NATIONAL QUALITY FORUM

Overview of PAC/LTC Programs

Program Name	Program Type	Program Description	MAP Overall Recommendations
Nursing Home Quality Initiative	Pay for Reporting, Public Reporting	• Required to complete the MDS as part of the federally mandated certification. • Quality measures are reported on the NH Compare website using a five-star Quality Reporting System.	• To promote alignment across programs, potential short-stay measures should align with measures selected for use in inpatient rehabilitation facilities. • 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 %increase. Subsets of measures are reported on HH Compare.	• 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, starting FY 2014. • No date has been specified to begin public reporting of quality data.	• The program measure set too limited could be greatly 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, starting FY 2014. • No date has been specified to begin public reporting of quality data.	• 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 % increase, starting FY 2014 • No date has been specified to begin public reporting of quality data.	• The measure set would be enhanced with measures that address the caregiver's role and timely referral to hospice.
End-Stage Renal Disease Quality Incentive Program	Pay for Performance, Public Reporting	• Payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. • Facility ESRD QIP scores are available online on Dialysis Facility Compare and each facility is required to display a Performance Score Certificate.	• The measure set should expand beyond dialysis procedures to include non-clinical aspects of care, such as care coordination. • Clinically focused measures could be combined in a composite measure for assessing optimal dialysis care.

NATIONAL QUALITY FORUM

Draft Program Summary

Nursing Home Quality Initiative

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]

Program Goals:

The overall goal of NHQI is to improve the quality of care in nursing homes using CMS' informational tools. The objective of these informational tools is to share quality information with consumers, health care providers, intermediaries and other key stakeholders to help them make informed decisions about nursing home care (e.g., Nursing Home Compare, Nursing Home Checklist).[2]

Program Update:

None

Critical Program Objectives (include program objectives and strategic issues):

Statutory Requirements

- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[3]:
    - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
    - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
    - Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
    - Applicable PAC programs are defined as: 1)HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program

- Directs the Secretary to reduce by 2% the update to the market basket percentage for skilled nursing facilities which do not report assessment and quality data under the newly required SNF Quality Reporting Program
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
    - New quality measures will address, at a minimum, the following domains:
        - functional status and changes in function;
        - skin integrity and changes in skin integrity;
        - medication reconciliation;
        - incidence of major falls; and
        - accurately communicating health information and care preferences when a patient is transferred
    - Resource use measures will address the following:
        - efficiency measures to include total Medicare spending per beneficiary;
        - discharge to community; and
        - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

MAP Previous Recommendation

- Determine whether (1) there are opportunities to combine the long-stay and short-stay measures using risk adjustment and/or stratification to account for patient variations and (2) any of the measures could be applied to other PAC/LTC programs to align measures across settings. [4]
- Add measures that assess discharge to the community and the quality of transition planning. [5]
- Include Nursing Home-CAHPS measures in the program to address patient experience. [6]

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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.

[2] Health Policy Monitor. Nursing Home Quality Initiatives. Available at http://hpm.org/en/Surveys/CMWF_New_York_-_USA/02/Nursing_Home_Quality_Initiatives.html. Last accessed September 2014

[3] https://www.congress.gov/bill/113th-congress/senate-bill/2553

[4] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

[5] Ibid

[6] NQF. Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012 Rulemaking. http://www.qualityforum.org/Publications/2012/02/MAP_Pre-Rulemaking_Report__Input_on_Measures_Under_Consideration_by_HHS_for_2012_Rulemaking.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

Home Health Quality Reporting Program

Program Type:
Pay for Reporting, Public Reporting

Incentive Structure:
Medicare-certified[1] home health agencies (HHAs) are required to collect and submit the Outcome and 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.[3] 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.[4]

Program Goals:
As home health quality goals, CMS has adopted the mission of The Institute of Medicine (IOM) which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness. [5]

Program Update:

- Updates listed in the CY 2015 Home Health Notice of Proposed Rulemaking:[6]
    - Specified the adoption of two claims based measures in the CY 2014 HH PPS final rule and the beginning date of CY 2014 for reporting. These claims based measures supported by MAP in the past pre-rulemaking cycle are: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH
    - Set a date of October 2014 for removal of the episode stratified process measures in the CASPER reports
    - Proposed a new pay-for-reporting performance requirement for OASIS reporting. HHAs will need to achieve a goal of 90% submission of admission and discharge OASIS data in an incremental fashion over a 3 year period, with the goal of reaching 70% compliance rate in the first year and increasing by 10% for each subsequent year to reach the 90% compliance rate.
    - Will continue to require HHCAHPS

Critical Program Objectives (include program objectives and strategic issues)
Statutory Requirements

- Home health is a covered service under the Part A Medicare benefit. It consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician.[7]

- Two categories of quality measures used in HH QRP are outcome measures and process measures. There are three types of outcome measures used including: [8]
    - Improvement measures (i.e., measures describing a patient's ability to get around, perform activities of daily living, and general health);
    - Measures of potentially avoidable events (i.e., markers for potential problems in care); and
    - Utilization of care measures (i.e., measures describing how often patients access other health care resources either while home health care is in progress or after home health care is completed).

- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[9]:
    - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
    - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
    - Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
    - Applicable PAC programs are defined as: 1)HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
    - Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
        - New quality measures will address, at a minimum, the following domains:
            - functional status and changes in function;
            - skin integrity and changes in skin integrity;
            - medication reconciliation;
            - incidence of major falls; and
            - accurately communicating health information and care preferences when a patient is transferred
        - Resource use measures will address the following:
            - efficiency measures to include total Medicare spending per beneficiary;
            - discharge to community; and
            - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
    - Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF,

and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

MAP Previous Recommendation

- MAP noted that the large measure set reflects the heterogeneity of home health population; however, the measure set could be more parsimonious. [10]

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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 2014.

[3] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html. Last accessed October 2014.

[4] The Official U.S. Government Site for Medicare. Introduction. Available at http://www.medicare.gov/HomeHealthCompare/About/What-Is-HHC.html. Last accessed October 2014.

[5] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html?redirect=/homehealthqualityinits/

[6] Proposed Home Health Rule CY 2015. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

[7] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

[8] Ibid

[9] https://www.congress.gov/bill/113th-congress/senate-bill/2553

[10] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

Inpatient Rehabilitation Facilities Quality Reporting Program

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]

Program Goals:
Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge. [3]

Program Update:

- IRF Prospective Payment System for Federal Fiscal Year 2015 final rule:[4]
  - For the FY 2017 adjustments to the IRF PPS annual increase factor, in addition to retaining the previously finalized measures, CMS adopted two new quality measures:
    - Measure NQF#1717 NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (supported by MAP in the 2014 pre-rulemaking report)
    - Measure NQF #1716 NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (conditionally supported by MAP in the 2014 pre-rulemaking report)

Critical Program Objectives (include program objectives and strategic issues)

Statutory Requirements

- 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.[5]

- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[6]:
  - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
  - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes

- Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
- Applicable PAC programs are defined as: 1)HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
    - New quality measures will address, at a minimum, the following domains:
        - functional status and changes in function;
        - skin integrity and changes in skin integrity;
        - medication reconciliation;
        - incidence of major falls; and
        - accurately communicating health information and care preferences when a patient is transferred
    - Resource use measures will address the following:
        - efficiency measures to include total Medicare spending per beneficiary;
        - discharge to community; and
        - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

MAP Previous Recommendation

- Reiterated its previous recommendation that the program measure set is too limited and could be enhanced by addressing core measure concepts not currently addressed in the set such as measures addressing functional status.[7]

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

[2] Ibid

[3] https://www.federalregister.gov/articles/2011/08/05/2011-19516/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal

[4] https://www.federalregister.gov/articles/2014/08/06/2014-18447/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal

[5] https://www.federalregister.gov/articles/2011/08/05/2011-19516/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal

[6] https://www.congress.gov/bill/113th-congress/senate-bill/2553

[7] NQF. MAP 2014 Recommendations on Measures for More Than 20 Federal Programs. http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

Long-Term Care Hospitals Quality Reporting Program

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]

Program Goals:
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]

Program Update:

- Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System FY 2015 Final Rule: [4]
  - For the FY 2018 payment determination and subsequent years, in addition to retaining the previously finalized measures, CMS adopted three new quality measures:
    - Percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function (conditionally supported by MAP in the 2014 pre-rulemaking report)
    - Functional Outcome Measure: change in mobility among patients requiring ventilator support (conditionally supported by MAP in the 2014 pre-rulemaking report)
    - Ventilator-Associated Event (supported by MAP in the 2014 pre-rulemaking report)

Critical Program Objectives (include program objectives and strategic issues)

Statutory Requirements

- 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).[5]
- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[6]:
  - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
  - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes

- Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
- Applicable PAC programs are defined as: 1)HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
    - New quality measures will address, at a minimum, the following domains:
        - functional status and changes in function;
        - skin integrity and changes in skin integrity;
        - medication reconciliation;
        - incidence of major falls; and
        - accurately communicating health information and care preferences when a patient is transferred
    - Resource use measures will address the following:
        - efficiency measures to include total Medicare spending per beneficiary;
        - discharge to community; and
        - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

MAP Previous Recommendation

- Functional status assessment should cover a broad range of mobility issues, such as position changes, locomotion, poor mobility, picking up objects, and chair-to-bed transfers. [7]
- Increased attention should be given to pain, agitation, and delirium among the ventilated population, as these factors are the biggest impediments to mobility. [8]
- Add measures to address cost, cognitive status assessment (e.g., dementia identification), medication management (e.g., use of antipsychotic medications), and advance directives. [9]

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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] Ibid

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

[4] https://www.federalregister.gov/articles/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

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

[6] https://www.congress.gov/bill/113th-congress/senate-bill/2553

[7] NQF. MAP 2014 Recommendations on Measures for More Than 20 Federal Programs. http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx

[8] Ibid

[9] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

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] Facility performance in the End Stage Renal Disease Quality Incentive Program (ESRD QIP) is publicly reported through three mechanisms: Performance Score Certificate, the Dialysis Facility Compare website, and ESRD QIP Dialysis Facility Performance Information.[2]

Program Goals:
Improve the quality of dialysis care and produce better outcomes for beneficiaries.[3]

Program Update:

- Proposed rule for End-Stage Renal Disease (ESRD) prospective payment system (PPS) for calendar year (CY) 2015:[4]
    - Proposed Measures for the PY 2017 ESRD QIP
        - Continue using measures finalized for the PY 2016 program measure set except one measure *Anemia Management: Hgb >12 Percentage of Medicare patients with a mean hemoglobin value greater than 12 g/dL' measure*, which CMS is proposing to remove because it is topped out.
        - Adopt the Standardized Readmission Ratio (SRR) clinical measure, which is currently under review by NQF (NQF#2496) and addresses care coordination.
    - Proposed Measures for the PY 2018 ESRD QIP
        - Continue using measures proposed for the PY 2017 program measure set with the exception of the ICH CAHPS reporting measure, which CMS is proposing to convert to a clinical measure, 0258 In-center hemodialysis CAHPS Survey.
        - Adopt three new measures which are based on NQF-Endorsed measures that MAP supported in 2014 (NQF #0420, NQF #0418, NQF #0431). CMS is proposing to adopt the following measures as a reporting measure until such time that they can collect the baseline data needed to score it as a clinical measure:
            - Pain Assessment and Follow-Up, a reporting measure.
            - Depression Screening and Follow-Up, a reporting measure
            - NHSN Healthcare Personnel Influenza Vaccination, a reporting measure
        - Adopt a new measure *Percentage of pediatric peritoneal dialysis patient-months with spKt/V greater than or equal to 1.8,* which was conditionally supported by MAP in 2014. HHS believes the measure is ready for adoption in the ESRD QIP because it has been fully tested for reliability and is planning to submit this measure to the NQF for endorsement in late 2014 or early 2015.

- Convert the current ICH CAHPS reporting measure with *#0258 In-Center Hemodialysis Consumer Assessment of Providers and Systems Survey* which is a clinical Measure.

Critical Program Objectives (include program objectives and strategic issues)

Statutory Requirements

- Program measure set should include 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. [5]

MAP Previous Recommendation

- Measure set expand beyond dialysis procedures to include nonclinical aspects of care such as care coordination, medication reconciliation, functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression.[6]
- Explore whether the clinically focused measures could be combined in a composite measure for assessing optimal dialysis care. [7]

Future direction of the ESRD QIP

- Outcome measures are preferred
- Inclusion of pediatric measures to assess the pediatric population that has been largely excluded from the existing measures
- Identify appropriate data elements and sources to support measures

[1] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/

[2] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-QIP-FAQ.pdf

[3] Ibid

[4] https://www.federalregister.gov/articles/2014/07/11/2014-15840/medicare-program-end-stage-renal-disease-prospective-payment-system-quality-incentive-program-

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

[6] http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx

[7] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

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]

Program Goals:
The goal of hospice care is to make the hospice patient as physically and emotionally comfortable as possible, with minimal disruption to normal activities, while remaining primarily in the home environment. The Hospice Quality Reporting Program aims to ensure the care provided to individuals is patient and family-centered, safe, and high-quality. [3]

Program Update:

- FY 2015 Hospice Final Rule:[4]
  - CMS finalized the Hospice Item Set (HIS) in last year's rule to meet the quality reporting requirements for hospices for the FY 2016 payment determination (data submission takes effect on or after July 1, 2014) and each subsequent year. HIS to be used by all hospices to collect and submit standardized data items about each patient admitted to hospice.
  - The CAHPS Hospice Survey has a Jan 1, 2015 implementation date. (Participation requirements for the survey begin January 1, 2015 for the FY 2017 annual payment update.)

Critical Program Objectives (include program objectives and strategic issues)

Statutory Requirements

- As of July 1, 2014, all Medicare-certified hospices are required to submit an HIS-Admission record and HIS-Discharge record for each patient admission to their hospice.[5]
  - The HIS is a patient-level data collection tool developed as part of the HQRP, which can be used to collect data to calculate 6 National Quality Forum-endorsed (NQF) Measures and 1 modified NQF Measure: [6]

1. NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
2. NQF #1634 Pain Screening
3. NQF #1637 Pain Assessment
4. NQF #1638 Dyspnea Treatment
5. NQF #1639 Dyspnea Screening
6. NQF #1641 Treatment Preferences
7. Modified NQF #1647 Beliefs/Values Addressed (if desired by the patient)

MAP Previous Recommendation

- Include measures addressing concepts such as goal attainment, patient engagement, care coordination, depression, caregiver's role, and timely referral to hospice. [7]

Future direction of the program

- Develop an outcome measure addressing pain.
- Select measures that address care coordination, communication, timeliness/responsiveness of care, and access to the healthcare team on a 24-hour basis.

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

[2] Ibid

[3] https://www.federalregister.gov/articles/2014/08/22/2014-18506/medicare-program-fy-2015-hospice-wage-index-and-payment-rate-update-hospice-quality-reporting

[4] Ibid

[5] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html

[6] Ibid

[7] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx