAL REPORT
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Contents

Guidance on Cross-Cutting Issues

Summary

- **MAP emphasized the importance of including the voice of the patient and patient-centered goals in quality measurement.**
- **MAP also discussed the potential impact of technology and interoperability, especially on care coordination.**
- **MAP supported CMS's Meaningful Measure Initiative changes: MAP emphasized the need to engage with electronic health record vendors and PAC/LTC facilities, use patient-reported outcome performance measures, and address quality measure gaps.**

The Measure Applications Partnership (MAP) reviewed two measures under consideration (MUC) for two setting-specific federal programs addressing post-acute care (PAC) and long-term care (LTC) and gave input on potential measure gaps. The programs with measures under consideration are listed below:

- Home Health Quality Reporting Program (HH QRP)
- Hospice Quality Reporting Program (Hospice QRP)

The following four programs did not have measures under consideration during this year's pre-rulemaking cycle:

- 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)

MAP's pre-rulemaking recommendations reflect the MAP Measure Selection Criteria (MSC) in addition to how well a measure under consideration could address the goals of the program or enhance the program's measure set. The MSC highlight characteristics of an ideal measure set and are intended to complement program-specific statutory and regulatory requirements. The selection criteria seek measures that are endorsed by the National Quality Forum (NQF) whenever possible, address a performance gap, diversify the mix of measure types, relate to person- and family-centered care and services, address disparities and cultural competency, and promote parsimony and alignment among public and private quality programs.

Overarching Themes

Patients requiring post-acute care (PAC) and long-term care (LTC) are clinically complex and may frequently transition between care settings. Performance measures are vital to understanding the quality of these transitions, but measures must also be meaningful and actionable to drive true improvement. The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) aimed to standardize PAC/LTC measurement with the goal of improving patient outcomes through shared decision making, care coordination, and enhanced discharge planning.

Meaningful Measures Initiative Considerations for PAC/LTC

MAP provided feedback on the Centers for Medicare and Medicaid Services (CMS) proposed changes to the Meaningful Measures Initiative. MAP generally supported the direction and focus of the proposed changes. In offering input to the Meaningful Measures Initiative, MAP focused on capturing the voice of patients through patient-reported outcome performance measures (PRO-PMs), making electronic health records (EHRs) and electronic clinical quality measures (eCQMs) more useful, and identifying measurement opportunities for the PAC/LTC population.

Including the Voice of the Patient and Patient-Centered Goals

MAP supported CMS's inclusion of Patient Reported Outcomes (PROs) in its Meaningful Measures Update. MAP identified PROs as one of the most important priorities for PAC/LTC programs. Thoughtfully soliciting and incorporating the voice of the patient into quality measurement will contribute to the alignment of care with patient goals and preferences. MAP members noted that traditional care goals focusing on improvement in function and health status may not be appropriate for the entire PAC/LTC population. The goal of care may be maintaining current functional status, limiting decline, and/or maximizing comfort. Assessment and measurement of patient goals should be an important focus in this population.

MAP members discussed the future state of PROs and PRO-PMs making suggestions for improvement in PRO-PM creation, development, and evaluation. Future areas of development should include more robust methodology around qualitative methods, models, and measures. MAP members also recommended examining the measure criteria used to evaluate PRO-PMs to ensure that the criteria, the instruments, and the measures are relevant and useful to both providers and patients. Providers and patients acknowledged the burden associated with PRO completion. This burden should be balanced with the goal of providing information that is useful to patients to select providers and for providers to understand how to improve care.

Impact of Technology and Interoperability

In its Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement, MAP highlighted that patients who receive care from PAC and LTC providers frequently transition among multiple sites of care. Patients may move among their home, the hospital, and other PAC or LTC settings as their health and functional status change. Improving care coordination and the quality of care transitions is essential to improving post-acute and long-term care. MAP identified care coordination as the highest priority measure gap for PAC/LTC programs.

MAP pointed out the potential of health information technology to improve quality and minimize the burden of measurement. MAP members noted that EHR adoption in PAC/LTC settings often lags other care settings since PAC/LTC settings have had fewer incentives to implement new technology. Increased use of technology could help to improve transitions and the exchange of information across providers.

MAP supported CMS in its effort to improve standardization and promote interoperability, specifically Health Level Seven's (HL7) Fast Health Interoperability Resources (FHIR) standards. MAP recommended that CMS work with vendors to improve EHR interoperability. Prioritizing interoperability across care settings will maximize its impact by allowing more organizations to share and receive data.

MAP members raised concerns about potential burden introduced through technology. Specifically, MAP encouraged CMS to monitor the impact of auto-populating EHRs to fulfill regulatory or other nonclinical requirements. This additional auto-populated information can crowd out or obscure critical clinical information. MAP encouraged vendors and healthcare organizations to be thoughtful in the design and implementation of EHRs.

Measurement Opportunities for the PAC/LTC Population

MAP identified measurement opportunities within PAC/LTC programs and across all CMS quality programs. MAP emphasized the need for alignment of measurement across the full continuum of care and developed an overarching list of concepts and priorities for performance measurement in PAC/LTC programs. MAP identified nine concepts for measurement within all PAC/LTC programs: access to care, care coordination, chronic illness care (quality of life), interoperability, mental health, pain management, PROs, social determinants, and serious illness. MAP then prioritized the list, allowing each voting member present two votes. The voting identified care coordination, interoperability, and PROs as the most important priorities for measurement for PAC/LTC programs. For the full voting results, see Table 1.

Table 1 MAP Post-Acute Care/Long-Term Care Workgroup Priorities for CMS

Total Votes	Item
Concepts	
8	Care Coordination
4	Interoperability
4	Patient Reported Outcomes
2	Chronic Illness Care (Quality of Life)
2	Pain Management
1	Mental Health
1	Serious Illness
0	Access to Care: e.g., Availability of Resources (Travel Distance)
0	Social Determinants (Drivers)
Alignment Across Continuum	
3	Function Across Individual Patient's Continuum of Care
2	Medication Management (Cross-Cutting Across All Concepts)
1	Aligning Facility and Practitioner Measures/Incentives

MAP discussed several specific measurement opportunities that could improve care transitions. First, MAP noted the need for future measures to be bidirectional between the discharging and receiving care settings. MAP members also underscored the need for care providers to share information across the care continuum, not just between post-acute sites. MAP pointed out the need to assess the transfer of information from the hospital to post-acute sites and to the patient's primary care physician. Measures that assess such transfer of information could promote shared accountability across care settings and ensure that all clinicians involved in a person's care have the information needed to provide safe, high-quality care.

MAP encouraged CMS to prioritize measures for patients with serious illnesses, including neurological conditions such as Alzheimer's disease and dementia. These conditions are particularly prevalent in the elderly PAC/LTC population. MAP stressed that for many serious illnesses, improvement in the condition is not always feasible. CMS was encouraged to address the challenge of measuring care in this population for conditions where improvement or recovery is not expected.

Across all PAC/LTC programs, MAP encouraged CMS to explore a pathway for full inclusion of patients enrolled in Medicare Advantage plans in quality measurement activities. Lack of availability of claims data for Medicare Advantage patients limits inclusion in measures that use claims for measurement or risk adjustment. This was identified as a cross-cutting data gap for PAC/LTC. Finally, MAP identified aligning facility and practitioner measures and incentives, functional status across each individual patient's continuum of care, and cross-cutting medication management as opportunities for alignment across all CMS programs.

Considerations for Specific Programs

Home Health Quality Reporting Program

The Home Health Quality Reporting Program (HH QRP) was established in accordance with Section 1895 of the Social Security Act. Under this program, home health agencies (HHAs) must submit quality reporting data from sources such as Medicare fee-for-service (FFS) claims, the Outcome and Assessment Information Set (OASIS), and the Home Health Care Consumer Assessment of Healthcare Providers and Systems survey (HH CAHPS®) or be subject to a 2-percentage-point reduction in the annual Prospective Payment System (PPS) increase factor.

MAP reviewed and recommended conditional support for rulemaking for a single measure under consideration for the HH QRP, MUC2019-34 *Home Health Within-Stay Potentially Preventable Hospitalization*. This measure reports a HHA-level rate of risk-adjusted potentially preventable hospitalizations or observation stays that occur within a home health (HH) stay for all eligible stays at each agency.

MAP conditionally supported MUC2019-34 *Home Health Within-Stay Potentially Preventable Hospitalization*, pending NQF endorsement. CMS clarified that it intends to eventually replace related measures, NQF 0171 *Acute Care Hospitalization During the First 60 Days of Home Health* and NQF 0173 *Emergency Department Use without Hospitalization During the First 60 Days of Home Health* with the measure under consideration. MAP agreed that the measure adds value to the program measure set by adding an assessment of potentially preventable hospitalizations and observation stays that may occur at any point in the home health stay. No measure in the program currently provides this information.

The measure supports alignment for the measure focus area of admissions and readmissions across care settings and providers. There is variation in performance on this measure, and home health agencies have the ability to implement processes and interventions that can positively influence the measure results. The MAP Rural Health Workgroup noted that older and sicker patients reflected in rural populations often have issues with access to care. No public comments were received on this measure or on the HH QRP. MAP encouraged consideration of including Medicare Advantage patients in future iterations of the measure.

MAP encouraged the NQF All-Cause Admissions and Readmissions Standing Committee to consider the definition for preventable hospitalization to ensure home health agencies can take adequate steps to improve these outcomes. MAP also encouraged the NQF Standing Committee to consider the look-back period used for risk adjustment. This measure aggregates a variety of causes for hospitalization at accountable home health agencies, and MAP encouraged CMS to provide detailed performance feedback to providers to allow them to separate these causes for quality improvement purposes.

MAP identified potential gaps in the HH QRP measure set. MAP members identified long-term tracking of activities of daily living and a measure that captures wound care holistically.

Hospice Quality Reporting Program

The Hospice Quality Reporting Program (Hospice QRP) was established under section 3004 of the Affordable Care Act (ACA). The Hospice QRP applies to all hospices, regardless of setting. Under this program, hospice providers must submit quality reporting data from sources such as the Hospice Item Set (HIS) data collection tool and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey or be subject to a 2-percentage-point reduction in the applicable annual payment update.

MAP reviewed a single measure under consideration for inclusion in Hospice QRP, MUC2019-33 *Hospice Visits in the Last Days of Life*. This measure captures the proportion of hospice patients who received in-person visits from a registered nurse or medical social worker on at least two out of the final three days of the patient's life.

MAP conditionally supported MUC2019-33 *Hospice Visits in the Last Days of Life* for rulemaking, pending NQF endorsement and removal of the existing hospice visit measures from the program. Generally, MAP agreed that collecting information about hospice staff visits will encourage hospices to visit patients and caregivers, provide services that will address their care needs, and improve quality of life during the patient's last days of life. MAP observed that currently, *Hospice Visits When Death is Imminent, Measure 1 and Measure 2*, address this quality objective in the Hospice QRP, but the measure under consideration performed better in validity and reliability testing, and has lower provider burden because it is reported using claims data.

MAP agreed that the goal of hospice is comfort. MAP suggested that future iterations of this measure consider the quality of provider visits in addition to the quantity of visits. MAP members reviewed analysis from CMS demonstrating that not all types of provider visits correlate positively with Hospice CAHPS® results. MAP examined the possible variations on the measure concept and generally agreed that the analysis supported the current proposed measure. The MAP Rural Health Workgroup noted concerns related to access to care in rural areas. Public comments expressed concern about overlap with the existing hospice visits measures. Commenters also had concerns with a hospice program's ability to accurately identify imminent death and expressed concern with only including some members of the interdisciplinary team in the visits captured in the measure. The commenters suggested examining other options for this measure concept such as different numbers of visits.

MAP encouraged the NQF Standing Committee to consider whether this process measure may result in a checkbox approach to providing visits, and that one high-quality visit may yield more than multiple lower-quality visits. MAP encouraged CMS to continue monitoring the measure performance to ensure that the measure functions as expected.

MAP reviewed the Hospice QRP measure set noting a gap in measures addressing safety, particularly around polypharmacy and medication reconciliation, PROs around symptom management, care aligned with the patient's goals, and communication of those goals to the next site of care should the patient leave hospice.

Inpatient Rehabilitation Facility Quality Reporting Program

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) was established under section 3004 of the ACA. This program applies to all IRF settings that receive payment under 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 (CAHs). Under this program, IRF providers must submit quality reporting data from sources such as Medicare FFS Claims, the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) data submissions , and the IRF-Patient Assessment Instrument (PAI) or be subject to a 2-percentage-point reduction in the applicable annual payment update.

MAP did not have any measures submitted for review for IRF QRP during this cycle.

MAP noted appropriate clinical prescribing and use of opioids as a potential measurement gap in the IRF QRP measure set.

Long-Term Care Hospital Quality Reporting Program

The Long-Term Care Hospital Quality Reporting Program (LTCH QRP) was established under section 3004 of the ACA. Under this program, LTCH providers must 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) or be subject to a 2-percentage-point reduction in the applicable annual payment update.

MAP did not have any measures submitted for review for LTCH QRP during this cycle.

MAP identified the availability of palliative care as a measure gap for LTCH QRP.

Skilled Nursing Facility Quality Reporting Program

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) was established under section 1899B of the IMPACT Act. SNFs that do not submit the required data are subject to a 2-percentage-point reduction in their annual payment rates.

MAP did not have any measures submitted for review for SNF QRP during this cycle.

MAP identified bidirectional transfer of information, quality and safety of care transitions, patient and family engagement, and care aligned with patient's goals as measure gaps in the program. They noted that the transfer of information should be robust and that measures need to encompass the quality of

the information transferred, not just that a transfer took place. They also stressed that accuracy of medication lists, and medication reconciliation are key elements in the quality and safety of care transitions.

Skilled Nursing Facility Value-Based Purchasing Program

The Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP) is a pay-for-performance program established under the Protecting Access to Medicare Act. CMS scores SNFs on both improvement and achievement on measures in the program. The higher performing score from improvement or achievement is used to determine a payment multiplier.

MAP did not have any measures submitted for review for SNF VBP during this cycle.

MAP did not discuss any gaps for the SNF VBP program.

Appendix A: Program Summaries

The material in this appendix was extracted from the CMS Program Specific Measure Priorities and Needs document, which was released in April 2019, as well as the CMS website.

Home Health Quality Reporting Program

Program History and Structure

The Home Health Quality Reporting Program (HH QRP) was established in accordance with section 1895 (b)(3)(B)(v)(II) of the Social Security Act. Home Health Agencies (HHAs) are required by the Act to submit quality data for use in evaluating quality for Home Health agencies. Section 1895(b) (3)(B)(v)(I) of the Act also requires that HHAs that do not submit quality data to the Secretary be subject to a 2 percent reduction in the annual payment update, effective in calendar year 2007 and every subsequent year.

Data sources for the HH QRP include the Outcome and Assessment Information Set (OASIS) and Medicare FFS claims. Data is publicly reported on the Home Health Compare website. The HH QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups.

Further, the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) to report standardized patient assessment data, and data on quality measures including resource use measures. The development of standardized data stems from specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers.

The IMPACT Act requires CMS to develop and implement quality measures from five measure domains: functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; and the transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings. The IMPACT Act also delineates the implementation of resource use and other measures in at least these following domains: total estimated Medicare spending per beneficiary; discharge to the community; and all condition risk adjusted potentially preventable hospital readmission rates.

Hospice Quality Reporting Program

Program History and Structure

The Hospice Quality Reporting Program (HQRP) was established in accordance with section 1814(i) of the Social Security Act, as amended by section 3004(c) of the Affordable Care Act. The HQRP applies to all hospices, regardless of setting. Proposed data sources for future HQRP measures include the Hospice Item Set and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. HQRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2014, hospices that fail to submit quality data will be subject to a 2.0 percentage point reduction to their annual payment update.

Inpatient Rehabilitation Facility Quality Reporting Program

Program History and Structure

The Quality Reporting Program (QRP) for Inpatient Rehabilitation Facilities (IRFs) was established in accordance with section 1886(j) of the Social Security Act as amended by section 3004(b) of the Affordable Care Act. The IRF QRP applies to all IRF facilities that receive the IRF PPS (e.g., IRF hospitals, IRF units that are co-located with affiliated acute care facilities, and IRF units affiliated with critical access hospitals [CAHs]). Data sources for IRF QRP measures include Medicare FFS claims, the Center for Disease Control's National Health Safety Network (CDC NHSN) data submissions, and Inpatient Rehabilitation Facility - Patient Assessment instrument (IRF-PAI) records. The IRF QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2014, IRFs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable IRF Prospective Payment System (PPS) payment update.

Plans for future public reporting of IRF QRP measures are under development.

Further, the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) to report standardized patient assessment data, data on quality measures including resource use measures. The development of standardized data stems from specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers.

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Long-Term Care Hospital Quality Reporting Program

Program History and Structure

The Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) was established in accordance with section 1886(m) of the Social Security Act, as amended by Section 3004(a) of the Affordable Care Act. The LTCH QRP applies to all LTCHs facilities designated as an LTCH under the Medicare program. Data sources for LTCH QRP measures include Medicare FFS claims, the Center for Disease Control and Prevention's National Health Safety Network (CDC's NHSN) data submissions, and the LTCH Continuity Assessment Record and Evaluation Data Sets (LCDS). The LTCH QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2014, LTCHs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable Prospective Payment System (PPS) increase factor.

Further, the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) to report standardized patient assessment data, data on quality measures including resource use measures. The development of standardized data stems from specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers.

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Skilled Nursing Facility Quality Reporting Program

Program History and Structure

The Improving Medicare Post-Acute Care Transitions Act of 2014 (The IMPACT Act) added Section 1899B to the Social Security Act establishing the Skilled Nursing Facility Quality Reporting Program (SNF QRP). Facilities that submit data under the SNF PPS are required to participate in the SNF QRP, excluding units that are affiliated with critical access hospitals (CAHs). Data sources for SNF QRP measures include Medicare FFS claims as well as Minimum Data Set (MDS) assessment data. The SNF QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2018, providers that fail to submit required quality data to CMS will have their annual updates reduced by 2.0 percentage points.

Further, the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs) to report standardized patient assessment data, data on quality measures including resource use measures. The development of standardized data stems from specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers.

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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 readmission measure performance. The SNF 30-Day All-Cause Readmission Measure (SNFRM) (NQF 2510) is the measure currently used in the Program. The SNFRM evaluates the risk-standardized rate of unplanned, all-cause inpatient hospital readmissions of Medicare beneficiaries. This measure assesses SNF patients' hospital readmissions within 30 days of being discharged from a prior hospital stay. CMS lacks the authority to implement additional measures beyond the measure described in statute.

Appendix B: MAP PAC/LTC Workgroup Roster and NQF Staff

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