# Agenda

## MAP Post-Acute Care/Long-Term Care Workgroup
## Web Meeting
## November 4, 2013   1:00 pm – 2:30 pm ET

## Participant Instructions:

Follow the instructions below 15 minutes prior to the scheduled start time.

1. Direct your web browser to the following URL: nqf.commpartners.com .
2. Under "Enter a meeting," type in the meeting number **379900** and click on "Enter."
3. In the "Display Name" field, type in your first and last name and click on "Enter Meeting."
4. Workgroup participant dial **1-888-799-0466** and use confirmation code **57162614**. Remember to turn off your computer speakers during the presentation. *Note: All workgroup members have an open line.*
5. Public participant dial **1-855-452-6871** and use confirmation code **57162614**. Remember to turn off your computer speakers during the presentation. Note: All workgroup members have an open line.

If you need technical assistance, you may press *0 to alert an operator or send an email to nqf@commpartners.com.

## Meeting Objectives:

- Orientation to MAP 2014 pre-rulemaking approach
- Review each program likely to be considered by the PAC/LTC Workgroup and the uptake of MAP's pre-rulemaking recommendation by HHS

**1:00 pm**      **Welcome, Disclosures of Interest, and Review of Meeting Objectives**
*Carol Raphael, Workgroup Chair*
*Ann Hammersmith, General Council, NQF,*

**1:20 pm**      **MAP Pre-Rulemaking Approach**
*Aisha Pittman, Senior Director, Strategic Partnerships*
- Review revised Measure Selection Criteria
- Review four-step pre-rulemaking approach
- Discussion

**1:40 pm**          **Overview of Programs Under Consideration and Uptake Analysis**
*NQF Staff*

- Review of anticipated programs
- Uptake of MAP's 2013 recommendations by HHS
- Discussion

**2:15 pm**          **Opportunity for Public comment**

**2:25 pm**          **Next Steps**
*Carol Raphael*

**2:30 pm**          **Adjourn**

# Measure Applications Partnership

## Post-Acute Care/Long-Term Care Workgroup Web Meeting

*November 4, 2013*

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## Agenda

- Welcome, Disclosures of Interest, and Review of Meeting Objectives

- MAP Pre-Rulemaking Approach

- Overview of Programs under Consideration and Uptake Analysis

- Opportunity for Public Comment

- Next Steps

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# Welcome, Disclosure of Interests, Review of Meeting Objectives

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## Meeting Objectives

- Orientation to MAP 2014 pre-rulemaking approach

- Review each program likely to be considered by the PAC-LTC Workgroup and the uptake of MAP's pre-rulemaking recommendation by HHS

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## Post-Acute Care/Long-Term Care Workgroup Membership

**Workgroup Chair:** Carol Raphael, MPA

**Organizational Members**

| Organization | Member |
|---|---|
| Aetna | Randall Krakauer, MD |
| American Medical Rehabilitation Providers Association | Suzanne Snyder Kauserud, PT |
| American Occupational Therapy Association | Pamela Roberts, PhD, OTR/L, SCFES, CPHQ, FAOTA |
| American Physical Therapy Association | Roger Herr, PT, MPA, COS-C |
| American Society of Consultant Pharmacists | Jennifer Thomas, PharmD |
| Family Caregiver Alliance | Kathleen Kelly, MPA |
| HealthInsight | Juliana Preston, MPA |
| Kidney Care Partners | Allen Nissenson, MD, FACP, FASN, FNKF |
| Kindred Healthcare | Sean Muldoon, MD |
| National Consumer Voice for Quality Long-Term Care | Lisa Tripp, JD |
| National Hospice and Palliative Care Organization | Carol Spence, PhD |
| National Transitions of Care Coalition | James Lett II, MD, CMD |
| Providence Health & Services | Dianna Reely |
| Service Employees International Union | Charissa Raynor |
| Visiting Nurses Association of America | Margaret Terry, PhD, RN |

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## Post-Acute Care/Long-Term Care Workgroup Membership

**Subject Matter Experts**

| Category | Expert |
|---|---|
| Clinician/Nephrology | Louis Diamond, MBChB, FCP (SA), FACP, FHIMSS |
| Clinician/Nursing | Charlene Harrington, PhD, RN, FAAN |
| Care Coordination | Gerri Lamb, PhD |
| Clinician/Geriatrics | Bruce Leff, MD |
| State Medicaid | Marc Leib, MD, JD |
| Measure Methodologist | Debra Saliba, MD, MPH |
| Health IT | Thomas von Sternberg, MD |

**Federal Government Members**

| Agency | Member |
|---|---|
| Agency for Healthcare Research and Quality (AHRQ) | D.E.B. Potter, MS |
| Centers for Medicare & Medicaid Services (CMS) | Shari Ling |
| Veterans Health Administration | Scott Shreve, MD |

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## MAP Pre-Rulemaking Timeline

- **December 1**: HHS list of measures under consideration provided to MAP

- **December 4**: All MAP Web Meeting to preview list of measures under consideration

- **December 10-20**: MAP workgroup meetings to provide input on program measure sets and measures under consideration

- **January 7-8**: MAP Coordinating Committee Meeting in-person to finalize MAP's recommendations to HHS

- **Mid-January**: 2-week public comment period on draft Pre-Rulemaking Report

- **February 1**: Pre-Rulemaking Report due to HHS

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# *MAP Pre-Rulemaking Approach*

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## MAP Measure Selection Criteria

**Background**

- MAP initially developed the Measure Selection Criteria (MSC) prior to the first round of pre-rulemaking activities in 2011, primarily to guide decisions on recommendations for measure use in federal programs, with an emphasis on measure *sets*.

- Per HHS' request, the MAP Strategy Task Force was re-convened this summer as the MAP Measure Selection Criteria and Impact Task Force to advise the Coordinating Committee about potential refinements to the MSC, emphasizing the following:
  - Applying lessons learned from the past two years.
  - Integrating the Guiding Principles developed by the Clinician and Hospital Workgroups during the 2012-13 pre-rulemaking cycle.

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## Revised MAP Measure Selection Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

3. Program measure set is responsive to specific program goals and requirements

4. Program measure set includes an appropriate mix of measure types

5. Program measure set enables measurement of person- and family-centered care and services

6. Program measure set includes considerations for healthcare disparities and cultural competency

7. Program measure set promotes parsimony and alignment

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## Revisions to the Measure Selection Criteria

**Overarching Changes**

- Added a preamble to emphasize that the criteria are meant as guidance rather than rules; application should be to *measure sets,* not individual measures; and focus should be placed on filling important measure gaps and promoting alignment.
- More consistent use of terminology and formatting.
- Removed extraneous content, including the "Response Option" rating scales for each criterion or sub-criterion.

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## Pre-Rulemaking Approach

1. Build on MAP's prior recommendations

2. Evaluate each finalized program measure set using MAP Measure Selection Criteria

3. Evaluate measures under consideration for what they would add to the program measure sets

4. Identify high-priority measure gaps for programs and settings

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## 1. Build on MAP's Prior Recommendations

| MAP's Prior Efforts | Pre-Rulemaking Use |
|---|---|
| **Coordination Strategies** (i.e., Safety, Clinician, PAC-LTC, Dual Eligible Beneficiaries Cross-Cutting Input) | • Provides setting-specific considerations that will serve as background information for MAP's pre-rulemaking deliberations.<br>• Key recommendations from each coordination strategy will be compiled in background materials. |
| **Gaps Identified Across All MAP Efforts** | • Provides historical context of MAP gap identification activities.<br>• Will serve as a foundation for measure gap prioritization.<br>• A universal list of MAP's previously identified gaps will be compiled and provided in background materials. |

**\*While MAP's prior efforts serve as guidance for this work, pre-rulemaking decisions are not restricted to measures identified within these efforts.**

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## 1. Build on MAP's Prior Recommendations

| MAP's Prior Efforts | Pre-Rulemaking Use |
|---|---|
| **2012 and 2013 Pre-Rulemaking Decisions** | • Provides historical context and represents a starting place for pre-rulemaking discussions.<br>• Prior MAP decisions will be noted in the individual measure information. |
| **Families of Measures**<br>    **NQS priorities (safety, care coordination)**<br>    **Vulnerable populations (dual eligible beneficiaries, hospice)**<br>    **High-impact conditions (cardiovascular, diabetes, cancer)** | • Represents a starting place for identifying the highest-leverage opportunities for addressing performance gaps within a particular content area.<br>• Setting- and level-of-analysis-specific core sets will be compiled, drawing from the families and population cores. Core measures will be flagged in the individual measure information.<br>• MAP will compare the setting and level-of-analysis cores against the program measure sets. |

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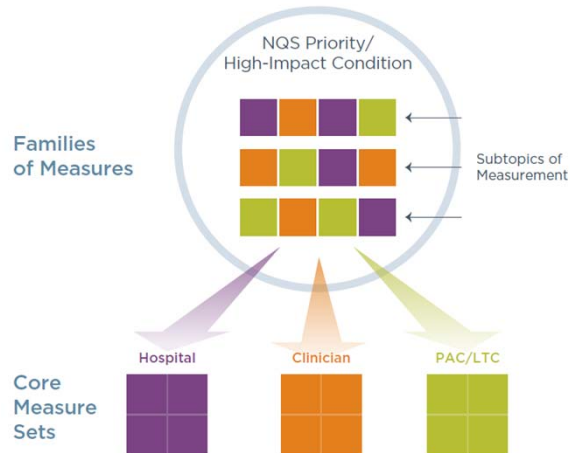
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## Families of Measures and Core Measure Sets

**Families of Measures**

"Related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS " (e.g., care coordination family of measures, diabetes care family of measures)
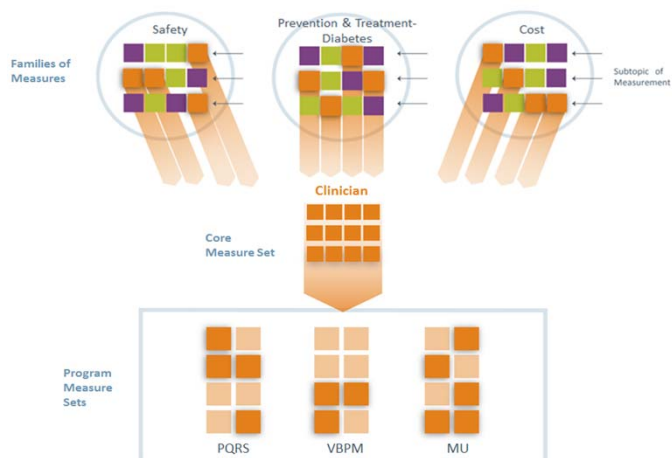
**Core Measure Sets**

"Available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., ambulatory clinician measure set, hospital core measure set, dual eligible beneficiaries core measure set)

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## Families of Measures



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## Families of Measures Populating Core Sets and Program Sets

## 2. Evaluate Finalized Program Measure Set Using MAP Measure Selection Criteria

**MAP identifies:**

- Potential measures for inclusion
- Potential measures for removal
- Gaps—implementation gaps (core measures not in the set) and other gaps (e.g., development, endorsement) along the measure lifecycle
- Additional programmatic considerations (e.g., guidance on implementing MAP recommendations, data collection and transmission, attribution methods)

## 3. Evaluate Measures Under Consideration

**MAP will indicate a decision and rationale for each measure under consideration:**

| MAP Decision Category | Decision Description | Rationale (Example) |
|---|---|---|
| Support | Indicates measures under consideration that should be added to a program measure set in the current rulemaking cycle. | • Measure addresses a previously identified measure gap<br>• Measure is included in a MAP Family of Measures<br>• Measure promotes parsimony and alignment across public and private sectors |
| Do Not Support | Indicates measures that are not recommended for inclusion in a program measure set. | • Measure is not appropriately specified or tested for the population, setting, or level of analysis<br>• A different measure better address a similar topic |
| Conditionally Support | Indicates measures, measure concepts, or measure ideas that should be phased into a program measure sets when contingent factor(s) are met. | • Measure should receive NQF endorsement before being use in the program<br>• Measure requires modification before use in the program<br>• Measures needs testing for the setting before use in the program |

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## 4. Identify High-Priority Measure Gaps for Programs and Settings

**MAP's Previously Identified Gaps**
- Compiled from all of MAP's prior reports and recent MAP activities
- Categorized by NQS priority and high-impact conditions
- Compared with gaps identified in other NQF efforts (e.g., NPP, endorsement reports)

**MAP will:**
- Identify priorities for filling gaps across settings and programs
- Present measure ideas to spur development
- Capture barriers to gap filling and potential solutions

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**_Overview of Programs under Consideration and Uptake Analysis_**

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## Potential Programs to Be Considered

- Nursing Home Quality Initiative and Nursing Home Compare

- Home Health Quality Reporting

- Inpatient Rehabilitation Facility Quality Reporting Program

- Long-Term Care Hospital Quality Reporting Program

- Hospice Quality Reporting Program

- End Stage Renal Disease Quality Incentive Program

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# PAC/LTC High-Leverage Opportunities and Core Measure Concepts

| Highest-Leverage Areas for Performance Measurement | Core Measure Concepts |
|---|---|
| Function | • Functional and cognitive status assessment<br>• Mental health |
| Goal Attainment | • Establishment of patient/family/caregiver goals<br>• Advanced care planning and treatment |
| Patient Engagement | • Experience of care<br>• Shared decision-making |
| Care Coordination | • Transition planning |
| Safety | • Falls<br>• Pressure ulcers<br>• Adverse drug events |
| Cost/Access | • Inappropriate medicine use<br>• Infection rates<br>• Avoidable admissions |

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# Core Concepts by Program

| PAC/LTC Core Concept | Program | | | | | |
|---|---|---|---|---|---|---|
| | NHQR | HHQR | LTCHQR | IRFQR | ESRD-QIP | Hospice Quality Reporting |
| Advanced care planning and treatment | | | | | | |
| Adverse drug events | | X | | | | |
| Avoidable admissions | | X | X | X | | |
| Establishment of patient/family/caregiver goals | | X | | | | |
| Experience of care | | X | | | X | |
| Falls | X | X | X | | | |
| Functional and cognitive status assessment | X | X | | X | | X |
| Inappropriate medicine use | X | | | | | |
| Infection rates | X | X | X | X | X | |
| Mental health | X | X | | | | |
| Pressure ulcers | X | X | X | X | | |
| Shared decision-making | | | | | | |
| Transition planning | X | X | | | | |

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## MAP Input on PAC-LTC Programs

**Opportunities for MAP to enhance its input?**

- *Nursing Home and Home Health*
  - These two programs have been stable for the past several years and the program measure sets address most of the MAP PAC/LTC core measure concepts.
  - What input should MAP provide on the future direction of these programs?
- *Long-term Care Hospital and Inpatient Rehab Facilities*
  - LTCHs and IRFs are newer programs and have been progressing towards the PAC/LTC core measure concepts.
  - What additional high-leverage measurement opportunities are missing from these programs?
- *Hospice*
  - All new finalized measures for this program address MAP's recommendations in the MAP Hospice and Palliative Care Coordination Strategy Report.
  - As hospice and palliative care are offered in multiple settings; does the Workgroup have any recommendations for improving hospice and palliative care quality measurement in other settings?
- *End Stage Renal Disease*
  - What additional information will you need to aid you in providing recommendations on measures under consideration for this program?

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## Nursing Home Quality Initiative and Nursing Home Compare

- **Program Type**: Pay for Reporting, Public Reporting

- **Incentive Structure**: Nursing homes are required to complete the MDS as part of the federally mandated certification

- **Statutory Requirements for Measures**: Must include domains of resident health and quality of life

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## Nursing Home Quality Initiative and Nursing Home Compare

- **Uptake of MAP recommendations by HHS**
  - MAP provided input on 5 measures for the Nursing Home Quality Initiative and Nursing Home Compare.
    - » MAP "Supported" 1 measure and "Supported Direction" for 4 measures, none of which were proposed

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## Home Health Quality Reporting

- **Program Type:** Pay for Reporting, Public Reporting

- **Incentive Structure:** Home health agencies (HHA) that do not submit data will receive a 2 percentage point reduction in their annual HHA market basket percentage increase.

- **Statutory Requirements for Measures:** None

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## Home Health Quality Reporting

**Uptake of MAP recommendations in 2013 HHS Proposed Rule**

- MAP provided input on 2 measures for HHQR
    - MAP "supported Direction" for both measures; both were proposed for CY 2014
        - » Rehospitalization During First 30 Days of Home Health
        - » Home Health Emergency Department Use without Readmission

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## Inpatient Rehabilitation Facility Quality Reporting

- **Program Type**: Pay for Reporting, Public Reporting

- **Incentive Structure**: Must submit data on quality measures to receive annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year. Incentive structure begins in FY 2014.

- **Statutory Requirements for Measures:** Measures for FY 2014 and subsequent years should:
    - Improve patient safety, reduce adverse events, and encourage better coordination of care and person- and family-centered care.
    - Address the primary role of IRFs—the rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community post-discharge.

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## Inpatient Rehabilitation Facility Quality Reporting

**Uptake of MAP recommendations in 2013 HHS Final Rule**

- MAP provided input on 10 measures for the IRF QRP
  - MAP "Supported Direction" for 6 measures, one of which was finalized for the FY 2017 IRF PPS annual increase factor
    - » All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities
  - MAP "Supported" 3 measures, one of which was finalized for the FY 2016 and one was finalized for the FY 2017 IRF PPS annual increase factor
    - » NQF #0431 Influenza Vaccination Coverage among Healthcare Personnel (FY 2016)
    - » NQF #0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (FY 2017)
  - MAP "Did not Support" 1 measure, which was not finalized
    - » Reliability Adjusted Central Line-Associated Blood Stream Infection (CLABSI)

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## Long-Term Care Hospital Quality Reporting

- **Program Type**: Pay for Reporting, Public Reporting

- **Incentive Structure**: Must submit data on quality measures in order to receive annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual payment update. Incentive structure begins in FY 2014.

- **Statutory Requirements for Measures:** Measures for FY 2014 and subsequent years should:
  - Promote patient safety, better coordination of care, and person- and family-centered care.
  - Address the primary role of LTCHs–to provide extended medical care to individuals with clinically complex problems.

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## Long-Term Care Hospital Quality Reporting

**Uptake of MAP recommendations in 2013 HHS Final Rule**

- MAP provided input on 29 measures for the LTCH QRP

  - MAP "Supported Direction" for 25 measures, 3 of which were finalized for the FY 2017 and one for the FY 2018 Payment Determination and Subsequent Payment Determinations
    - ❖ NQF #1716 NHSN Facility-wide Inpatient Hospital-onset MRSA Bacteremia Outcome Measure. (FY 2017)
    - ❖ NQF #1717 NHSN Facility-wide Inpatient Hospital-onset CDI Outcome Measure. (FY 2017)
    - ❖ All-cause Unplanned Readmission Measure for 30 days Post-Discharge from Long-term Care Hospitals. (FY 2017)
    - ❖ Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674). (FY 2018)

- MAP "Did not Support" four measures, none of which were finalized
  - Those measures had lost NQF endorsement or did not address PAC/LTC core concepts

## Hospice Quality Reporting

- **Program Type**: Pay for Reporting, Public Reporting

- **Incentive Structure**: Failure to submit required quality data shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year. Incentive structure begins in FY2014.

- **Statutory Requirements for Measures:** None

## Hospice Quality Reporting

**Uptake of MAP recommendations in 2013 HHS Final Rule**

- MAP provided input on 8 measures for the Hospice Quality Reporting Program
  - MAP "Supported" all 7 measures under consideration, of which 6 were finalized as the Hospice Item Set (HIS) for implementation in July 2014
    - » NQF #1617 Patients treated with an Opioid who are given a bowel regimen
    - » NQF #1634 Pain screening
    - » NQF #1637 Pain assessment
    - » NQF #1638 Dyspnea treatment
    - » NQF #1639 Dyspnea Screening
    - » NQF #1641 Treatment Preferences

  - MAP "Supported" one additional measure (included in the MAP Hospice Family of Measures), which was finalized as part of the HIS for implementation in July 2014
    - » NQF #1647 Beliefs/Values Addressed (if desired by the patient) (modified)

  - A Hospice Experience of Care survey is under development; CMS had technical objections to the Family Evaluation of Hospice Care (FEHC) survey, #0208, which MAP had supported

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## End-Stage Renal Disease Quality Incentive program

- **Program Type**: Pay for Performance, Public Reporting Website

- **Incentive Structure**: Starting in PY 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions will be on a sliding scale, which could amount to a maximum of 2 percent per year.

- **Statutory Requirements for Measures:** Measures specified for the ESRD QIP include measures that:
  - Assess anemia management that reflect the labeling approved by the FDA for such management;
  - Assess dialysis adequacy;
  - Assess patient satisfaction; and
  - Additional measures, such as, iron management, bone mineral metabolism, and vascular access, including maximizing the placement of arterial venous fistula.

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## End- Stage Renal Disease Quality Incentive Program

**Uptake of MAP recommendations in 2013 HHS Proposed Rule**

- MAP provided input on 21 measures for the ESRD-QIP
    - MAP "Supported Direction" for 9 measures,  none of which were proposed
    - MAP "Supported" 11 measures, one of which was proposed for ESRD QIP for PY 2016 and subsequent years
        - » NQF #1454 Proportion of Patients with Hypercalcemia
    - MAP "Did not Support" 1 measure, which was not proposed
        - » Measurement of Serum Calcium Concentration

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## MAP Input on PAC-LTC Programs

**Opportunities for MAP to enhance its input?**

- *Nursing Home and Home Health*
    - These two programs have been stable for the past several years and the program measure sets address most of the MAP PAC/LTC core measure concepts.
    - What input should MAP provide on the future direction of these programs?
- *Long-term Care Hospital and Inpatient Rehab Facilities*
    - LTCHs and IRFs are newer programs and have been progressing towards the PAC/LTC core measure concepts.
    - What additional high-leverage measurement opportunities are missing from these programs?
- *Hospice*
    - All new finalized measures for this program address MAP's recommendations in the MAP Hospice and Palliative Care Coordination Strategy Report.
    - As hospice and palliative care are offered in multiple settings; does the Workgroup have any recommendations for improving hospice and palliative care quality measurement in other settings?
- *End Stage Renal Disease*
    - What additional information will you need to aid you in providing recommendations on measures under consideration for this program?

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# Opportunity for Public Comment

# Next Steps

## Next Steps

- **December 1**: HHS list of measures under consideration provided to MAP

- **December 4**: All MAP Web Meeting

- **December 10**: PAC-LTC Workgroup In-Person Meeting

- **January 7-8**: Coordinating Committee In-Person Meeting

- **Mid-January**: 2-week public comment period on draft Pre-Rulemaking Report

- **February 1**: Pre-Rulemaking Report due to HHS

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# *Adjourn*

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# Overview of PAC/LTC Programs

| Program Name | Program Type | Program Description/Statutory Requirements for Measures | MAP Overall Recommendations |
|---|---|---|---|
| **Nursing Home Quality Reporting** | Pay for Reporting, Public Reporting | • Required to complete the MDS as part of the federally mandated certification.<br>• Measures must include domains of resident health and quality of life. | • To promote alignment across programs, potential short-stay measures should align with measures selected for use in inpatient rehabilitation facilities.<br>• Including Nursing Home-CAHPS measures in the program to address patient experience. |
| **Home Health Quality Reporting** | Pay for Reporting, Public Reporting | • Required to submit OASIS and Home Health CAHPS; failure to submit will result in a 2 percentage point reduction in the annual HHA market basket percentage increase. | • MAP recommended the measure set be more parsimonious but also reflect the heterogeneity of HH population |
| **Inpatient Rehabilitation Facility Quality Reporting** | Pay for Reporting, Public Reporting | • Failure to report quality data will result in a 2 percent reduction in the annual increase factor.<br>• Measures should align with the NQS and be relevant to the IRFs priorities and their primary role. | • The program measure set is too limited and could be enhanced by addressing the core measures concepts not addressed in the set. |
| **Long-Term Care Hospital Quality Reporting Program** | Pay for Reporting, Public Reporting | • Failure to report quality data will result in a 2 percent reduction in the annual payment update.<br>• Measures should align with the NQS and be relevant to the LTCH priorities and their primary role. | • Continue to support alignment by including measures that are used in other settings; however, the measures need to be tested for the LTCH setting. |
| **Hospice Quality Reporting Program** | Pay for Reporting, Public Reporting | • Failure to submit required quality data will result in a 2-percentage point reduction to the market basket percentage increase. | • The measure set would be enhanced with measures that address the caregiver's role and timely referral to hospice. |
| **End Stage Renal Disease Quality Improvement** | Pay for Performance, Public Reporting | • Payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score.<br>• Measures of anemia management that reflect labeling approved by the FDA, dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access. | • The measure set should expand beyond dialysis procedures to include non-clinical aspects of care, such as care coordination.<br>• Clinically focused measures could be combined in a composite measure for assessing optimal dialysis care. |

# Nursing Home Quality Initiative and Nursing Home Compare

## Program Type:

Pay for Reporting, Public Reporting

## Incentive Structure:

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. Part of this requirement includes completing the Minimum Data Set (MDS), a clinical assessment of all residents in Medicare- or Medicaid-certified nursing facilities. Quality measures are reported on the Nursing Home Compare website using a Five-Star Quality Rating System, which assigns each nursing home a rating of 1 to 5 stars, with 5 representing highest standard of quality, and 1 representing the lowest.[1]

## Care Settings Included:

Medicare- or Medicaid-certified nursing facilities

## Statutory Mandate:

The 1987 Omnibus Budget Reconciliation Act mandated the development of a nursing home resident assessment instrument.

## Statutory Requirements for Measures:

OBRA mandated the inclusion of the domains of resident health and quality of life in the resident assessment instrument.

## MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP supported the direction of 2 measures that address the PAC/LTC core concept of inappropriate medication use, noting that the measures should have as few exclusions as possible and monitoring should be incorporated into program implementation to detect unintended consequences. MAP noted the need for measures that address the overall improvement of dementia care and cautioned that focus on reducing inappropriate use of one class of medication may lead to inappropriate use of other medication classes.
- MAP also supported the direction of two measures addressing avoidable admissions, a core measure concept. MAP recognized the importance of measuring readmissions in the nursing home setting but would prefer fewer measures to address readmissions across settings.

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[1] Centers for Medicare and Medicaid Services. Five-Star Quality Rating System. Available at https://www.cms.gov/CertificationandComplianc/13_FSQRS.asp#TopOfPage. Last accessed October 2011.

# Home Health Quality Reporting

## Program Type:

Pay for Reporting, Public Reporting

## Incentive Structure:

Medicare-certified[1] home health agencies (HHAs) are required to collect and submit the Outcome Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.[2] Home health agencies meet their quality data reporting requirements through the submission of OASIS assessments and Home Health CAHPS. HHAs that do not submit data will receive a 2 percentage point reduction in their annual HH market basket percentage increase.

Subsets of the quality measures generated from OASIS are reported on the Home Health Compare website, which provides information about the quality of care provided by HHAs throughout the country.[3] Currently, 23 of the 97 OASIS measures are finalized for public reporting on Home Health Compare.

## Care Settings Included:

Medicare-certified home health agencies

## Statutory Mandate:

Section 1895(b)(3)(B)(v)(I) of the Social Security Act, as amended by section 5201 of the Deficit Reduction Act, established the requirement that HHAs that do not report quality data would not receive the full market basket payment increase.

## Statutory Requirements for Measures:

None.

## MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP reviewed two measures under consideration for the Home Health Quality Reporting Program. MAP supported the direction of both because they address the PAC/LTC core concept of avoidable admissions. MAP recognized the importance of reducing rehospitalizations and ED visits but noted that these measures should replace or be harmonized with currently finalized measures addressing hospitalizations and ED visits in order to reduce redundancy in the set.
- MAP noted that the large measure set reflects the heterogeneity of home health population; however, the measure set could be more parsimonious.

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[1] "Medicare-certified" means the home health agency is approved by Medicare and meets certain Federal health and safety requirements.

[2] Centers for Medicare and Medicaid Services. Background. June 2011. Available at http://www.cms.gov/OASIS/02_Background.asp#TopOfPage. Last accessed October 2011.

[3] The Official U.S. Government Site for Medicare. Introduction. Available at http://www.medicare.gov/HomeHealthCompare/About/overview.aspx. Last accessed October 2011.

# Inpatient Rehabilitation Facility Quality Reporting

## Program Type:

Pay for Reporting, Public Reporting

## Incentive Structure:

For fiscal year of 2014, and each year thereafter, Inpatient Rehabilitation Facility providers (IRFs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive annual payment updates. Failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year.[1] The data must be made publicly available, with IRF providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[2]

## Care Settings Included:

Inpatient Rehabilitation Facilities

## Statutory Mandate:

Section 3004(b) of the Affordable Care Act (ACA) directs the Secretary to establish quality reporting requirements for IRFs.

## Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), be relevant to the priorities of IRFs (such as patient safety, reducing adverse events, better coordination of care, and person- and family-centered care), and address the primary role of IRFs—rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community post-discharge. [1]

## MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP found the program measure set too limited and noted that it could be greatly enhanced by addressing the core measures concepts not addressed in the set—care coordination, functional status, and medication reconciliation—and the safety issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and *C. difficile*.
- MAP supported the direction of two measures that address CAUTI and *C. difficile*, in addition to supporting three immunization measures.
- MAP supported the direction of three functional status outcome measures and one avoidable admissions measure, noting that the measures are important but still in development.
- MAP did not support one CLABSI measure, which has a low incidence in this setting.

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[1] FY 2012 IRF PPS final rule The Office of the Federal Register.
http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

[1]   CMS.gov. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

[2] CMS.gov. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

# Long-Term Care Hospital Quality Reporting

## Program Type:

Pay for Reporting, Public Reporting

## Incentive Structure:

For fiscal year 2014, and each year thereafter, Long-Term Care Hospital providers (LTCHs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive full annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual payment update.[1] The data must be made publicly available, with LTCH providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[2]

## Care Settings Included:

Long-Term Care Hospitals

## Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for LTCHs.

## Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), promote enhanced quality with regard to the priorities most relevant to LTCHs (such as patient safety, better coordination of care, and person- and family-centered care), and address the primary role of LTCHs—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).[3]

## MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP noted that many measures under consideration would support alignment with other settings; however, measures should be tested in LTCHs to determine if they are feasible for implementation.
- MAP supported the direction of one cost measure, noting that the measure under consideration would exclude LTCHs because the measure methodology excludes hospitals whose average inpatient length of stay exceeds 25 days. MAP recommends that additional measures be added to address cost. For example, assessing whether individuals are appropriately placed in LTCHs would help determine whether they could receive care in less costly settings.

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[1] CMS.gov. LTCH Quality Reporting.http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/
[2] CMS.gov. LTCH Quality Reporting.http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/
[3] FY 2012 IPPS/LTCH PPS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

- MAP did not support four measures under consideration that did not address PAC/LTC core concepts or had lost NQF endorsement.
- Measures should address the PAC/LTC core measures not currently addressed in the measure set including cognitive status assessment (e.g. dementia identification), advance care planning and treatment, and  inappropriate medication use (e.g., use of antipsychotic medications).

# Hospice Quality Reporting Program

## Program Type:

Pay for Reporting, Public Reporting

## Incentive Structure:

Failure to submit required quality data, beginning in FY 2014 and for each year thereafter, shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.[1] The data must be made publicly available, with Hospice Programs having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of hospice quality data. [2]

## Care Settings Included:

Multiple; hospice care can be provided in inpatient and outpatient settings.

## Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Programs.[3]

## Statutory Requirements for Measures:

None.

## MAP 2012 Pre-Rulemaking Program-Specific Input:

- MAP reviewed two measures currently finalized for the program measure set and seven measures under consideration; they supported all of these measures since they were all included in the MAP Hospice and Palliative Care Coordination Strategy (2012)
- MAP recommended that other measures in the MAP Hospice Family of Measures be added to the measure set; specifically NQF #1647 Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss
- MAP noted that the measure set failed to address several core measure concepts, including pain, goal attainment, patient engagement, care coordination, and depression
- MAP also recommended that the measure set would be enhanced with measures that address the caregiver's role and timely referral to hospice.

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[1] Ibid
[2] CMS. Hospice Quality Reporting. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html
[3] Ibid

# End Stage Renal Disease Quality Incentive Program

## Program Type:

Pay for Performance, Public Reporting

## Incentive Structure:

Starting in 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions will be on a sliding scale, which could amount to a maximum of two percent per year.[1] Performance is reported on the Dialysis Facility Compare website.

## Care Settings Included:

Dialysis Providers/Facilities

## Statutory Mandate:

The ESRD Quality Incentive Program (QIP), required by section 1881 (h) of the Social Security Act and added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c), was developed by CMS to be the first pay-for-performance (also known as "value-based purchasing") model quality incentive program.[2]

## Statutory Requirements for Measures:

Measures of anemia management that reflect labeling approved by the Food and Drug Administration (FDA), dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access. [3]

## MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP supported the only measure under consideration that addresses a cross-cutting topic, NQF # 0258 CAHPS In-Center Hemodialysis Survey, in alignment with its previous recommendation that the measure set expand beyond dialysis procedures to include non-clinical aspects of care, such as care coordination.
- Recognizing that the program is statutorily required to include measures of dialysis adequacy, MAP supported 11 measures under consideration that are clinically focused.
- MAP supported the direction of an additional 9 clinically focused measures under consideration, because the measures would address statutory requirements but they are undergoing development and need to be brought forward for NQF endorsement.
- MAP did not support 1 measure under consideration because its NQF endorsement has been removed.
- MAP recommended exploring whether the clinically focused measures could be combined in a composite measure for assessing optimal dialysis care.
- The core measure concepts not addressed in this measure set include advance care planning, care coordination, medication reconciliation, functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression.

[1] Federal Register. Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Bad Debt Reductions for All Medicare Providers. https://www.federalregister.gov/articles/2012/07/11/2012-16566/medicare-program-end-stage-renal-disease-prospective-payment-system-quality-incentive-program-and

[2] Final rule ESRD PY 2012-2013-2014. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

[3] Final rule ESRD PY 2012-2013-2014. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

# MAP MEASURE SELECTION CRITERIA

**NATIONAL QUALITY FORUM**

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

## Criteria

### 1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

*Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.*

| | |
|---|---|
| **Sub-criterion 1.1** | Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need |
| **Sub-criterion 1.2** | Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs |
| **Sub-criterion 1.3** | Measures that are in reserve status (i.e., topped out) should be considered for removal from programs |

### 2. Program measure set adequately addresses each of the National Quality Strategy's three aims

*Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:*

| | |
|---|---|
| **Sub-criterion 2.1** | Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment |
| **Sub-criterion 2.2** | Healthy people/healthy communities, demonstrated by prevention and well-being |
| **Sub-criterion 2.3** | Affordable care |

## 3. Program measure set is responsive to specific program goals and requirements

*Demonstrated by a program measure set that is "fit for purpose" for the particular program.*

| | |
|---|---|
| **Sub-criterion 3.1** | Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s) |
| **Sub-criterion 3.2** | Measure sets for public reporting programs should be meaningful for consumers and purchasers |
| **Sub-criterion 3.3** | Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period) |
| **Sub-criterion 3.4** | Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program. |
| **Sub-criterion 3.5** | Emphasize inclusion of endorsed measures that have eMeasure specifications available |

## 4. Program measure set includes an appropriate mix of measure types

*Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program.*

| | |
|---|---|
| **Sub-criterion 4.1** | In general, preference should be given to measure types that address specific program needs |
| **Sub-criterion 4.2** | Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes |
| **Sub-criterion 4.3** | Payment program measure sets should include outcome measures linked to cost measures to capture value |

## 5. Program measure set enables measurement of person- and family-centered care and services

*Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration*

| | |
|---|---|
| **Sub-criterion 5.1** | Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination |
| **Sub-criterion 5.2** | Measure set addresses shared decision-making, such as for care and service planning and establishing advance directives |
| **Sub-criterion 5.3** | Measure set enables assessment of the person's care and services across providers, settings, and time |

## 6. Program measure set includes considerations for healthcare disparities and cultural competency

*Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).*

**Sub-criterion 6.1**    Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

**Sub-criterion 6.2**    Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

## 7. Program measure set promotes parsimony and alignment

*Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.*

**Sub-criterion 7.1**    Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

**Sub-criterion 7.2**    Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)