NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

PAC-LTC Workgroup Orientation Web Meeting

October 30, 2019

Welcome, Introductions, and Review of Meeting Objectives

Agenda

- Welcome and Review of Meeting Objectives
- MAP Pre-Rulemaking Approach
- Overview of Programs Under Consideration
- CMS Presentation
  - *CMS Feedback Loop 2019*
- Opportunity for Public Comment
- Next Steps

Workgroup Staff

- Amy Moyer, MS, PMP, Director
- Janaki Panchal, MSPH, Project Manager
- Jordan Hirsch, MHA, Project Analyst

PAC-LTC Workgroup Membership

Workgroup Co-chairs: Gerri Lamb, PhD, RN, FAAN; Kurt Merkelz, MD, MHS

Organizational Members (voting)	
AMDA – The Society for Post-Acute and Long-Term Care Medicine	Kindred Healthcare
American Academy of Physical Medicine and Rehabilitation (AAPM&R)	Legal Counsel for the Elderly
American Geriatrics Society	National Hospice and Palliative Care Organization
American Occupational Therapy Association	National Pressure Ulcer Advisory Panel
American Physical Therapy Association	National Transitions of Care Coalition
Centene Corporation	Visiting Nurse Associations of America

PAC-LTC Workgroup Membership

Individual Subject Matter Experts (Voting)
Sarah Livesay, DNP, RN, ACNP-BC, CNS-BC
Rikki Mangrum, MLS
Paul Mulhausen, MD
Eugene Nuccio, PhD
Ashish Trivedi, PharmD

Federal Government Liaisons (Non-Voting)
Center for Disease Control and Prevention (CDC)
Centers for Medicare and Medicaid Services (CMS)
Office of the National Coordinator for Health Information Technology (ONC)

CMS Welcoming Remarks

MAP Pre-Rulemaking Approach

MAP Pre-Rulemaking Approach

October

- The Workgroups and Coordinating Committee meet via web meeting to:
  - *Review the pre-rulemaking approach and evaluation of measures under consideration*
  - *Familiarize themselves with finalized program measure set for each program*

November

- The Rural Health Workgroup meets via web meetings to provide rural perspectives on the selection of quality measures in MAP

