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Measure Applications Partnership (MAP)

PAC/LTC Workgroup Orientation Web Meeting

September 29, 2020

Agenda

- Welcome and Review of Meeting Objectives
- CMS Welcoming Remarks
- MAP Pre-Rulemaking Approach
- Overview of Programs Under Consideration
- 2019 – 2020 MAP PAC/LTC Overarching Themes
- MAP Rural Workgroup Review of MUC
- CMS Feedback Loop 2020
- Opportunity for Public Comment
- Next Steps
- Adjourn

Welcome, Introductions, and Review of Meeting Objectives

Workgroup Staff

- **Amy Moyer, MS, PMP,** Director
- **Katie Berryman, MPAP,** Project Manager
- **Janaki Panchal, MSPH,** Manager
- **Wei Chang, MPH,** Analyst

PAC/LTC Workgroup Membership

Workgroup Co-Chairs: Gerri Lamb, PhD, RN, FAAN; Kurt Merkelz, MD, CMD

Organizational Members (Voting)

- AMDA – The Society for Post-Acute and Long-Term Care Medicine
- American Academy of Physical Medicine and Rehabilitation (AAPM&R)
- American Geriatrics Society
- American Occupational Therapy Association
- American Physical Therapy Association
- ATW Health Solutions
- Kindred Healthcare
- LeadingAge
- National Hospice and Palliative Care Organization
- National Partnership for Hospice Innovation
- National Pressure Injury Advisory Panel
- National Transitions of Care Coalition
- SNP Alliance

Individual Subject Matter Experts (Voting)

- Dan Andersen, PhD
- Terrie Black, DNP, MBA, CRRN, FAHA, FAAN
- Sarah Livesay, DNP, APRN, ACNP-BC, ACNS-BC
- Paul Mulhausen, MD, MHS
- Rikki Mangrum, MLS
- Eugene Nuccio, PhD

Federal Government Liaisons (Non-voting)

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Office of the National Coordinator for Health Information Technology (ONC)

