MEASURE APPLICATIONS PARTNERSHIP

MAP Off-Cycle Deliberations 2015: Measures under Consideration to Implement Provisions of the IMPACT Act

FINAL REPORT

MARCH 2015

NATIONAL QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I Task Order HHSM-500-T0002.

CONTENTS

SUMMARY

- HHS has requested MAP to perform an off-cycle review of measures under consideration to implement provisions of the IMPACT Act of 2014.
- The Act requires standardized assessments across four different post-acute care settings: skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs).
- In its deliberations, MAP highlighted the importance of integrating data with existing assessment instruments where possible, as well as noted the challenges in standardizing between the four different care settings.

External from the annual pre-rulemaking cycle process, the federal government can seek input from the Measure Applications Partnership (MAP) on additional measures under consideration under an expedited 30-day timeline in an "off-cycle review". MAP convened in February to conduct an off-cycle review to provide recommendations to the Department of Health and Human Services (HHS) on a selection of performance measures to meet requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 that could potentially be used across post-acute care and long-term care settings to provide standardized quality data.

The IMPACT Act passed in September 2014 requires post-acute care (PAC) providers to report standardized patient assessment data as well as data on quality, resource use, and other measures. The IMPACT Act further requires the implementation of measures to address resource use and efficiency such as total Medicare spending per beneficiary, discharge to community, and risk-adjusted hospitalization rates of potentially preventable admissions and readmissions. This review affords MAP the opportunity to promote measure alignment and shared accountability across the healthcare continuum.

The IMPACT Act aims to enable CMS to compare quality across PAC settings, improve hospital and PAC discharge planning, and use standardized data to reform PAC payments, while ensuring beneficiaries have access to the most appropriate care. Recognizing that under the current system patients can receive post-acute care from four different settings, the IMPACT Act requires standardized patient assessment data that will enable comparisons across skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs).

The standardized quality measures will address several domains including functional status and changes in function, skin integrity and changes in skin integrity, medication reconciliation, incidence of major falls, and the accurate communication of health information and care preferences when a patient is transferred. The IMPACT Act also requires the implementation of measures to address resource use and efficiency such as total Medicare spending per beneficiary, discharge to community, and risk-adjusted hospitalization rates of potentially preventable admissions and readmissions.

REVIEW OF FOUR MEASURES UNDER CONSIDERATION

MAP convened to evaluate measures under consideration and make recommendations on their potential use in federal programs within the post-acute and long-term care settings. Four measures were reviewed across multiple federal health programs (skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospital, and home health agencies).

E0678 Percent of Residents/Patients/ Persons with Pressure Ulcers That Are New or Worsened

MAP supported this measure as a way to address the IMPACT Act domain of skin integrity and changes in skin integrity. MAP noted that this measure addresses one of its previously identified PAC/LTC core concepts as well as an IMPACT Act domain. The measure is NQF-endorsed for the SNF, IRF, and LTCH settings (NQF #0678). The measure is currently in use in the IRF and LTCH Quality Reporting Programs and the Nursing Home Quality Initiative. In the 2015 MAP pre-rulemaking cycle, MAP conditionally supported X3704 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened for the Home Health Quality Reporting program. Some MAP members raised concerns about the importance of caregivers in preventing pressure ulcers in the home health setting. MAP recommended that CMS continue to work to refine the adaption of this measure for the home health setting to ensure proper risk adjustment and exclusions.

Public commenters were generally supportive of MAP's recommendation but expressed concerns regarding the measure's ability to adequately and reliably collect data on pressure ulcers and the quality of care in home health settings. One commenter noted the distinction between the level of pressure ulcer care in a home health setting versus institutionalized care particularly as it relates to the adequacy of the caregiver. Commenters also noted the added burden of this measure on providers and suggested that MAP consider recommending only one measure in each category until it is clear how the measure compares across settings. Moreover, commenters cautioned that CMS properly risk adjust the measure for environmental factors as well as add to the exclusion criteria. Another commenter highlighted the importance of partnerships with caregivers as a critical aspect of care, particularly for patients with limited mobility. Commenters agreed with CMS's phased approach for implementation but asked that CMS move quickly to make the measure specification publicly available allowing providers time to identify challenges with data collection prior to reporting the measure.

E0674 Percent of Residents/Patients/ Persons Experiencing One or More Falls with Major Injury

MAP conditionally supported this measure to address the domain of incidence of major falls. MAP noted that this measure addresses an IMPACT domain and a MAP PAC/LTC core concept. This measure is currently in use in the Nursing Home Quality Initiative and finalized for use in the LTCH QRP for the FY 2018 payment determination and subsequent years. MAP members debated the importance of addressing unique concerns for the home health setting versus ensuring comparability in the measures to show consumers differences in performance between settings. MAP conditionally supported this measure pending proper risk adjustments and attribution for the home health setting.

Public commenters agreed with MAP's conditional support of this measure and echoed the need for proper risk adjustment for home health setting as data collection for this population will differ from other settings because home health patients will not be under the care and supervision provided to patients at the other PAC sites. Overall, commenters noted that this measure is currently NQF-endorsed for use in skilled nursing facilities but there needs to be reliability and validity testing across other PAC settings. Additional comments noted that consistent data collection and reporting and a clear definition of a fall with injury are key to this measurement effort. One commenter suggested additional focus on the measurement of all falls and risk of falls for further measure-based consideration.

X4210 All-Cause Readmission Measure

MAP supported this measure noting that it addresses an IMPACT domain and a MAP PAC/LTC core concept. NQF has recently endorsed these readmission measures for all four settings: IRF #2502; SNF #2510; LTCH #2512; and HH #2380. In the 2015 pre-rulemaking cycle, MAP supported #2510 for the SNF Value-Based Purchasing Program in skilled nursing facilities. Measure #2510 was also recently finalized for use in MSSP in the 2015 PFS rule. The IRFQR, LTCHQR, and HHQR programs currently include an all-cause unplanned readmission measure. The measures are all harmonized in the approach to capturing readmissions. Some MAP members noted the importance of considering these measures for risk adjustment for sociodemographic status.

Comments received on this measure were mixed. One commenter raised concerns about measure #2510, including a lack of a standardized assessment tool across PAC settings, as well as issues with the specifications of the measure which included not addressing observation status admissions, using a predicted actual rate for the numerator which adjusts based on bed size, and a lack of risk adjustment for illness severity or functional status. A number of commenters noted a need to consider risk adjusting this measure for sociodemographic factors. Commenters also noted the need to ensure measures are applicable and appropriately adjusted for each care setting. One commenter indicated support of the measure and suggested consideration of greater alignment with currently used hospital readmission measures.

S2631 Percent of Patients/Residents/Persons with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

MAP conditionally supported this measure. The measure addresses an IMPACT domain and a MAP PAC/LTC core concept. MAP conditionally supported this measure pending NQF endorsement and resolution of concerns about the use of two different functional status scales for quality reporting and payment purposes. MAP reiterated its support for adding measures addressing function, noting the group's special interest in this PAC/LTC core concept and desire to see more measurement in this critical area.

Public comments were mixed in regard to MAP's recommendation of conditional support for this measure. Some public commenters noted that they would support this measure under certain conditions as functional status is an important concept for PAC settings. For example, one commenter recommended that functional assessments be performed when a patient is transferred to another setting (i.e., from LTCH to SNF). Another commenter supported the functional status measures for PAC settings with the caveat that they be risk-adjusted and diagnosis/impairment group specific using a definitive inclusion/exclusion criteria. Other commenters did not support MAP's recommendation, noting that this measure needs further development and testing prior to receiving the MAP conditional support recommendation. One commenter stated that there are many questions about whether this measure is feasible

to implement and suitable for public reporting programs and expressed concern that this measure is not aligned with CMS-mandated functional status assessments used for payment purposes. Another commenter urged CMS to first develop and share with stakeholders the common patient assessment tool elements being considered and required under the IMPACT Act before proceeding with this measure. One commenter raised concern that this measure has never been considered as a measure for other care settings and—given that one of the goals of the IMPACT Act is to achieve harmonization across settings, particularly for functional status—true testing and validation for a measure along these lines in each of the formal post-acute care settings is key. Lastly, one commenter noted that there are alternate measures currently undergoing NQF review that CMS could consider to meet measurement goals in this domain.

PROCESS AND APPROACH

The MAP post-acute care and long-term care workgroup convened via webinar in February to evaluate measures under consideration and make recommendations on their potential use in federal programs. Four measures were reviewed across multiple federal health programs (skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospital, and home health agencies). To assist in their deliberations, MAP members received detailed materials, encompassing all measures, their specifications, and preliminary analysis of each measure.

After the MAP post-acute care/long-term care workgroup met, the workgroup's recommendations were released for public comment. During the comment period, the MAP dual eligible workgroup discussed the measures to consider how they might affect the dual eligible population. The workgroup recommendations were then reviewed by the MAP Coordinating Committee, who also considered the public and Member comments received on those recommendations. Following deliberations, the Coordinating Committee finalized MAP's recommendations for consideration by HHS.

Overall Approach

MAP reviewed the measures under consideration during the off-cycle review as it did for the 2014-2015 pre-rulemaking deliberations. It followed a three-step process:

1. **Define critical program objectives**. Taking into account the structure and goals of each federal health program, MAP describes its perspective on critical program objectives. MAP updates its input based on the most recent changes for federal programs, and MAP also considers its prior strategic input and prior pre-rulemaking decisions. The critical program objectives help to establish a framework for the future direction of measurement within each program.
2. **Evaluate measures under consideration for potential inclusion in particular programs**. MAP received a preliminary analysis to assist in deliberations. Prepared by NQF staff, the analysis used a pre-defined decision algorithm (described below) based on the MAP Measure Selection Criteria. During its February web meeting, the MAP post-acute care/long-term care workgroup considered the results of the preliminary analysis

when making its recommendations to the Coordinating Committee.

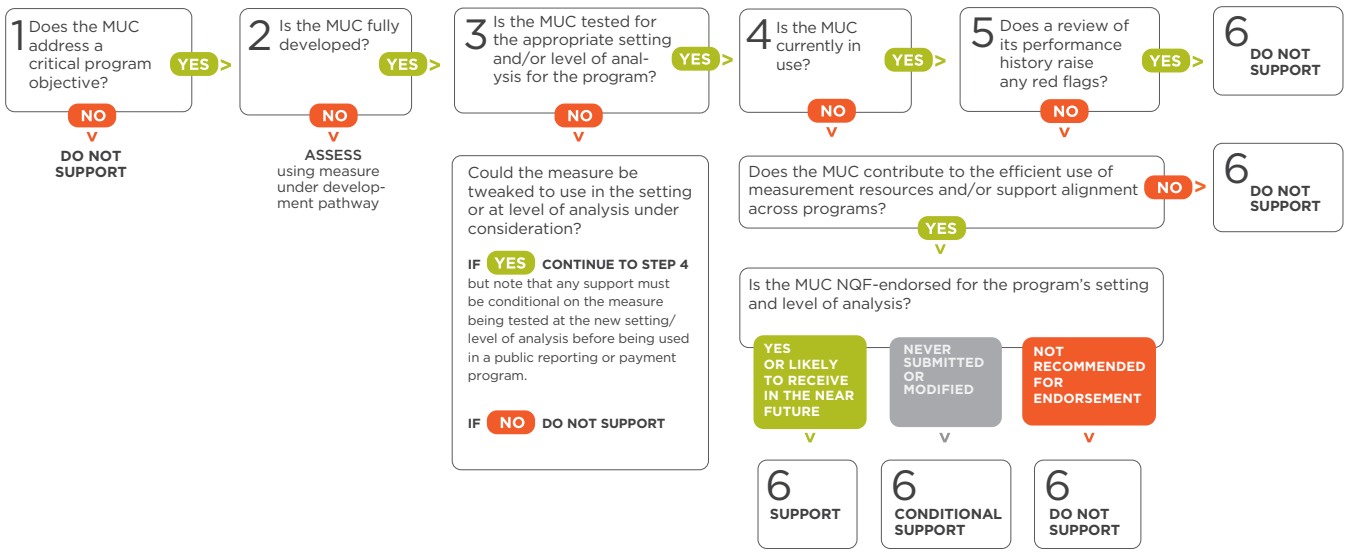
3. **Identify and prioritize measurement gaps for programs and settings.** MAP continues to identify gaps in measurement capabilities for each program; in some cases, it may also suggest measure concepts that could help fill those gaps. Furthermore, MAP considers measurement gaps across settings, prioritizing by importance and feasibility when possible.

Preliminary Analysis

To support MAP decisionmaking, staff provided a preliminary analysis of all measures under consideration using a pre-defined and standard algorithm. The algorithm is based on the MAP Measure Selection Criteria and the identified critical program objectives, and its results serve as a starting point for MAP discussions. As illustrated in Figure 1, the algorithm involves several questions on each measure:

- