Measure Applications Partnership

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

December 10, 2013

NATIONAL QUALITY FORUM

Meeting Objectives

- Review and provide input on currently finalized program measure sets for federal programs applicable to PAC/LTC settings
- Review and provide input on measures under consideration for federal programs applicable to PAC/LTC settings
- Identify high-priority measure gaps for each program measure set
- Finalize input to the MAP Coordinating Committee on measures for use in federal programs

Agenda

- Welcome, Review Meeting Objectives, and Pre-Rulemaking Approach
- Pre-Rulemaking Input on Inpatient Rehabilitation Facility Quality Reporting Program Measure Set
- Pre-Rulemaking Input on Long-Term Care Hospital Quality Reporting Program Measure Set
- Pre-Rulemaking Input on End Stage Renal Disease Quality Incentive Program Measure Set
- Opportunity for Public Comment
- Input on Alignment Issues across PAC/LTC Programs
- Pre-Rulemaking Input on Home Health Quality Reporting Program Measure Set
- Pre-Rulemaking Input on Hospice Quality Reporting Program and Palliative Care Measures for Hospital Quality Measurement Programs
- Pre-Rulemaking Input on Nursing Home Quality Initiative Program
- Opportunity for Public Comment
- Summary of Day and Adjourn

Post-Acute Care/Long-Term Care Workgroup Membership

Workgroup Chair: Carol Raphael, MPA

Organizational Members

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

Post-Acute Care/Long-Term Care Workgroup Membership

Subject Matter Experts

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 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

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

MAP Pre-Rulemaking Approach

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

1. Build on MAP's Prior Recommendations

MAP's prior efforts serve as guidance for pre-rulemaking decisions

- Coordination Strategies
  - Key recommendations included in Discussion Guide
- Gaps identified across all MAP efforts
  - MAP Previously Identified Gaps list in background materials
- 2012 and 2013 pre-rulemaking decisions
  - Measure charts and Discussion Guide note prior pre-rulemaking decisions
- Families of measures
  - Measure charts note measures that are included in families

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

Through discussion MAP identifies:

- Potential measures for inclusion
- Potential measures for removal
- Gaps—implementation gaps (measures in a family 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)

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

Process for Meeting:

A. Staff will review program summary and initial staff evaluation of each finalized program measure set

B. Workgroup will discuss and make recommendations about the current finalized measure set

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

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 the program measure set during the current rulemaking cycle.**	• NQF-endorsed measure • Addresses National Quality Strategy aim or priority not adequately addressed in program measure set • Addresses program goals/requirements • Addresses a measure type not adequately represented in the program measure set • Promotes person- and family-centered care • Provides considerations for healthcare disparities and cultural competency • Promotes parsimony • Promotes alignment across programs, settings, and public and private sector efforts • Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries • Included in a MAP family of measures

3. Evaluate Measures Under Consideration

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

MAP Decision Category	Decision Description	Rationale (Example)
Do Not Support	**Indicates measures that are not recommended for inclusion in the program measure set.**	• Measure does not adequately address any current needs of the program • A finalized measure addresses a similar topic and better addresses the needs of the program • A 'Supported' measure under consideration addresses as similar topic and better addresses the needs of the program • NQF endorsement removed (the measure no longer meets the NQF endorsement criteria) • NQF endorsement retired (the measure is no longer maintained by the steward) • NQF endorsement placed in reserve status (performance on this measure is topped out) • Measure previously submitted for endorsement and was not endorsed
Conditionally Support	**Indicates measures, measure concepts, or measure ideas that should be phased into program measure sets over time, subject to contingent factor(s).**	• Not ready for implementation; measure concept is promising but requires modification or further development • Not ready for implementation; should be submitted for and receive NQF endorsement • Not ready for implementation; data sources do not align with program's data sources • Not ready for implementation; measure needs further experience or testing before being used in the program

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

Process for Meeting:

- Workgroup will identify gaps in the program measure set
  - Staff will capture any new gaps raised during the course of discussion
- Workgroup will discuss gap priorities for the program

Overview of Programs under Consideration and Uptake Analysis

PAC/LTC Programs to Be Considered

- Inpatient Rehabilitation Facility Quality Reporting Program
- Long-Term Care Hospital Quality Reporting Program
- End Stage Renal Disease Quality Incentive Program
- Home Health Quality Reporting
- Hospice Quality Reporting Program
- Nursing Home Quality Initiative and Nursing Home Compare

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	• Establishment of patient/family/caregiver goals • Advanced care planning and treatment
Patient Engagement	• Experience of care • Shared decision-making
Care Coordination	• Transition planning
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions

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				X
Experience of care		X			X	X
Falls	X	X	X			
Functional and cognitive status assessment	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				

Pre-Rulemaking Input on the Inpatient Rehabilitation Facility Quality Reporting Program

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.

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)

Pre-Rulemaking Input on the Long-Term Care Hospital Quality Reporting Program

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.

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

Pre-Rulemaking Input on the End Stage Renal Disease Quality Improvement Program

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.

End- Stage Renal Disease Quality Incentive Program

Uptake of MAP recommendations in 2013 HHS Final Rule

- MAP provided input on 21 measures for the ESRD-QIP
  - MAP "Supported Direction" for 9 measures, none of which were finalized
  - MAP "Supported" 11 measures, one of which was finalized for ESRD QIP for PY 2016 and subsequent years
    - NQF #1454 Proportion of Patients with Hypercalcemia
    - MAP supported NQF #1460 Bloodstream Infection in Hemodialysis Outpatients ; CMS adopted a modified version of #1460 with new programmatic implementation requirements
  - MAP "Did not Support" 1 measure, which was not proposed
    - Measurement of Serum Calcium Concentration

The ESRD Quality Incentive Program

Kathy Lester & Robyn Nishimi

Context and Background

MAP's recommendations for the ESRD Quality Incentive Program (QIP) have a *significantly* higher degree of non-concordance compared to recommendations for all other programs; 1 of 11 measures MAP supported adopted last year

- How we got here – the history of MIPPA
- Demographics and economics of ESRD
- Why a high bar is set for what measures are included
- Current measures and why adding new measures to QIP is difficult
- The problem with case-mix adjustments

Setting the Stage for the First VBP in Medicare

2005: Kidney Care Quality Improvement Act

- Called for demonstration projects for an outcomes-based ESRD financial incentives reimbursement system

2007: Kidney Care Quality & Education Act

- Called for a three-year continuous quality improvement initiative under which quality payments are provided to renal dialysis facilities, providers of services, and physicians
- Required the Secretary to make quality incentive payments to improvement and attainment

Congress Incorporated Community Concept in MIPPA, BUT…

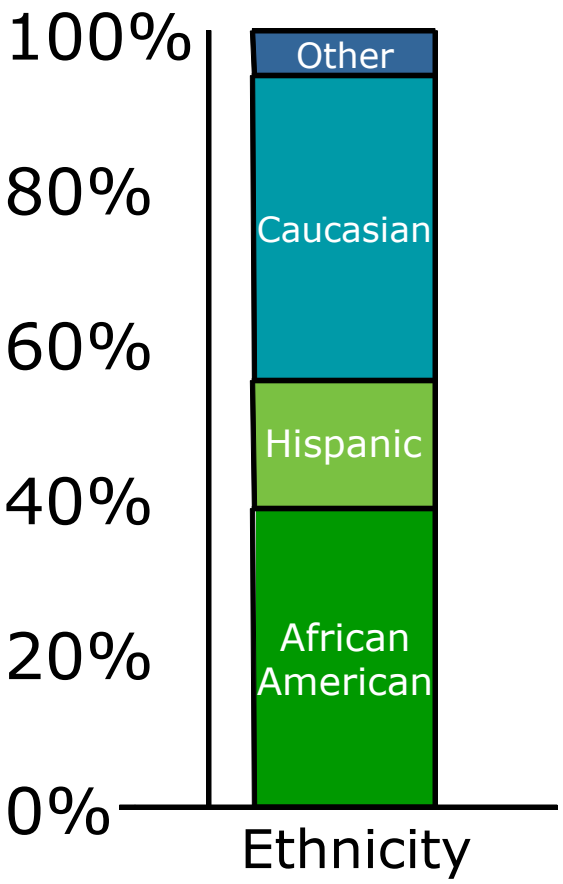
Community supported passage of MIPPA

- Was politically controversial at the time

MIPPA included VBP, but

- Authorized the quality incentive program
- Instead of rewarding quality, ***penalizes providers*** up to 2 percent (CMS has implemented the full amount as the highest tier penalty)
- Instead of allow for testing, program was implemented as VBP directly

Dialysis Facilities Disproportionately Dependent on Medicare and Disproportionately Impact Minority Populations



80%+ Medicare beneficiaries

40%+ dual-eligible

50%+ minority

3+ co-morbidities (diabetes/hypertension)

~8 medications

20% mortality

~8% of Medicare spending

~$85K per patient per year

2+ hospitalizations per year

Source: USRDS, Healthy People 2010, HRSA: Health Disparity Prevention.

Overview of the Current QIP Measures

	PY 2012	PY 2013	PY 2014	PY 2015
Anemia	>12 g/dL	>12 g/dL	>12 g/dL	>12 g/dL + reporting ESA dosage
Adequacy	URR ≥65%	URR ≥65%	URR ≥65%	Kt/V ≥1.2 Kt/V ≥1.7 spKt/V ≥1.2
Vascular			Catheter ≥ 90 days + months AVF in use	Catheter ≥ 90 days + AVF placement
Infection				NHSN
Satisfaction				CAHPS
Bone Mineral				Reporting Phos & Ca

Overview of PY 2016 Measures

10 measures for PY 2016

Maintain PY 2015 measures

- Replace NHSN Bloodstream Infection with clinical measure
- Hgb > 12 g/dL
- Dialysis Adequacy (HD adult & pediatric; PD adult)
- Vascular Access Type (Fistula & catheter)

Modified measures

- ICH CAHPS
- Mineral Metabolism
- Anemia Management

Adopted new measure

- Hypercalcemia

MAP Recommendations and Non-concordance

- MAP's recommendations for the QIP likely do not align well with current program because
  - As noted earlier, evidence bar set high because system is penalty-based
  - Paucity of developed and tested "simple" performance measures because underlying evidence is not as robust as other areas
  - Cross-cutting measures recommended by MAP even more problematic
    - Need risk adjustment or stratification (or both) given complex population, many with multiple co-morbidities
    - Poor to total inability to do this because neither CMS nor facilities have appropriate data

Case-Mix Adjustment -- Extremely Difficult for Facilities to Obtain the Information

Source of Medicare CMS Related Claims					
Co-Morbidity	ESRD Facilities	After Including Nephrologists	After Including Physician Offices of All Other Specialties	After Including Inpatient and Outpatient Hospital Claims	After Including Home Health, Hospice, DME, and Skilled Nursing Facility
Bacterial Pneumonia	0.01%	0.15%	1.64%	2.34%	2.44%
GI Bleed	0.00%	0.03%	0.72%	1.16%	1.19%
Pericarditis	0.00%	0.05%	0.35%	0.42%	0.43%
Sickle Cell	0.08%	0.08%	0.22%	0.32%	0.33%
Monoclonal Gammopathy	0.27%	0.29%	1.06%	1.21%	1.22%
Myelodysplastic Syndrome	0.17%	0.21%	1.22%	1.44%	1.46%

Source: The Moran Company "Review of 5% random sample of Medicare SAF file for 2007, 2008 Industry Claims. Outpatient Claims include Rural Health Centers, Federally-Qualified Health Centers, Rehabilitation Facilities, and Psychiatric Facilities"

Opportunity for Public Comment

Input on Alignment Issues Across PAC/LTC Programs

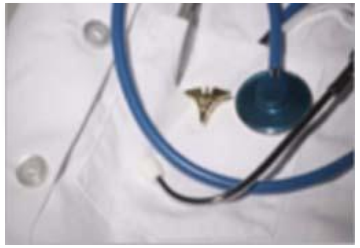
Input on Alignment Issues Across PAC/LTC Programs

- Continuity Assessment Record and Evaluation (CARE) tool Demonstration and Implications for Use across PAC/LTC Settings

- Gaps in Assessing Cost across PAC/LTC Settings
  - How should access to care be assessed across PAC/LTC settings?
  - What are the main drivers of cost in PAC/LTC settings, and how can they be measured and improved?
  - How can cost measurement promote shared accountability among settings?
  - What clinical quality measures should be linked with cost measures to assess efficiency in PAC/LTC settings?

- Admission/Readmission Measures for Use in PAC/LTC Settings
  - What barriers inhibit alignment of readmission measures across settings?
  - What options are there to overcome these barriers?
  - What factors should be considered in a risk adjustment approach? SES, disease severity, other?
  - How can we utilize readmission measurement to promote shared accountability across settings?

The Continuity Assessment Record and Evaluation (CARE) Tool and Functional Status Quality Measures



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Data Assessment Elements Goal

When we keep in mind the ultimate goal of

quality care for all

and step back to look at the big picture of what's been done to prepare, it becomes clearer where the work converges; how much of the work is connected and has already been done to achieve

quality care for all

Achieving Uniformity to Facilitate Effective Communication for Better Care of Individuals and Communities

CARE: Background

- **2000: Benefits Improvement & Protection Act (BIPA)**
  - mandated standardized assessment items across the Medicare program, to supersede current items
- **2005: Deficit Reduction Act (DRA)**
  - Mandated the use of standardized assessments across acute and post-acute settings
  - Established Post-Acute Care Payment Reform Demonstration (PAC-PRD) which included a component testing the reliability of the standardized items when used in each Medicare setting
- **2006: Post-Acute Care Payment Reform Demonstration requirement:**
  - Data to meet federal HIT interoperability standards

CARE: *Concepts*

Guiding Principles and Goals:

Assessment Data is:

- Standardized
- Reusable
- Informative
- Communicates in the same information across settings
- Ensures data transferability forward and backward allowing for interoperability

Standardization:

- Reduces provider burden
- Increases reliability and validity
- Offers meaningful application to providers
- Facilitates patient centered care, care coordination, improved outcomes, and efficiency
- Fosters seamless care transitions
- Evaluates outcomes for patients that traverse settings
- Allows for measures to follow the patient
- Assesses quality across settings, and Inform payment modeling

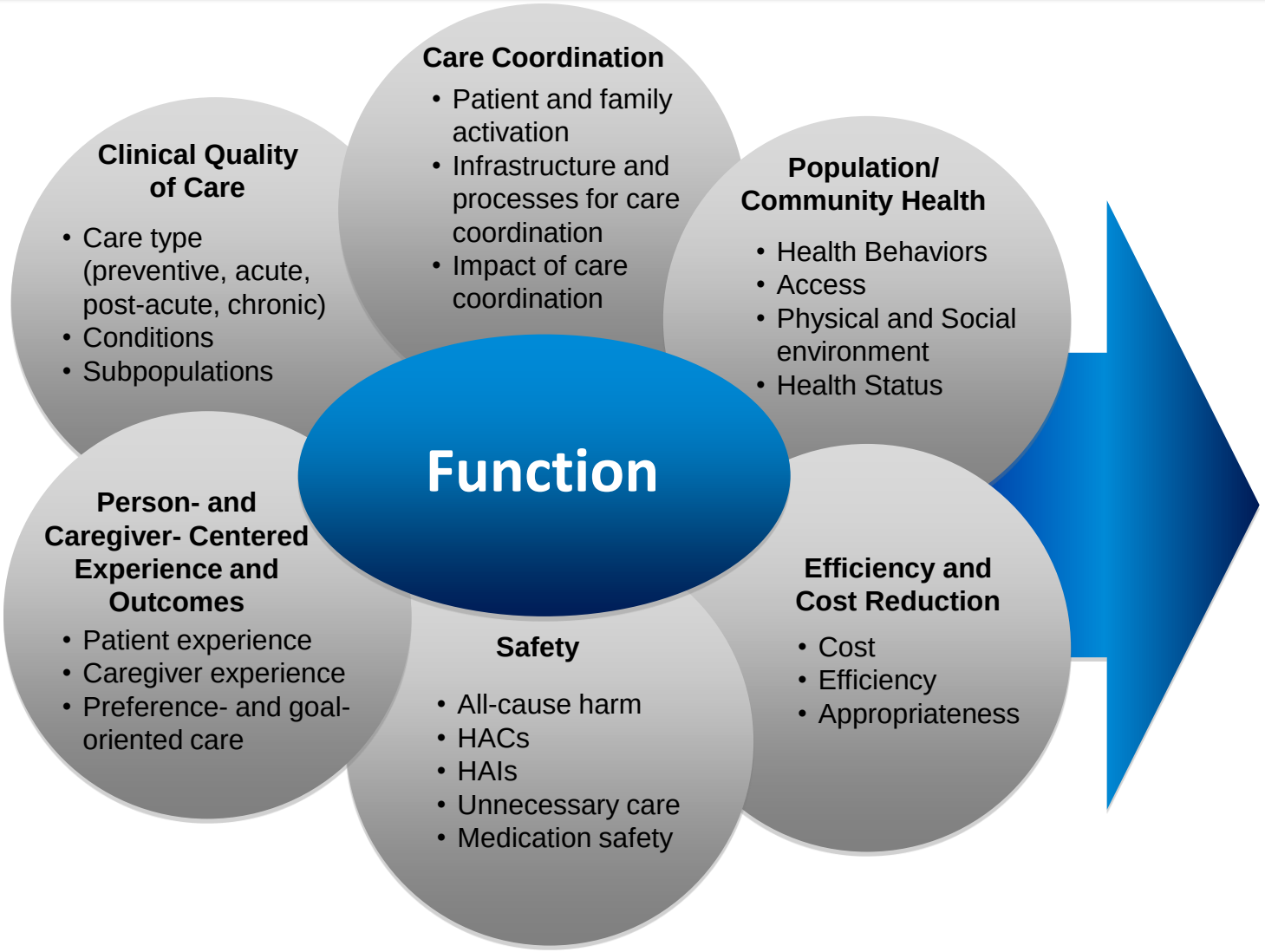
Keeping in Mind, the Ideal State

- Facilities are able to transmit electronic and interoperable Documents and Data Elements
- **Provides convergence** in language/terminology
- Data Elements used are **clinically relevant**
- Care is coordinated using **meaningful information** that is spoken and **understood by all**
- Measures **can evaluate quality across settings and** evaluate **intermittent and long term outcomes**
- **Measures follow the person**
- **Incorporates** needs **beyond healthcare system**

CMS Vision for Quality Measurement

- Align measures with the **National Quality Strategy and Six Measure Domains**
- Implement measures that **fill critical gaps** within the six domains
- Develop parsimonious sets of measures - **core sets of measures**
- Remove measures that are no longer appropriate (e.g., topped out)
- Align measures with external stakeholders, including private payers and boards and specialty societies
- Continuously improve quality measurement over time
- **Align measures across CMS programs whenever and wherever possible**

CMS Framework for Measurement



- **Measures should be patient-centered and outcome-oriented whenever possible**
- **Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures**

Functional Status

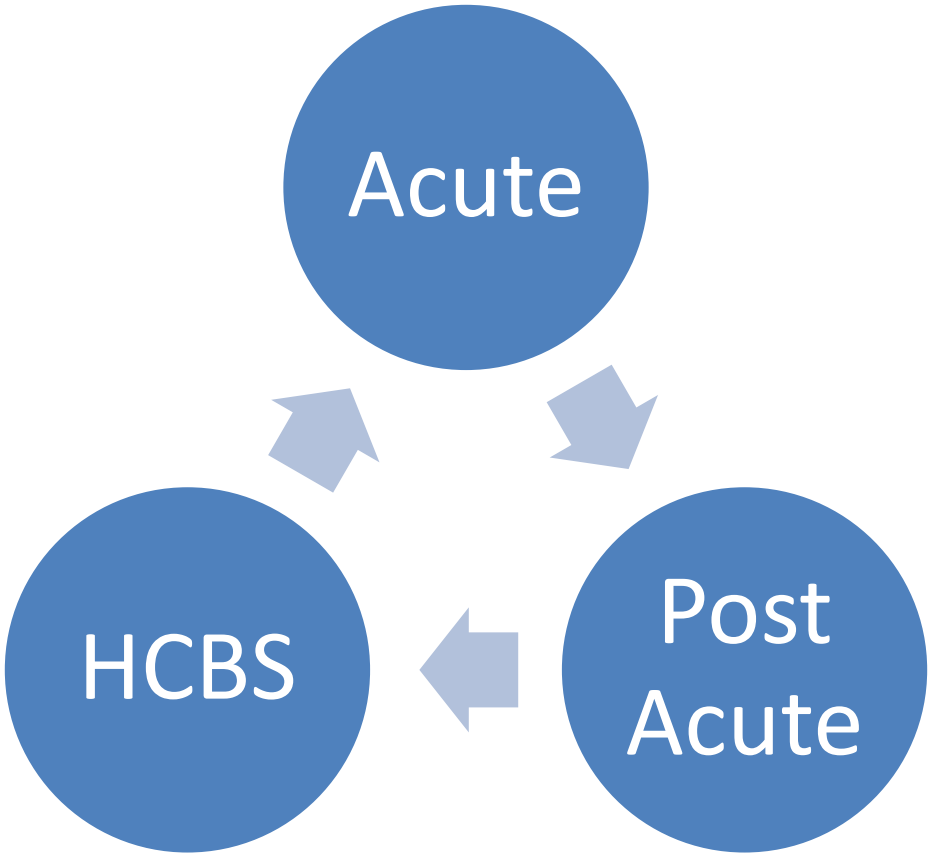
- Function is a measurement area that touches on all 6 Priorities.

- Functional status is relevant to all settings:
  - High priority to consumers
  - Specialized area of care provided by post-acute care providers, including IRFs, LTCHs, SNFs, and HHAs
  - Long term outcomes link to function

- Functional Status data are collected by post acute care providers for payment and quality monitoring: IRFs (payment), SNFs (payment), LTCHs (risk adjustor for quality) and HHAs (payment and quality).

- However, functional status data are currently setting-specific and are not easily compared.

Standardizing Function



Measures in Development

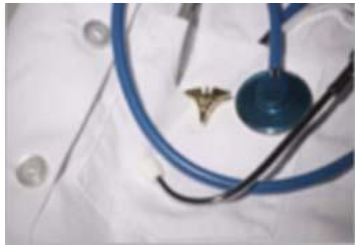
- **IRF** Functional Outcome Measure: Change in self-care score for medical rehabilitation patients.
- **IRF** Functional Outcome Measure: Change in mobility score for medical rehabilitation patients.
- **IRF** Functional Outcome Measure: Discharge mobility score for medical rehabilitation patients.
- **IRF** Functional Outcome Measure: Discharge self-care score for medical rehabilitation patients.
- Percent of **LTCH** patients with an admission and discharge functional assessment and a care plan that addresses function.
- **LTCH** Functional Outcome Measure: Change in mobility among patients requiring ventilator support.

Functional Status Quality Measures

- Data collection using the CARE Item Set occurred as part of the Post Acute Care Payment Reform Demonstration and included 206 acute and PAC providers

  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html

PAC/LTC Readmission Measures



Joel Andress, PhD

Government Task Lead

Centers for Medicare and Medicaid Services

Measures Developed or Under Development

CMS Post-Acute Care and Long-Term Care Outcome Measures					
Measure Domain	SNF	IRF	LTCH	ESRD	Home Health
30-day Post-Hospital Discharge Readmission Measure	SNF Hospital Readmission Reduction Measure - Short Stay	Begin development Spring 2014	Begin development Spring 2014	Standardized Readmission Ratio	Rehospitalization during first 30 days of Home Health
30-day Post-PAC Setting Discharge Readmission Measure	Begin development Spring 2014	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCH)	TBD	TBD
PAC Hospitalization Measure	TBD	TBD	TBD	Standardized Hospitalization Ratio (NQF endorsed)	Acute Hospitalization Measure (NQF endorsed)
PAC Mortality Measure	TBD	TBD	TBD	Standardized Mortality Ratio (NQF endorsed)	TBD
ED Use Measure	TBD	TBD	TBD	TBD	Emergency Department (ED)

Endorsement Timeline

- February 2014 – Submission of measures to NQF for endorsement consideration (specifications and documentation will be publicly available)
- May 2014 – NQF Steering Committee meets for discussion
- Sept-Oct 2014 – Anticipated endorsement date

Implementation Timeline

- IRF Quality Reporting – Finalized through rulemaking in 2013
- LTCH Quality Reporting – Finalized through rulemaking in 2013
- Nursing Home Compare - TBD
- Home Health Quality Reporting – Finalized through rulemaking in 2013
- ESRD Quality Incentive Program - TBD

Alignment Barriers

- Different patient populations
- Different processes and regulations governing transitions into and out of settings
- Different data sources
- Coordination between measures

Alignment Efforts

- HWR (NQF# 1789) was considered as the basis of the PAC/LTC readmission measures
- Individual project teams
- Readmission Workgroup
- AHCA discussions

Key Areas of Alignment

- Numerator and Denominator Definitions
- Exclusion Criteria
- Planned Readmission Exclusions
- Risk Adjustment

Other Issues for Consideration

- ED Use
- Observation Stays

Shared Accountability

- Measure transitions of care to…
  - Assess the degree to which transitions are successful
  - Hold all providers involved in readmissions accountable to the extent possible by assessing readmissions attributable to their patients
  - Monitoring patterns of care transitions to protect patients against unintended consequences
- Implement outcome measures across settings and programs

Future Plans

CMS Post-Acute Care and Long-Term Care Outcome Measures					
Measure Domain	SNF	IRF	LTCH	ESRD	Home Health
30-day Post-Hospital Discharge Readmission Measure	SNF Hospital Readmission Reduction Measure - Short Stay	**Begin development Spring 2014**	**Begin development Spring 2014**	Standardized Readmission Ratio	Rehospitalization during first 30 days of Home Health
30-day Post-PAC Setting Discharge Readmission Measure	**Begin development Spring 2014**	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCH)	TBD	TBD
PAC Hospitalization Measure	TBD	TBD	TBD	Standardized Hospitalization Ratio (NQF endorsed)	Acute Hospitalization Measure (NQF endorsed)
PAC Mortality Measure	TBD	TBD	TBD	Standardized Mortality Ratio (NQF endorsed)	TBD
ED Use Measure	TBD	TBD	TBD	TBD	Emergency Department (ED)

Pre-Rulemaking Input on Measures for the Home Health Quality Reporting Program

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

Home Health Quality Reporting

Uptake of MAP recommendations in 2013 HHS Final Rule

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

Pre-Rulemaking Input on Measures for the Hospice Quality Reporting Program

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

Pre-Rulemaking Input on Measures for the Nursing Home Quality Initiative

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

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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Nursing Home Value Based Purchasing Demonstration Quality Measures

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Demonstration Overview

- NHVBP began July 1, 2009 and ended June 30, 2012.
- The demonstration includes 171 nursing homes from 3 States
  - Arizona: 38 nursing homes
  - New York: 72 nursing homes
  - Wisconsin: 61 nursing homes
- The demonstration tests whether value-based purchasing can improve the quality of nursing home care while reducing overall Medicare expenditures.

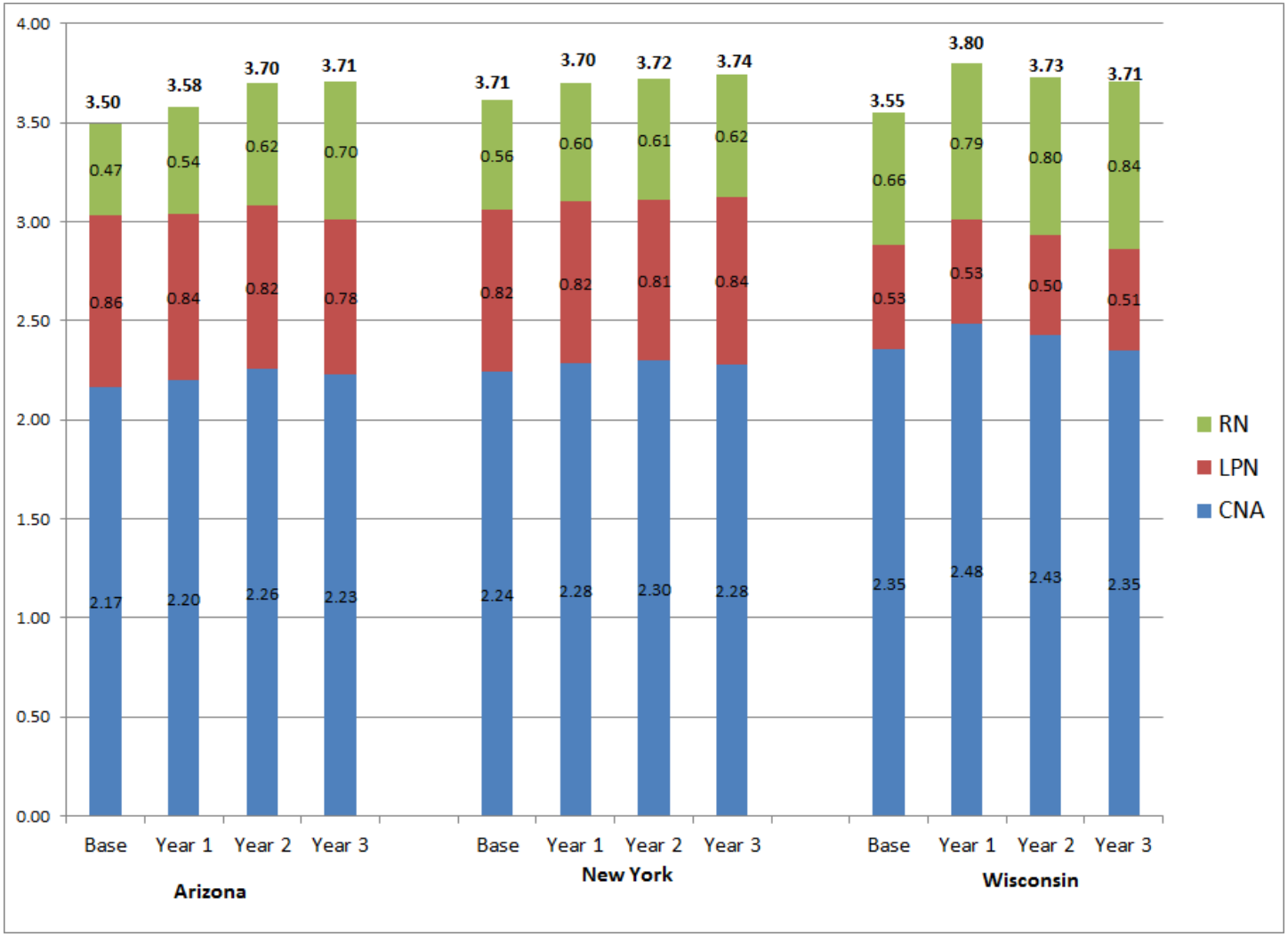
Performance Measures

- Assess the performance of participating nursing homes using measure from four domains:
  - Rates of potentially avoidable hospitalizations (30 percent)
  - Nurse staffing (30 percent)
  - MDS Outcomes (20 percent)
  - Survey deficiencies (20 percent)
- In each state, nursing homes qualify for performance payments based on performance level or improvement over time.

Staffing Measures

- NHVBP uses four staffing performance measures
  - Registered nurse/ Director of nursing (RN/DON) hours per resident day (10 points)
  - Total licensed nursing hours (RN/DON/licensed practical nurse) per resident day (5 points)
  - Certified nurse aide (CNA) hours per resident day (5 points)
  - Nursing staff turnover rate (10 points)
- Staffing levels measures adjusted for casemix using RUG-III.
- Data source: Payroll data submitted by demonstration nursing homes.

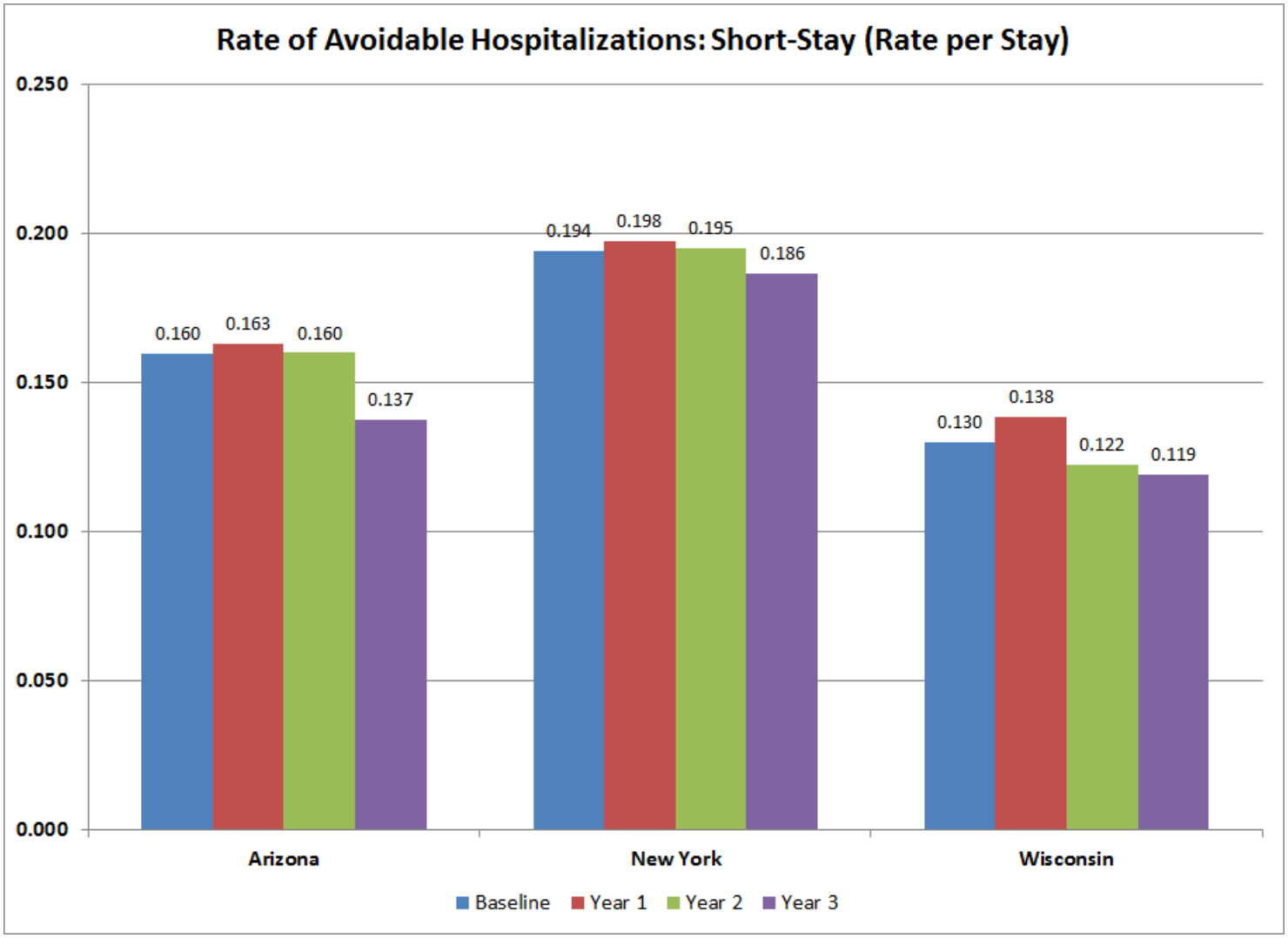
Staffing Measure Results



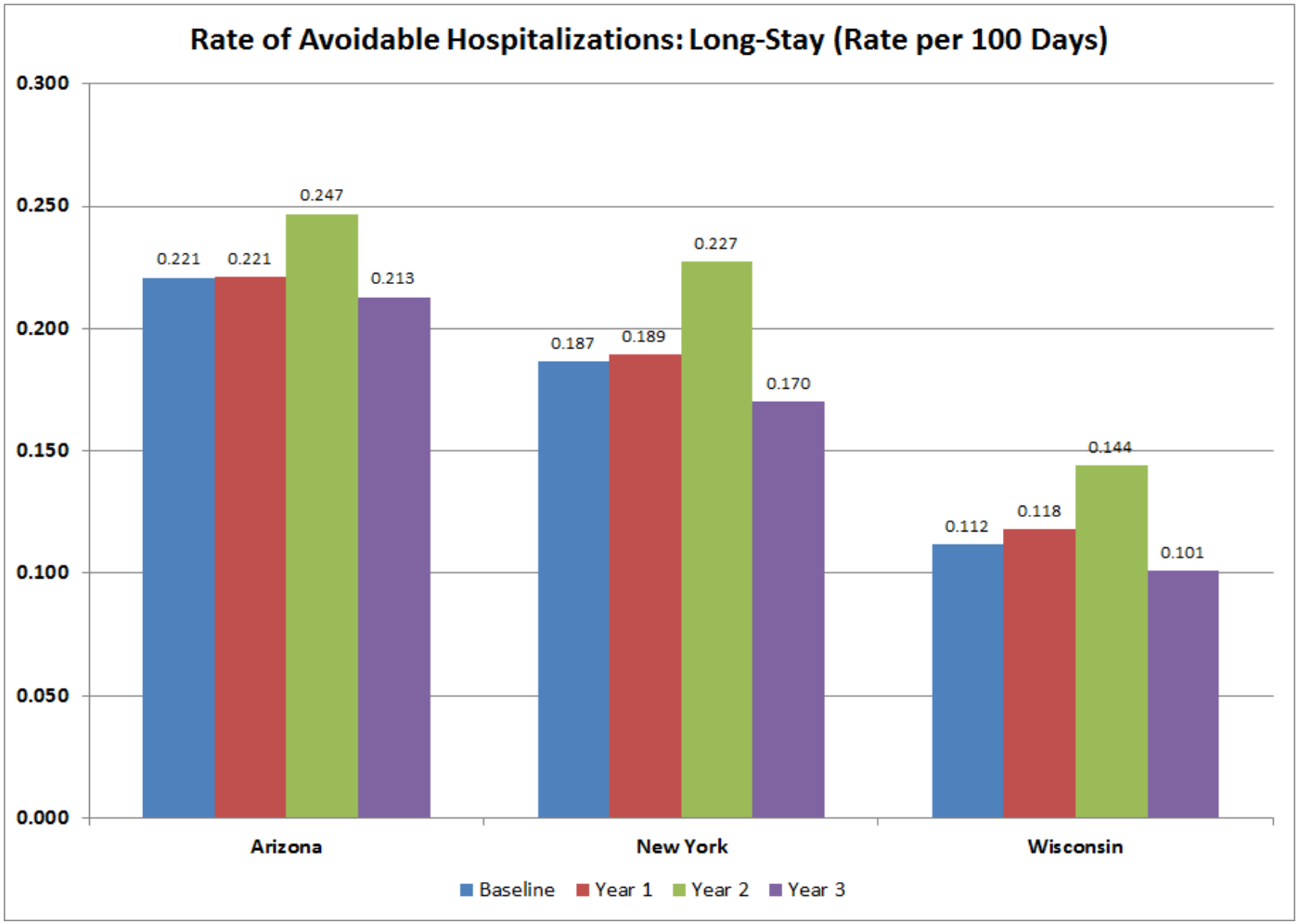
Potentially Avoidable Hospitalizations

- "Avoidable" is defined as hospitalizations with any of these diagnoses: CHF, electrolyte imbalance, respiratory disease, sepsis, urinary tract infection.
  - Anemia is also included for long-stay residents.
  - Examine both primary and secondary diagnoses
- Risk-adjusted using models developed for the demonstration.
- Includes hospitalizations up to 3 days after the end of a nursing home stay.
- Calculated separately for short and long-stays.
- Hospitalizations count for 30 points.

Short Stay Hospitalizations



Long Stay Hospitalizations



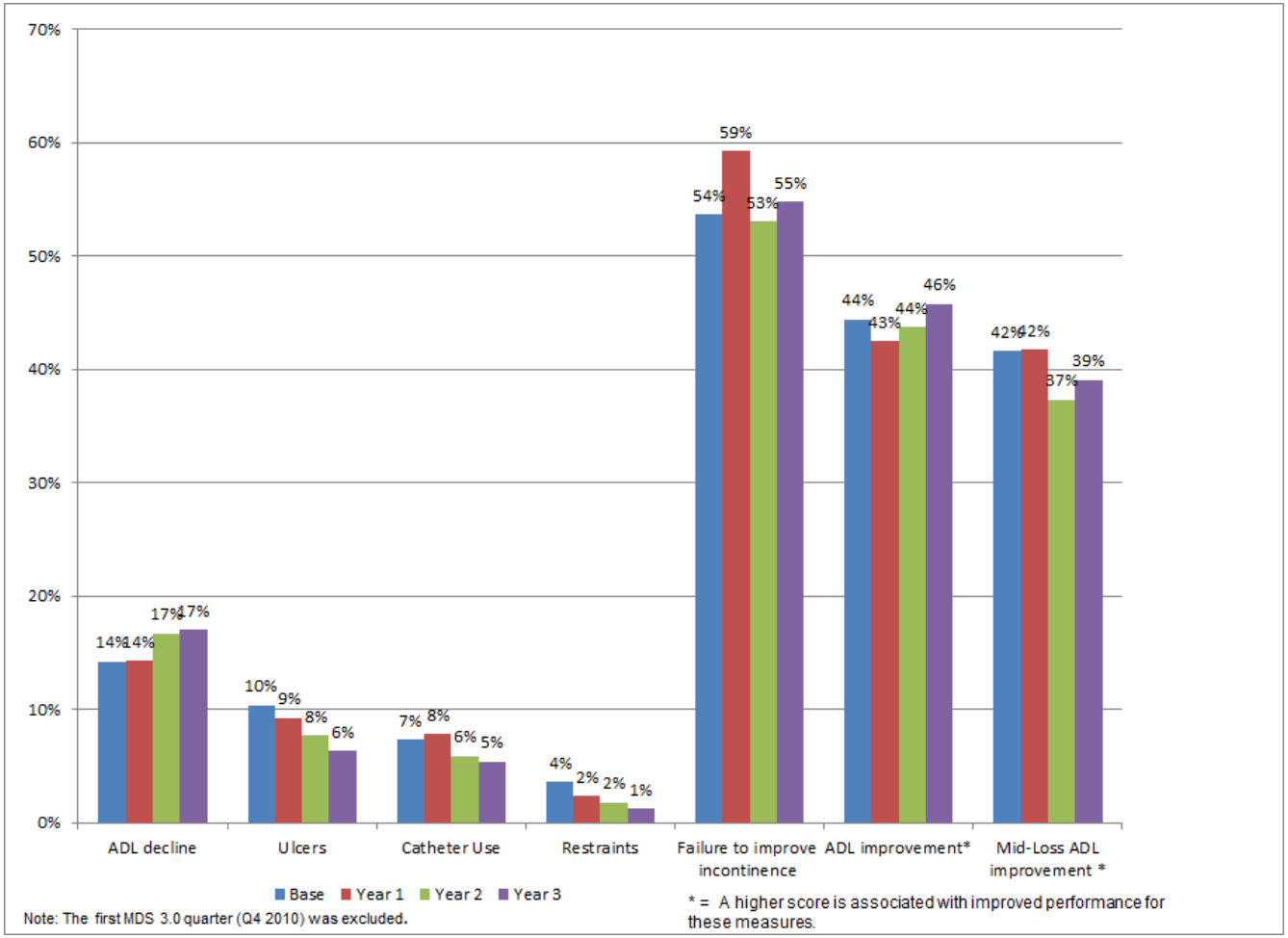
MDS Based Quality Measures

- Measures for long-stay residents:
  - % of residents whose need for help with daily activities has increased
  - % of high-risk residents with pressure sores
  - % of residents who had a catheter inserted and left in their bladder
  - % of residents who were physically restrained
- Measures for short-stay residents
  - % of residents with improved level of ADL functioning
  - % of residents who improve status on mid-loss ADL functioning
  - % of residents with failure to improve bladder incontinence

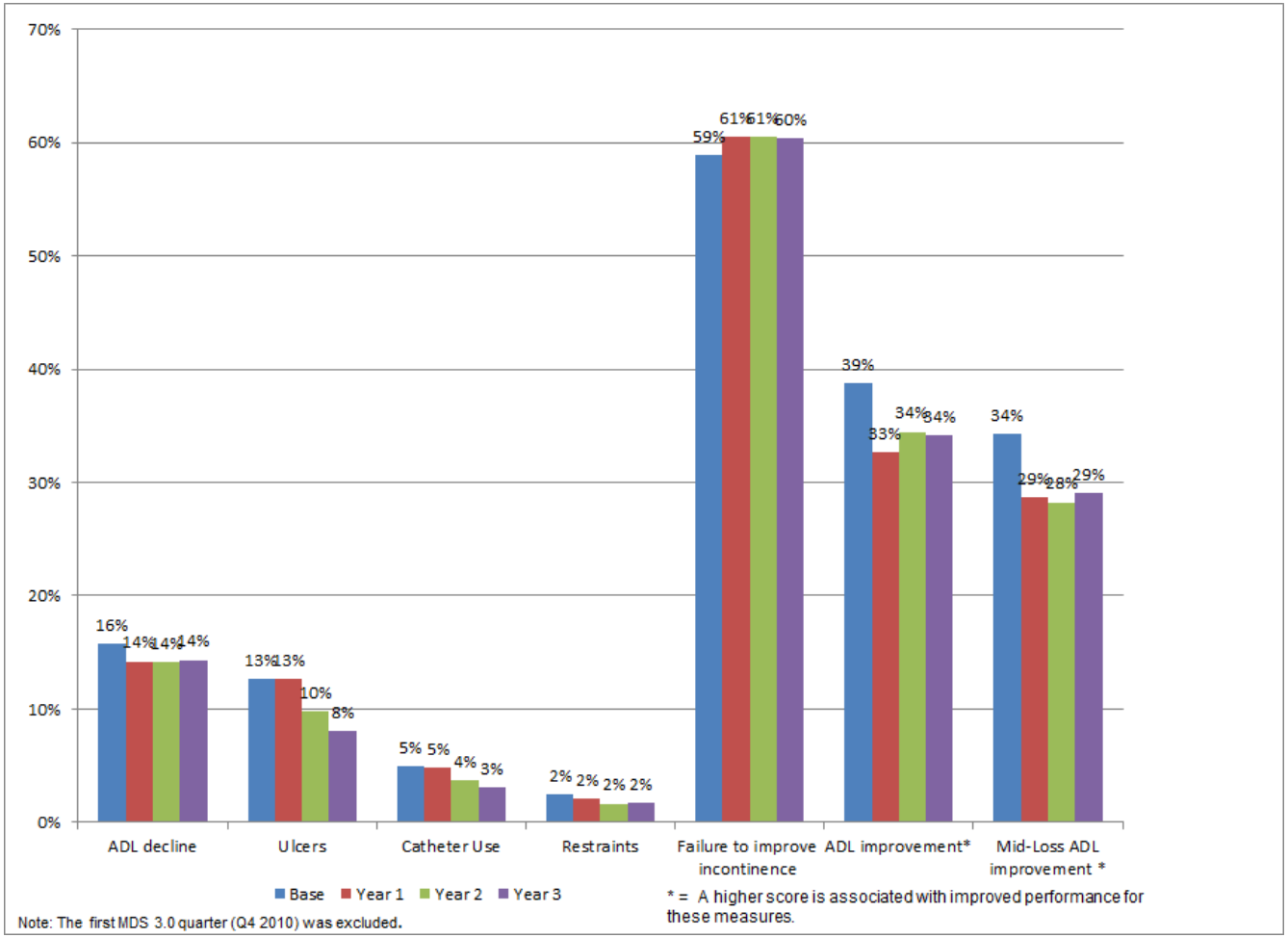
Performance Payments

- Long-stay measures use same specifications as for Nursing Home Compare, except that we use the MDS 2.0 definition of long-stays.
- Short-stay measures are not publicly reported.
- MDS performance measures count for 20 points (20% of overall performance score).
  - Long-stay measures count 3 points each.
  - Short-stay measures count 2.67 points each.

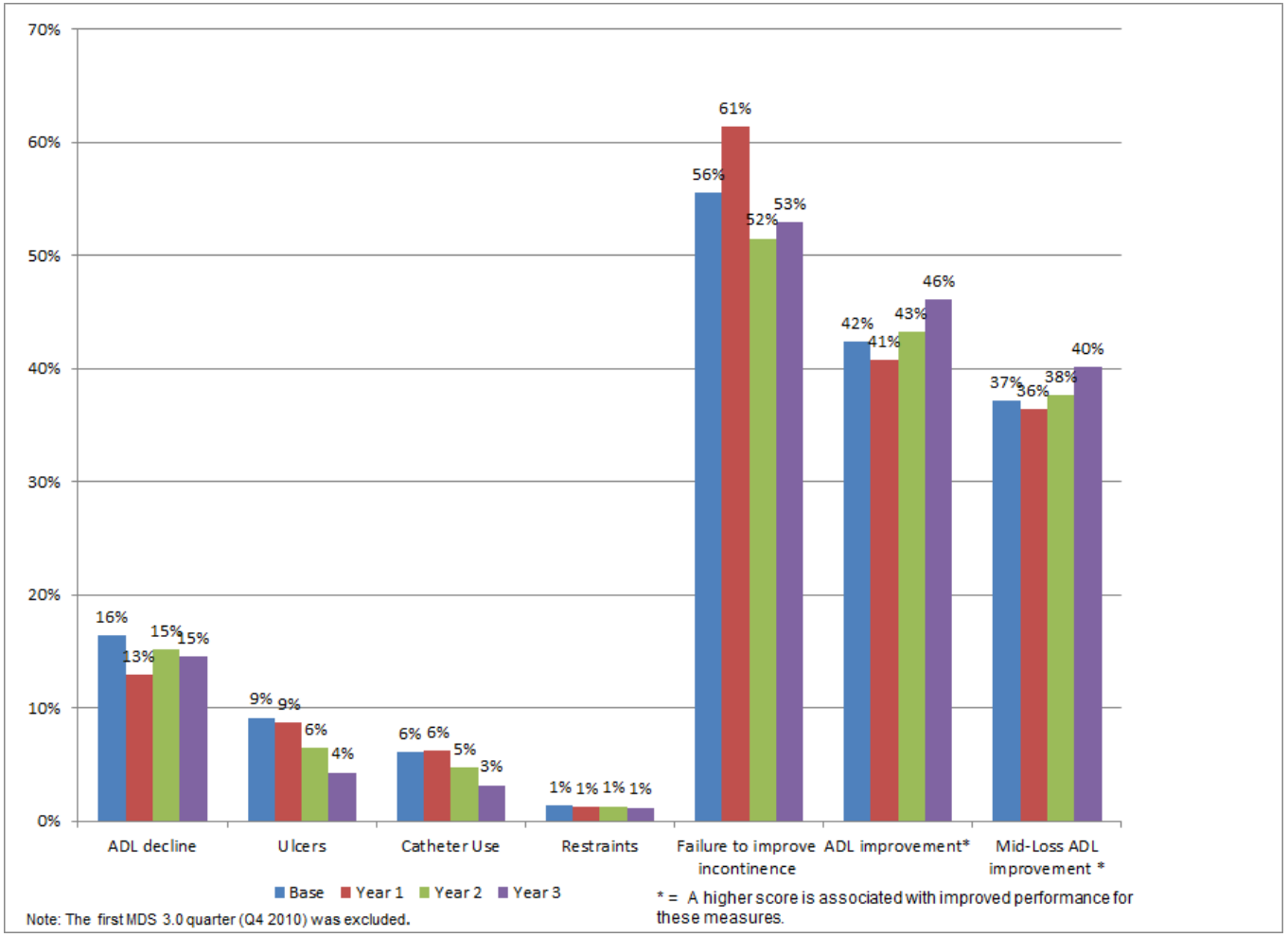
Change in MDS Measures: Arizona



Change in MDS Measures: New York



Change in MDS Measures: Wisconsin



State Inspection Surveys

- Findings from state surveyors provide a broad perspective of the quality of care furnished by the nursing home.
- Methodology is like that used for 5-Star Rating System, except that only one survey cycle is considered.
  - Deficiencies weighted based on scope and severity for survey associated with Year 1
  - Complaint surveys and repeat revisits are also considered.
- Survey domain counts for 20 points (out of 100 total).

State Inspection: Arizona

	Median				Mean			
	Base	Yr. 1	Yr. 2	Yr. 3	Base	Yr. 1	Yr. 2	Yr. 3
Total weight	48	58	40	38	71.8	83.3	42.6	37.9
Total number of deficiencies	9.5	10.5	7	6.5	11.8	12.1	7.3	6.5
Deficiencies from standard surveys	7	9.5	6	6	8.7	10.1	6.1	6.1
Deficiencies from complaint surveys	1	0	0	0	3.2	2.0	1.3	0.4
Any substandard deficiency	0	0	0	0	0.1	0.1	0.1	0.0

State Inspections: New York

	Median				Mean			
	Base	Yr. 1	Yr. 2	Yr. 3	Base	Yr. 1	Yr. 2	Yr. 3
Total weight	16	16	16	16	19.8	41.0	24.0	36.7
Total number of deficiencies	3	3	3	4	3.4	4.0	4.2	4.5
Deficiencies from standard surveys	2.5	2	3	3	3.1	3.3	3.9	4.0
Deficiencies from complaint surveys	0	0	0	0	0.3	0.7	0.3	0.5
Any substandard deficiency	0	0	0	0	0.0	0.1	0.0	0.1

State Inspection: Wisconsin

	Median				Mean			
	Base	**Yr. 1**	**Yr. 2**	**Yr. 3**	**Base**	**Yr. 1**	**Yr. 2**	**Yr. 3**
Total weight	32	28	36	36	49.2	44.8	56.9	62.9
Total number of deficiencies	4	6	5	6	5.2	6.3	6.0	7.7
Deficiencies from standard surveys	4	5	4	5	4.2	5.0	5.1	6.3
Deficiencies from complaint surveys	0	0	0	0	1.1	1.3	0.9	1.5
Any substandard deficiency	0	0	0	0	0.1	0.1	0.1	0.1

Consistency of Performance Over Time

- During the 3 years of the demonstration, the majority of participants were *eligible* for a performance payment in at least one year:
  - 40% were not eligible in any of the three years.
  - 34% were eligible for a single year.
  - 18% were eligible in two years.
  - 8% were eligible in all three years.

Other Implementation Findings

Average Performance Scores for Facilities Eligible for a Year 1 Performance Payment		
	Average Performance Score	
Year	Not eligible	Eligible
Year 1	41.94	60.41
Year 2	45.72	55.75
Year 3	44.16	57.50

Average Performance Scores Based on Whether Nursing Home Was Eligible In Year 1 Based on Improvement				
Variable	Base	Year 1	Year 2	Year 3
Eligible based on improvement	47.39	58.05	53.03	55.45
Not eligible based on improvement	51.49	45.10	47.83	46.54

Questions?

Opportunity for Public Comment

Next Steps

Next Steps

- **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

Adjourn