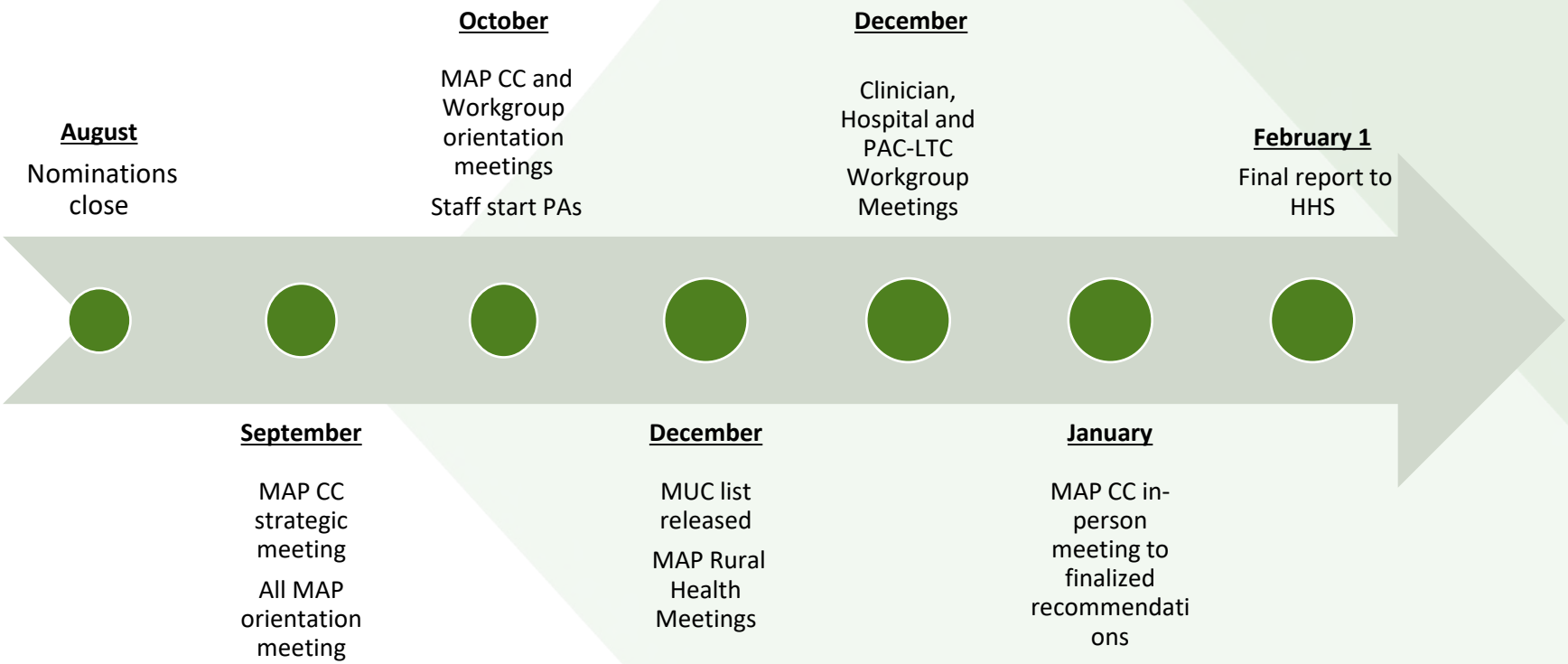
Goals for Today's Meeting

- Review the goals and structure of each program
- Review the critical objectives of each program
- Identify measurement gap areas

CMS Welcoming Remarks

MAP Pre-Rulemaking Approach

Timeline of MAP Activities



Overview of PAC/LTC Programs Under Consideration

Programs to be Considered by the PAC-LTC Workgroup

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

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

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

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

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

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

SNF QRP: Current Program Measure Information

Type	NQF ID	Measure Title	NQF Status
Outcome	Based on 0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Endorsed
Process	Based on 2631	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	Endorsed
Outcome	3481	Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Endorsed
Process	N/A	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post-Acute Care Skilled Nursing Facility Quality Reporting Program	Not Endorsed
Cost/ Resource	N/A	Total Estimated Medicare Spending per Beneficiary —Post-Acute Care Skilled Nursing Facility Quality Reporting Program	Not Endorsed
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program.	Not Endorsed

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SNF QRP: Current Program Measure Information (Continued)

Type	NQF ID	Measure Title	NQF Status
Outcome	Based on 2633	Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Endorsed
Outcome	Based on 2634	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	Endorsed
Outcome	Based on 2635	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	Endorsed
Outcome	Based on 2636	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	Endorsed
Outcome	N/A	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Not Endorsed
Process	N/A	Transfer of Health Information to the Provider - Post-Acute Care (PAC)	Not Endorsed
Process	N/A	Transfer of Health Information to the Patient - Post-Acute Care (PAC)	Not Endorsed

CMS High-Priority Meaningful Measure Areas for Future Measure Consideration – SNF QRP

- Making Care Safer: Healthcare Associated Infections
- Exchange of Electronic Health Information and Interoperability measure concept

Gaps Identified by PAC/LTC Workgroup 2019-2020 – SNF QRP

- Bi-directional transfer of information
- Quality and safety of care transitions
- Patient and family engagement
- Care aligned with patient's goals

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Workgroup Discussion

- Does the Workgroup have suggestions for refinement or additions to the high-priority domains for future measurement?
- Does the Workgroup have suggestions for refinement or additions to the identified gaps?

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.

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HH QRP: Current Program Measure Information

Type	NQF ID	Measure Title	NQF Status
Outcome	0171	Acute Care Hospitalization During the First 60 Days of Home Health	Endorsed
Outcome	0173	Emergency Department Use without Hospitalization During the First 60 Days of Home Health	Endorsed
Outcome	0167	Improvement in Ambulation/Locomotion	Endorsed
Outcome	0174	Improvement in Bathing	Endorsed
Outcome	0179	Improvement in Dyspnea	Endorsement Removed
Outcome	0176	Improvement in Management of Oral Medication	Endorsed
Outcome	0177	Improvement in Pain Interfering with Activity (Will be removed from program in CY 2022)	Endorsed
Process	0526	Timely Initiation Of Care	Endorsement Removed
Process	0522	Influenza Immunization Received for Current Flu Season	Endorsement Removed
Outcome	0175	Improvement in Bed Transferring	Endorsed
PRO	0517	CAHPS Home Health Care Survey (experience with care)	Endorsed

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HH QRP: Current Program Measure Information (Continued)

Type	NQF ID	Measure Title	NQF Status
Process	N/A	Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care	Not Endorsed
Process	N/A	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Home Health Quality Reporting Program	Not Endorsed
Cost/ Resource	N/A	Total Estimated Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)	Not Endorsed
Outcome	3477	Discharge to Community-Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP) (Will exclude baseline nursing facility residents starting CY 2021)	Endorsed
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Home Health Quality Reporting Program	Not Endorsed
Outcome	N/A	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Not Endorsed
Outcome	Based on 0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury	Endorsed
Process	Based on 2631	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Endorsed
Process	N/A	Transfer of Health Information to the Provider - Post-Acute Care (PAC) (Will be added to program in CY 2022)	Not Endorsed
Process	N/A	Transfer of Health Information to the Patient - Post-Acute Care (PAC) (Will be added to program in CY 2022)	Not Endorsed

CMS High-Priority Meaningful Measure Areas for Future Measure Consideration – HH QRP

- Person and Family Engagement: Care is Personalized and Aligned with the Patient's Goals

Gaps Identified by PAC/LTC Workgroup 2019-2020 – HH QRP

- Long-term tracking of activities of daily living
- Capturing wound care holistically

Workgroup Discussion

- Does the Workgroup have suggestions for refinement or additions to these high-priority domains for future measurement?

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.

IRF QRP: Current Program Measure Information

Type	NQF ID	Measure Title	NQF Status
Outcome	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed
Process	0431	Influenza Vaccination Coverage Among Healthcare Personnel	Endorsed
Outcome	0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed
Outcome	2634	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	Endorsed
Outcome	2633	IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Endorsed
Outcome	Based on 0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	Endorsed
Process	Based on 2631	Application of Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	Endorsed
Outcome	2635	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	Endorsed
Outcome	2636	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	Endorsed

IRF QRP: Current Program Measure Information (Continued)

Type	NQF ID	Measure Title	NQF Status
Outcome	3479	Discharge to Community: Discharge to Community-Post Acute Care Inpatient Rehabilitation Facility Quality Reporting Program	Endorsed
Process	N/A	Drug Regimen Review Conducted with Follow-Up for Identified Issues	Not Endorsed
Cost/ Resource	N/A	Medicare Spending Per Beneficiary-Post Acute Care Inpatient Rehabilitation Facility Quality Reporting Program	Not Endorsed
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program	Not Endorsed
Outcome	N/A	Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facilities	Not Endorsed
Outcome	N/A	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Not Endorsed
Process	N/A	Transfer of Health Information to the Provider - Post-Acute Care (PAC)	Not Endorsed
Process	N/A	Transfer of Health Information to the Patient - Post-Acute Care (PAC)	Not Endorsed

CMS High-Priority Meaningful Measure Areas for Future Measure Consideration – IRF QRP

- Exchange of Electronic Health Information and Interoperability measure concept
- Healthcare Acquired Infection (HAI)

Gaps Identified by PAC/LTC Workgroup 2019-2020 – IRF QRP

- Clinical prescribing and use of opioids

Workgroup Discussion

- Does the Workgroup have suggestions for refinement or additions to these high-priority domains for future measurement?

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

- **Program Type**:
  - Pay for reporting and public reporting
- **Incentive Structure**:
  - 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).

LTCH QRP: Current Program Measure Information

Type	NQF ID	Measure Title	NQF Status
Outcome	Based on 0674	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).	Endorsed
Process	2631	Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).	Endorsed
Process	Based on 2631	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).	Endorsed
Outcome	2632	Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital (LTCH) Patients Requiring Ventilator Support (NQF 2632).	Endorsed
Process	N/A	Drug Regimen Review Conducted With Follow-Up for Identified Issues—Post Acute Care (PAC) Long- Term Care Hospital (LTCH) Quality Reporting Program (QRP).*	Not Endorsed
Outcome	0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure (NQF #0138).	Endorsed
Outcome	0139	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection Outcome Measure (NQF #0139).	Endorsed
Outcome	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717).	Endorsed

LTCH QRP: Current Program Measure Information (Continued)

Type	NQF ID	Measure Title	NQF Status
Process	0431	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431).	Endorsed
Cost/ Resource	N/A	Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP).	Not Endorsed
Outcome	3480	Discharge to Community—Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP).	Endorsed
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP).	Not Endorsed
Process	N/A	Compliance With Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay	Not Endorsed
Outcome	N/A	Ventilator Liberation Rate	Not Endorsed
Outcome	N/A	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Not Endorsed
Process	N/A	Transfer of Health Information to the Provider - Post-Acute Care (PAC)	Not Endorsed
Process	N/A	Transfer of Health Information to the Patient - Post-Acute Care (PAC)	Not Endorsed

CMS High-Priority Meaningful Measure Areas for Future Measure Consideration – LTCH QRP

- Person and Family Engagement: Functional Outcomes
- Exchange of Electronic Health Information and Interoperability measure concept
- Healthcare Acquired Infection (HAI)

Gaps Identified by PAC/LTC Workgroup 2019-2020 – LTCH QRP

- Availability of palliative care

Workgroup Discussion

- Does the Workgroup have suggestions for refinement or additions to these high-priority domains for future measurement?

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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Hospice QRP: Current Program Measure Information

Type	NQF ID	Measure Title	NQF Status
Process	1638	Dyspnea Treatment	Endorsed
Process	1639	Dyspnea Screening	Endorsed
Process	1637	Pain Assessment	Endorsed
Process	1634	Pain Screening	Endorsed
Process	1641	Treatment Preferences	Endorsed
Process	1617	Patients Treated with an Opioid who are Given a Bowel Regimen	Endorsed
Process	1647	Beliefs/Values Addressed (if desired by the patient)	Endorsed
Patient Reported Outcome	2651	CAHPS Hospice Survey	Endorsed
Process	N/A	Hospice Visits When Death is Imminent Measure 1	Not Endorsed
Process	N/A	Hospice Visits When Death is Imminent Measure 2	Not Endorsed
Composite	3235	Hospice and Palliative Care Composite Process Measure - Comprehensive Assessment at Admission	Endorsed

CMS High-Priority Meaningful Measure Areas for Future Measure Consideration – Hospice QRP

- Patient-focused Episode of Care
- Care is Personalized and Aligned with Patient's Goals

Gaps Identified by PAC/LTC Workgroup 2019-2020 – Hospice QRP

- Safety, in particular polypharmacy and medication reconciliation
- PROs around symptom management
- Care aligned with the patient's goals
- Communication of patient's goals to next site of care should the patient leave hospice

Workgroup Discussion

- Does the Workgroup have suggestions for refinement or additions to these high-priority domains for future measurement?

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.

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.

SNF VBP: Current Program Measure Information

Type	NQF ID	Measure Title	NQF Status
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program.	Not Endorsed
Outcome	2510	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Endorsed

2019 - 2020 MAP PAC/LTC Overarching Themes

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Overarching Themes

- Including the Voice of the Patient and Patient-Centered Goals
- Impact of Technology and Interoperability
- Measurement Opportunities for the PAC/LTC Population

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Including the Voice of the Patient and Patient-Centered Goals

- Patient Reported Outcomes (PROs) and PRO-PMs important for PAC/LTC programs
  - Contribute to alignment with patient goals and preferences
  - Should include robust methodology around qualitative methods, models, and measures
  - Ensure criteria, instruments, and measures relevant and useful to patients and providers
  - Burden must be balanced with goal of providing useful information
- Traditional care goals focused on improvement in function and health status may not be appropriate for entire PAC/LTC population
- Goal of care may be maintaining current functional status, limiting decline, and/or maximizing comfort
- Assessment and measurement of patient goals should be important focus

Impact of Technology and Interoperability

- PAC/LTC patient population frequently transition among multiple sites of care
- Improving care coordination and quality of care transitions is essential for improving care
- Care coordination identified as highest priority measure gap for PAC/LTC programs
- Health IT can improve quality and minimize burden. Adoption lags in PAC/LTC settings.
- Prioritizing interoperability across care settings will maximize its impact by allowing more organizations to share and receive data.
- Monitor the impact of auto-populating EHRs to fulfill regulatory or other nonclinical requirements. Auto-populated information can crowd out or obscure critical clinical information.

Measurement Opportunities for the PAC/LTC Population

- Nine concepts for measurement identified 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.
- Workgroup vote identified care coordination, interoperability, and PROs as the most important priorities for measurement for PAC/LTC programs.
- 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.
- Alignment opportunities: aligning facility and practitioner measures and incentives, functional status across each individual patient's continuum of care, and cross-cutting medication management
- See slide 13 for full list and results.

MAP Rural Workgroup Review of MUC

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

Rural Health Workgroup Review of MUCs

- The Rural Health Workgroup will review the MUCs and provide the following feedback to the setting-specific Workgroups:
  - Relative priority/utility of MUC measures 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
  - Gap areas in measurement relevant to rural residents/providers for specific programs

Rural Health Workgroup Review (Continued)

- Rural Health Workgroup feedback will be provided to the setting-specific Workgroups through the following mechanisms:
  - 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
  - Attendance of a Rural Health Workgroup liaison at all three pre-rulemaking meetings in December

CMS Presentation

PAC-LTC Workgroup Webinar Meeting

CMS Feedback Loop 2020

Alan Levitt M.D.

alan.levitt@cms.hhs.gov

September 29, 2020

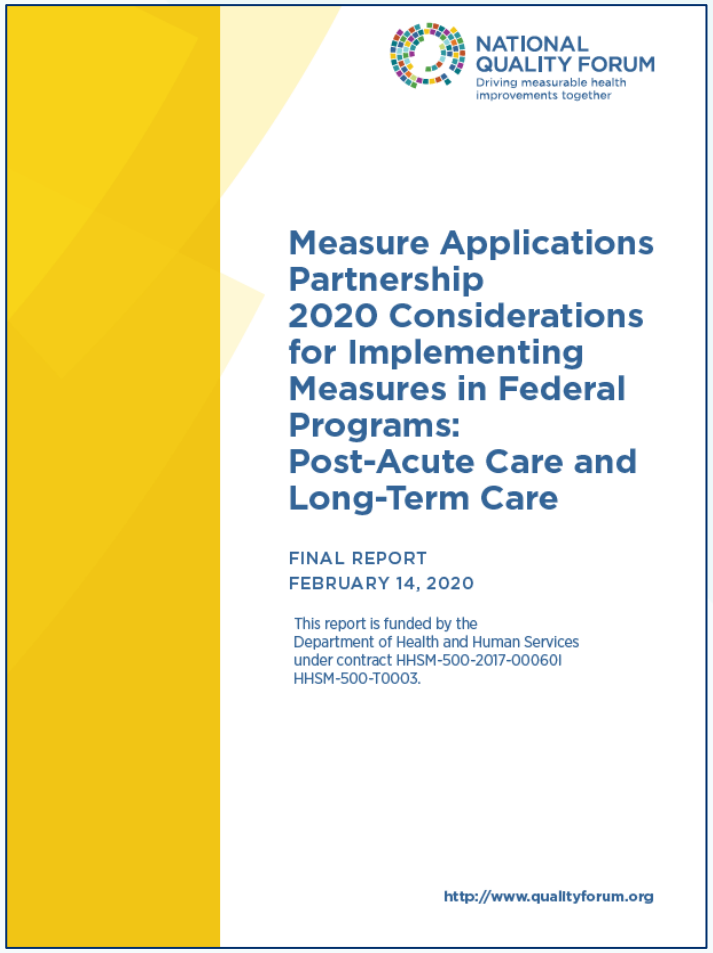
CMS Feedback Loop

The purpose of the Feedback Loop is to show how PAC-LTC Workgroup discussions have been incorporated into the rule proposals and current work of the Post-Acute Care (PAC) Quality Reporting Programs (QRPs)

December 2019 PAC-LTC Workgroup

Measures under consideration

- MUC2019-34: Home Health Within-Stay Potentially Preventable Hospitalization
- MUC2019-33: Hospice Visits in the Last Days of Life



MUC2019-34: Home Health Within-Stay Potentially Preventable Hospitalization

- Conditional support pending NQF endorsement
- Encouraged including Medicare Advantage patients in future iterations of the measure
- Consider attribution, look-back period for risk adjustment, provide detailed performance feedback to providers
- CMS clarified intent to replace related measures, NQF #0171 and NQF #0173 Emergency Department Use without Hospitalization During the First 60 Days of Home Health with MUC2019-34

MUC2019-33: Hospice Visits in the Last Days of Life

- Conditional support pending NQF endorsement and removal of the existing hospice visit measures from the Hospice QRP
- Consider quality of provider visits in addition to quantity
- Monitor performance to ensure that measure functions as expected
- Public comments – challenges identifying imminent death, capturing only some team member visits

COVID-19 Public Health Emergency (PHE)

- No measure proposals in Fiscal year (FY) or Calendar year (CY) PAC QRP rulemaking
- Exceptions and extensions for QRP requirements: Quarter 4 (Q4) 2019, Q1 and Q2 2020
- Delayed release of updated assessment instruments – Transfer of Health (TOH) Information Quality Measures and Standardized Patient Assessment Data Elements (SPADEs):
  - Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) - at least 1 full FY after the end of the COVID-19 PHE
  - LTCH Continuity Assessment Record and Evaluation Data Set (LCDS) - at least 1 full FY after the end of the COVID-19 PHE
  - Outcome and Assessment Information Set (OASIS) - at least 1 full CY after the end of the COVID-19 PHE
  - Minimum Data Set (MDS) - at least 2 full FYs after the end of the COVID-19 PHE

Delay of TOH Information Quality Measures

- December 2018 PAC/LTC Workgroup: conditional support
- Proposed and adopted in FY and CY 2020 rulemaking
  - Updated IRF-PAI, LCDS, MDS: October 1, 2020
  - Updated OASIS: January 1, 2021
- Delayed assessment instrument release due to PHE
  - PHE ends October 1, 2020 – December 31, 2020
    - IRF-PAI, LCDS release: October 1, 2022
    - OASIS release: January 1, 2022
    - MDS release: October 1, 2023
  - PHE ends January 1, 2021 – September 30, 2020
    - IRF-PAI, LCDS release: October 1, 2022
    - OASIS release: January 1, 2023
    - MDS release: October 1, 2023
- Public reporting 2 years after implementation date

Thank You!

Opportunity for NQF Member and Public Comment

Next Steps

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 4, 7, 9
- **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 Website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html
- MAP Member Guidebook: https://share.qualityforum.org/Projects/MAP%20Post-Acute%20Care%20Long-Term%20Care%20Workgroup/CommitteeDocuments/MAP%20Member%20Guidebook%202020.pdf

Questions

Contact Information

- **Project Page:**
  https://www.qualityforum.org/Project_Pages/MAP_Post-Acute_CareLong-Term_Care_Workgroup.aspx
- **Workgroup SharePoint Site:**
  https://share.qualityforum.org/Projects/MAP%20Post-Acute%20Care%20Long-Term%20Care%20Workgroup/SitePages/Home.aspx
- **Email: MAP PAC/LTC Project Team**
  mappac-ltc@qualityforum.org

THANK YOU.

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