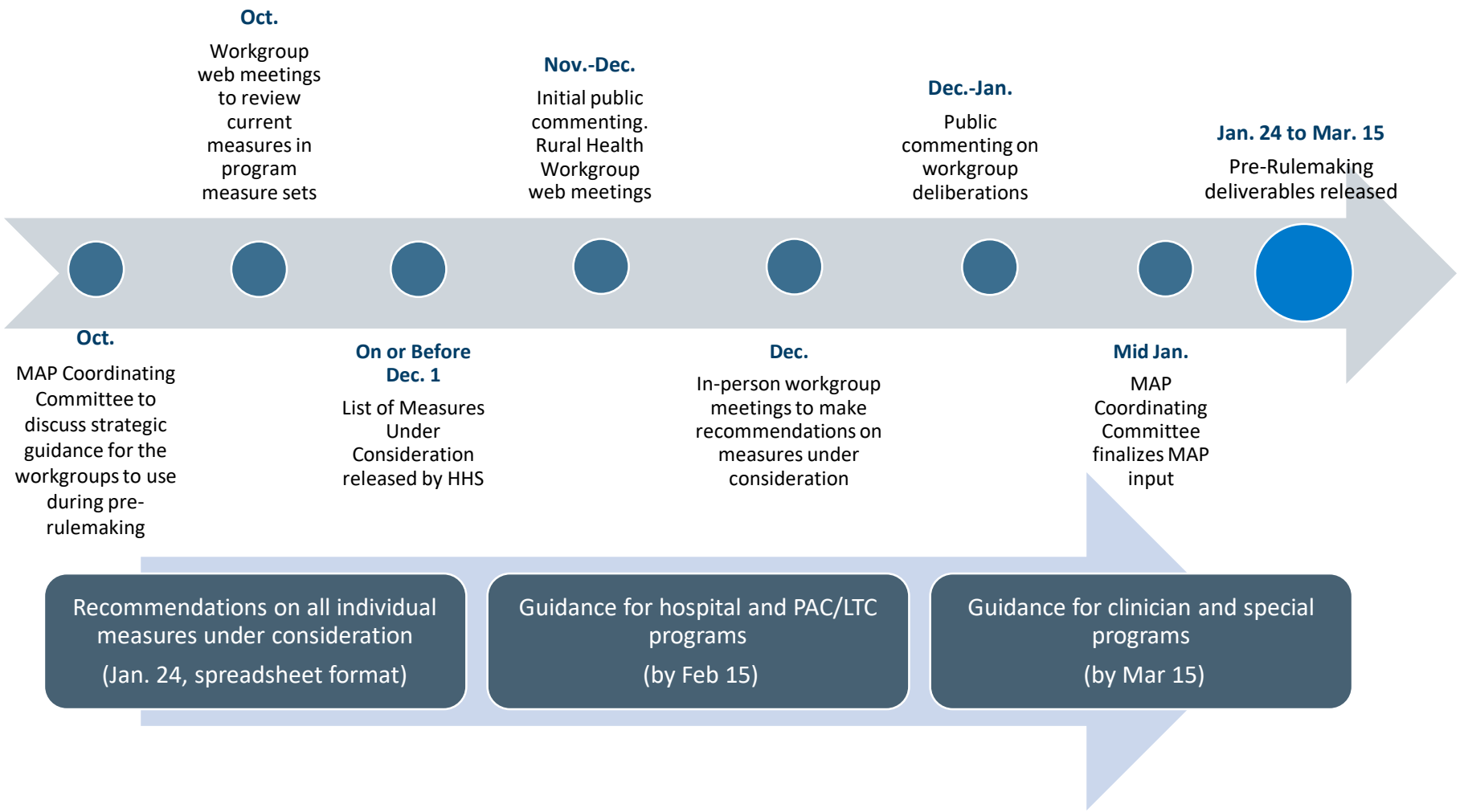
December

- The MAP setting-specific Workgroups will evaluate measures under consideration during their December in-person meetings informed by the preliminary evaluations completed by NQF staff

January

- The MAP Coordinating Committee will examine the MAP Workgroup recommendations and key cross-cutting issues

MAP Pre-Rulemaking Approach



MAP Pre-Rulemaking Approach—Goals for Today's meeting

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

Overview of PAC-LTC Programs under Consideration

Programs to Be Considered by the PAC-LTC Workgroup

- Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)
- 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)
- Hospice Quality Reporting Program (HQRP)
- Home Health Quality Reporting Program (HH QRP)

PAC/LTC High-Leverage Opportunities and Core Measure Concepts

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental health
Goal Attainment	• Achievement of patient/family/caregiver goals • Advanced care planning and treatment
Patient and Family Engagement	• Experience of care • Shared decision making • Patient and family education
Care Coordination	• Effective transitions of care • Accurate transmission of information
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions
Quality of Life	• Symptom Management • Social determinants of health • Autonomy and control • Access to lower levels of care

Identified in the MAP Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement (2012)

IMPACT Act Programs

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- **Program Type:**
  - *Penalty for failure to report*
- **Incentive Structure:**
  - *Section 1888(e)(6)(A)(i) to the Social Security Act, as added by section 2(c)(4) of the IMPACT ACT, required CMS to reduce the annual payment update to SNFs that do not submit required quality data by two percentage points.*
- **Program Information:**
  - *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.*

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

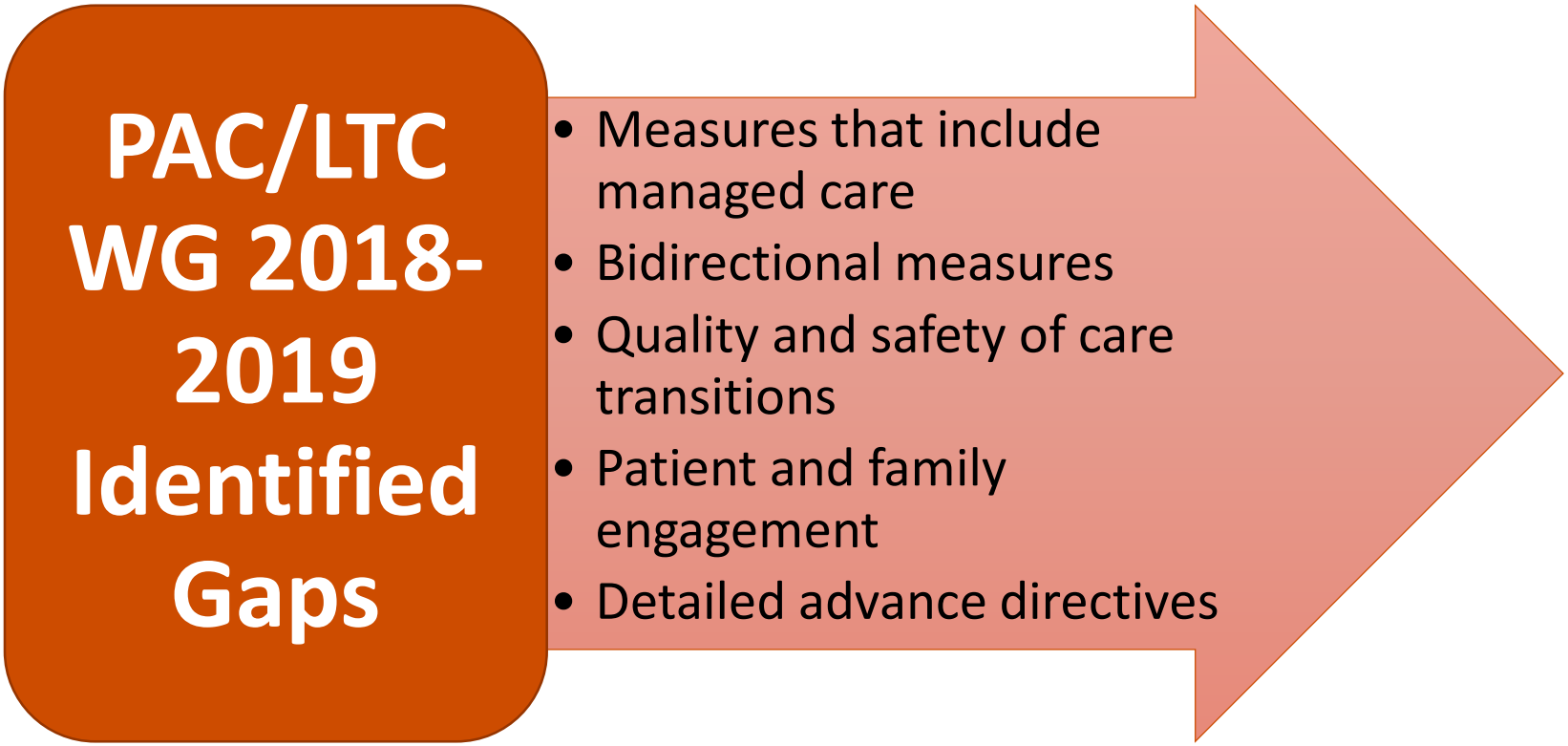
SNF QRP: Current Program Measure Information (Continued)

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

Previous Gaps Identified



Workgroup Discussion

- Does the Workgroup have suggestions for refinement to the identified gaps?

Home Health Quality Reporting Program (HH QRP)

- **Program Type:**
  - *Penalty for failure to report; Data are reported on the Home Health Compare website.*
- **Incentive Structure:**
  - *The HH QRP was established in accordance with section 1895 of the Social Security Act. Home health agencies (HHAs) that do not submit data receive a 2 percentage point reduction in their annual HH market basket percentage increase.*
- **Program Information:**
  - *Data sources for the HH QRP include the Outcome and Assessment Information Set (OASIS) and Medicare FFS claims*

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 (Proposed for removal in CY 2020 HH PPS Rule)	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

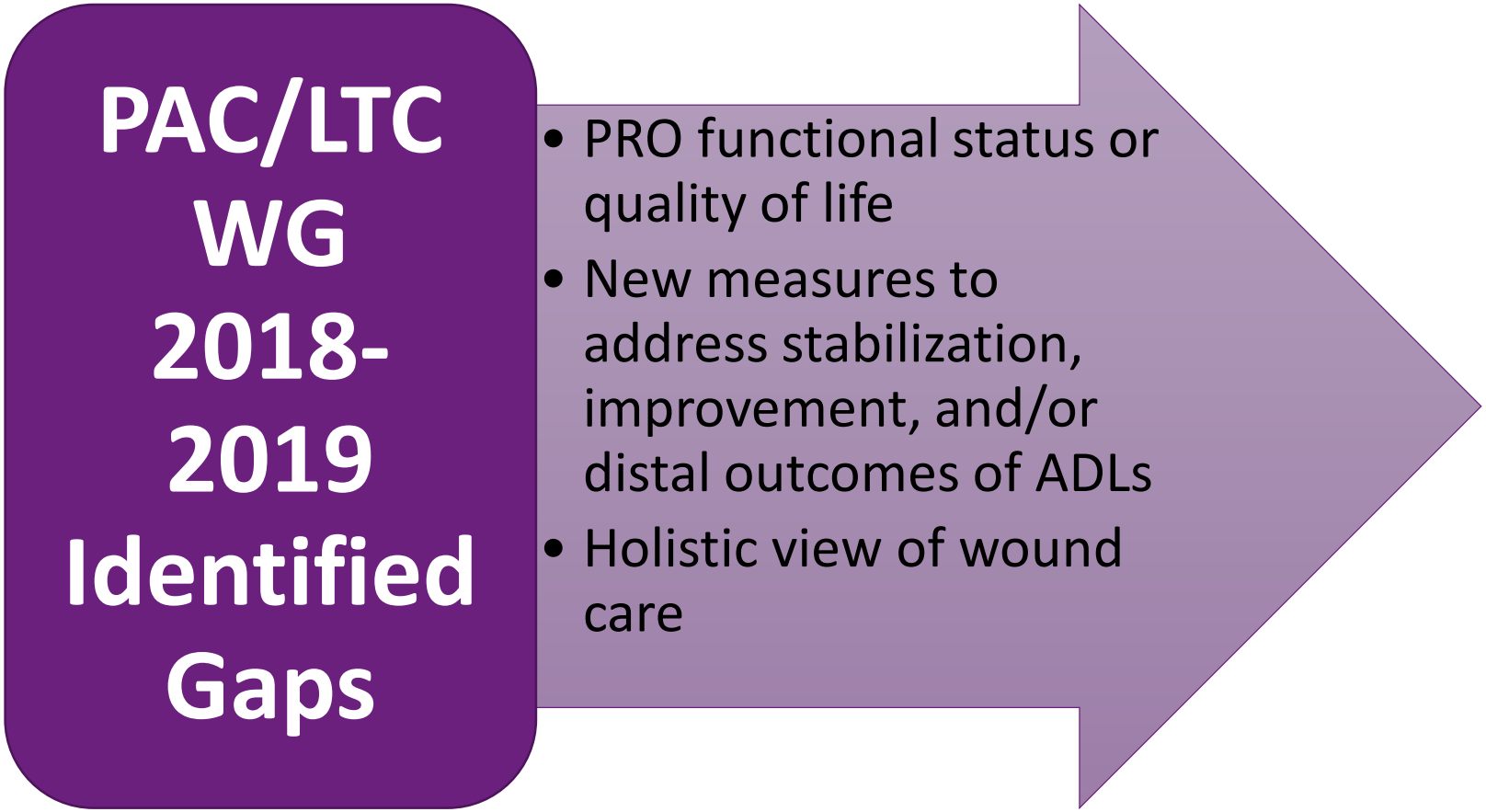
HH QRP: Current Program Measure Information (Continued)

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)	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) (Proposed for addition in CY 2020 HH PPS Rule)	Not Endorsed
Process	N/A	Transfer of Health Information to the Patient - Post-Acute Care (PAC) (Proposed for addition in CY 2020 HH PPS Rule)	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
- Communication/Care Coordination: Admissions and Readmission to Hospitals
- Exchange of Electronic Health Information and Interoperability measure concept

Previous Gaps Identified



Workgroup Discussion

- Does the Workgroup have suggestions for refinement to the identified gaps?

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

- **Program Type:**
  - *Penalty for failure to report*
- **Incentive Structure:**
  - *The IRF QRP was established under the Affordable Care Act. 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.*
- **Program Goal:**
  - *Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.*
- **Program Information:**
  - *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.*

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

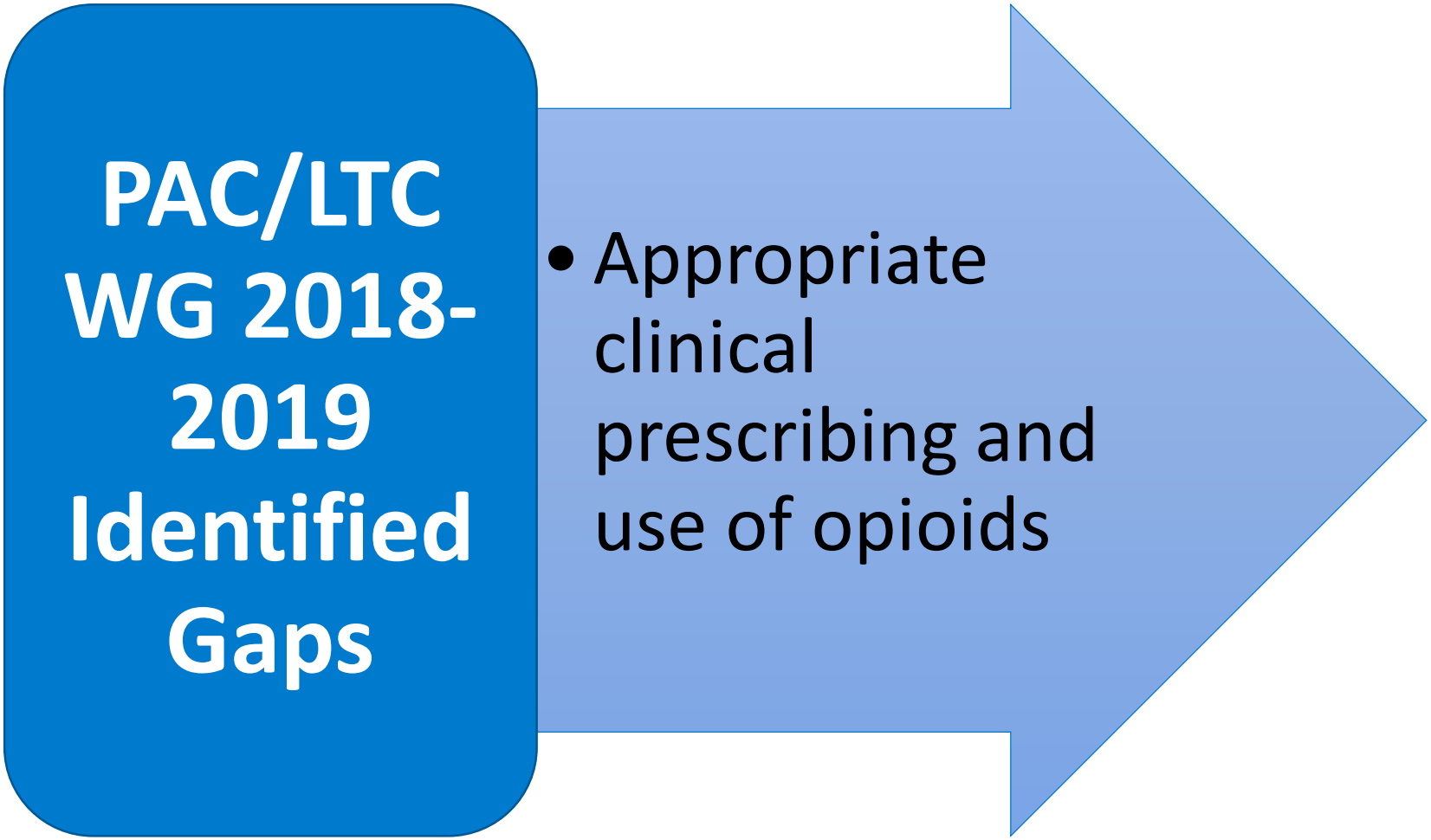
IRF QRP: Current Program Measure Information (Continued)

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

Previous Gaps Identified



Workgroup Discussion

- Does the Workgroup have suggestions for refinement to the identified gaps?

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

- **Program Type**:
  - *Penalty for failure to report*
- **Incentive Structure**:
  - *The LTCH QRP was established under the Affordable Care Act. Beginning in FY 2014, LTCHs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable annual payment update (APU).*
- **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).*
- **Program Information**:
  - *Data sources for LTCH QRP measures include Medicare FFS claims, the Center for Disease Control's National Health Safety Network (CDC NHSN) data submissions, and Long Term Care Hospital Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS).*

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

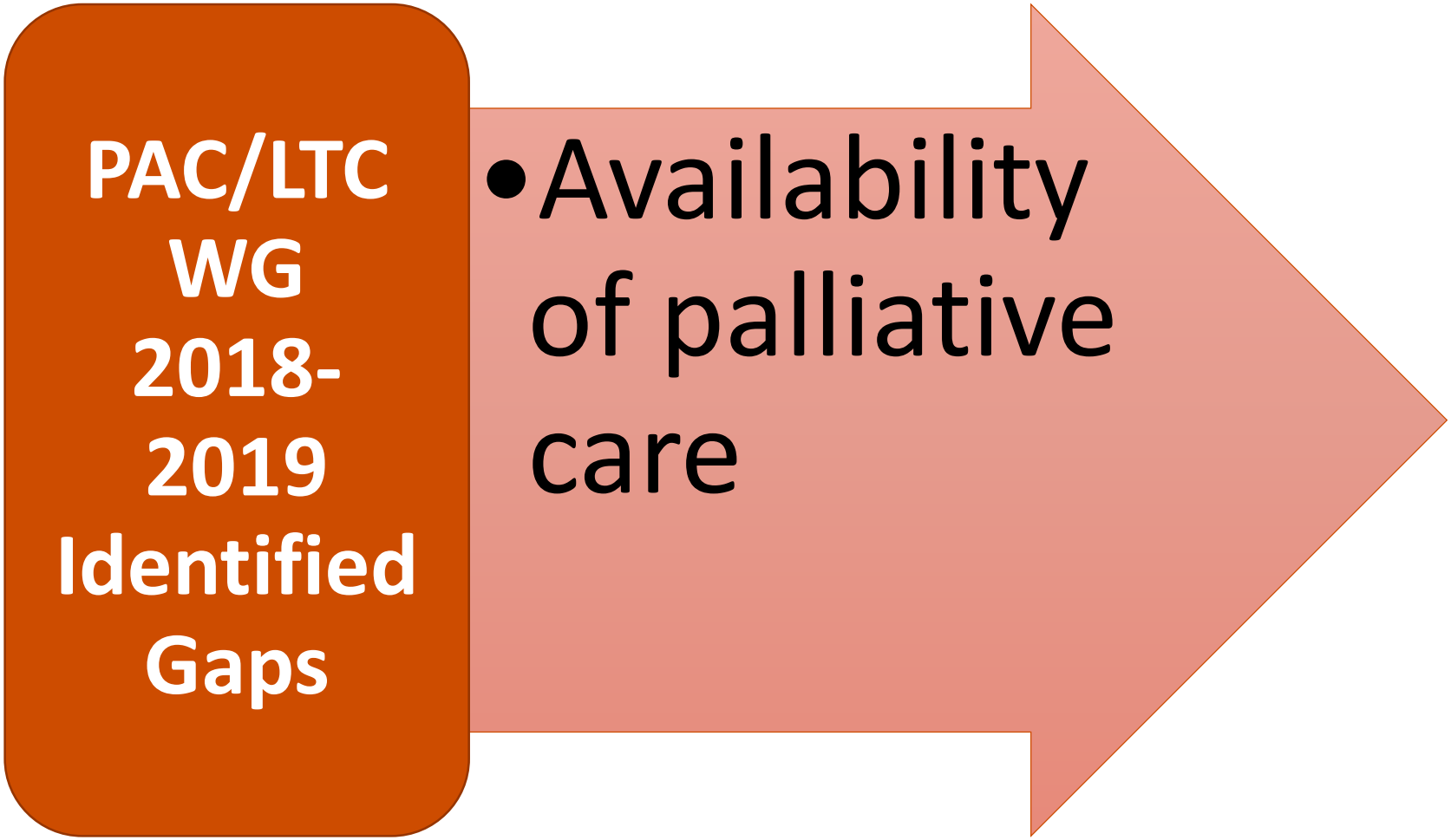
LTCH QRP: Current Program Measure Information (Continued)

Type	NQF ID	Measure Title	NQF Status
Process	431	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).*	Not Endorsed
Outcome	N/A	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP).	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

Previous Gaps Identified



Workgroup Discussion

- Does the Workgroup have suggestions for refinement to the identified gaps?

Non-IMPACT Act Programs

Skilled Nursing Facility Value-Based Purchasing (SNF VBP)

- **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. The SNF VBP Program began awarding incentive payments on October 1, 2018. VBP payments are made to SNFs in a fiscal year based by their performance on a hospital readmission measure.*
- **SNF VBP Scoring:**
  - *CMS scores SNFs on both improvement and achievement, and earn incentive payment multipliers (negative or positive) based on their performance. The higher of the achievement and improvement scores becomes the SNF's performance score.*
- **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)

- 2014 Protecting Access to Medicare Act (PAMA) legislation mandates that CMS specify:
  - *A SNF all-cause all-condition 30 day-hospital readmission measure (currently finalized in the program)*
  - *A resource use measure that reflects resource use by measuring all-condition risk-adjusted potentially preventable 30-day hospital readmission rates for SNFs no later than October 1, 2016 (This measure will replace the all-cause all-condition measure)*

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

Hospice Quality Reporting Program

- **Program Type:**
  - *Penalty for failure to timely report*
- **Incentive Structure:**
  - *The Hospice QRP was established under the Affordable Care Act. 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.*
- **Program Goal:**
  - *Addressing pain and symptom management for hospice patients and meeting their patient-centered goals, while remaining primarily in the home environment.*
- **Program Information:**
  - *Data sources for the Hospice QRP include the Hospice Item Set (HIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. HIS + CAHPS = Hospice QRP*

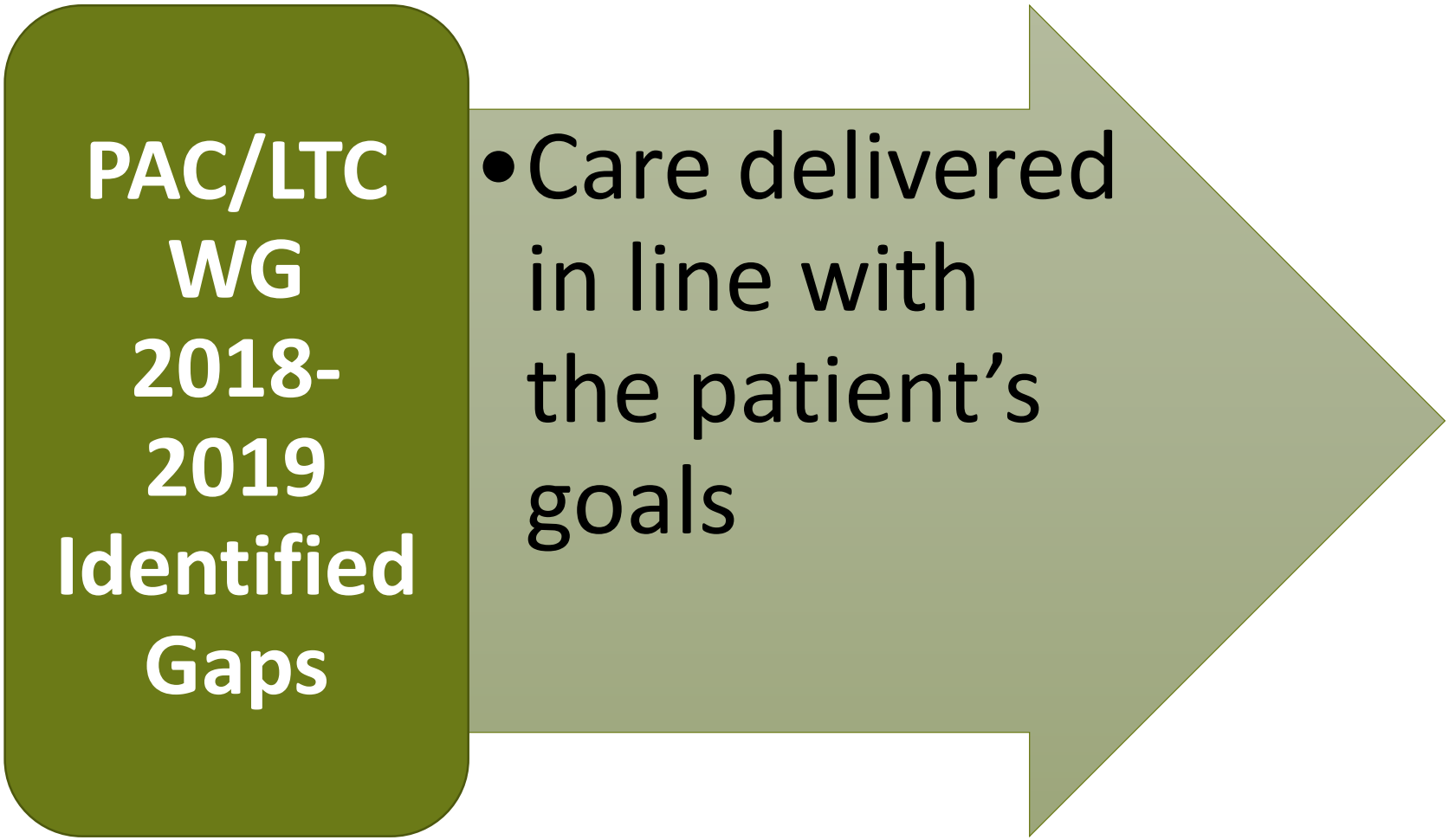
Hospice QRP: Current Program Measure Information

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

- Communication/Care Coordination

Previous Gaps Identified



Workgroup Discussion

- Does the Workgroup have suggestions for refinement to the identified gaps?

2018-2019 MAP PAC-LTC Overarching Themes

Overarching Themes

Improving Care Coordination and Care Transitions

Ensuring Meaningful Information for All Stakeholders

Improving Care Coordination and Care Transitions

- Patients may move among their home, the hospital, and 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.
- Health information technology could improve quality and minimize the burden of measurement. Electronic health record adoption in PAC/LTC settings often lags behind other care settings as there have been fewer incentives to implement new technology.
- Enhancing and facilitating the use of technology through greater standardization could help to improve transitions and the exchange of information across providers.

Improving Care Coordination and Care Transitions Cont.

- Measures should ensure a timely transfer of information so that patients and receiving providers can ensure that they have the medications and equipment needed for a safe and effective transition of care.
- People have varying degrees of health literacy, and healthcare providers should ensure that patients understand the information on their medications, including proper timing and dosages and when to discontinue use.

Ensuring Meaningful Information for All Stakeholders

- There is a need for measures that are person-centered and address aspects of care that are most meaningful to patients and families. Need to engage patients and families into quality improvement efforts and not use judgmental terms such as “adherence” or “compliance.”
- Measures should produce information as granular as is possible to ensure that clinicians and providers can act on that information to improve quality.
- Facility-level information can prove challenging to act upon, while patient-level data can help identify root causes of quality issues.
- Information from claims-based measures can be delayed, thus difficult to make timely improvements.

MAP Rural Workgroup Review of MUC

Rural Health Workgroup Charge

- To provide timely input on measurement issues to other MAP Workgroups and committees
- To provide rural perspectives on the selection of quality measures for program use in the MAP process
- To help address priority rural health issues, including the challenge of low case-volume and updating the rural-relevant core measure set

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 (cont.)

- 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
  - *In-person attendance of a Rural Health Workgroup liaison at all three pre-rulemaking meetings in December*

CMS Presentation

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PAC/LTC Workgroup Webinar Meeting

CMS Feedback Loop 2019

Alan Levitt M.D.

alan.levitt@cms.hhs.gov

October 30, 2019

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 2018 PAC/LTC Workgroup

- Measures under consideration:
  - *MUC18-131,132,133,136: Transfer of Health Information to Provider—Post-Acute Care*
  - *MUC18-135,138,139,141: Transfer of Health Information to Patient—Post-Acute Care*
  - *MUC18-101: Transitions from Hospice Care, Followed by Death or Acute Care*

Transfer of Health Information to Provider/Transfer of Health Information to Patient—Post-Acute Care

"Conditional Support for Rulemaking pending NQF endorsement"

- Adopted for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH) and Skilled Nursing Facility (SNF) QRP
- Proposed for the Home Health (HH) QRP
- Future plans for NQF endorsement

Transitions from Hospice Care, Followed by Death or Acute Care

- "Do Not Support with Potential for Mitigation"
  - *Reconsider the exclusion criteria (patient choice; Medicare Advantage)*
  - *Separate the concepts (death, admission to acute care)*
  - *Consider shortening the timeframe*
- Not proposed for the Hospice QRP
- Continuing measure development, taking Workgroup comments into consideration

Other PAC QRP Cross-Setting Highlights

- Adoption* of standardized patient assessment data elements
  - *Social Determinants of Health: race and ethnicity; preferred language and interpreter services; health literacy; transportation; and social isolation.*
- Exclusion* of baseline nursing facility (NF) residents from the Discharge to Community–PAC measure
- Proposal to include data on all patients, regardless of their payer - not adopted

(Proposed for the HH QRP in the CY 2020 HH PPS proposed rule. Final decision on the proposal is pending.)*

Meaningful Measures: Objectives

Meaningful Measures focus everyone's efforts on the same quality areas and lend specificity, which can help identify measures that:

Address high-impact measure areas that safeguard public health

Are patient-centered and meaningful to patients, clinicians and providers

Are outcome-based where possible

Fulfill requirements in programs' statutes

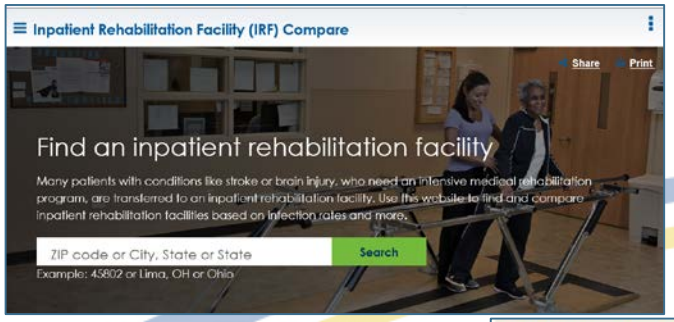
Minimize level of burden for providers

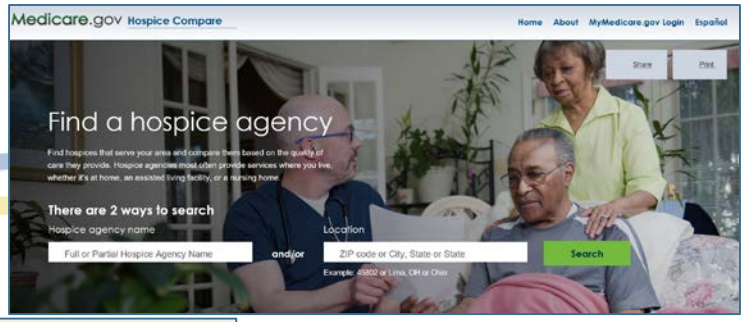
Identify significant opportunity for improvement

Address measure needs for population based payment through alternative payment models

Align across programs and/or with other payers

Questions?





66

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

- November 18, 19, 20

In-Person Meetings

- PAC/LTC Workgroup – **December 3**
- Hospital Workgroup – **December 4**
- Clinician Workgroup – **December 5**
- Coordinating Committee – **January 15**

Public Comment Period #2 – December 18, 2019 – January 8, 2020

Resources

- CMS' Measurement Needs and Priorities Document:
  - *Final 4_29_2019_MUC_Program_Priorities_Needs*
- Pre-Rulemaking URL:
  - *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html*
- MAP Member Guidebook:
  - *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=80515*

Questions?

Contact Information

- Project page
  - *http://www.qualityforum.org/Setting_Priorities/Partnership/PAC-LTC_Workgroup/Post-Acute_Care/Long-Term_Care_Workgroup.aspx*
- Workgroup SharePoint site
  - *http://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*

NATIONAL QUALITY FORUM ANNUAL CONFERENCE

2020

Driving Value Through the Next Generation of Quality

March 23—25, 2020

OMNI SHOREHAM HOTEL, WASHINGTON, D.C.
QUALITYFORUM.ORG

#NQF20

LEARN MORE ABOUT THIS PREMIER EVENT IN HEALTHCARE QUALITY

Take a Peek at the Conversations Ahead

MAINSTAGE

- Approaches to Driving Improved Value in the Pharmaceutical Landscape
- The Future of Population Health: Addressing Challenges and Advancing Opportunities
- The ROI of 20 Years of Quality and the Road Ahead
- Healthcare Centers of Excellence: How Payers and Purchasers Define Success
- The Role of Healthcare Quality in Artificial Intelligence
- Hearing Directly from Patients and Consumers: Rating Systems and Activating Consumers

BREAKOUTS

- *Seeking Better Solutions for Marginalized Populations*
- *How Quality is Responding to Public Health Crises*

Thank You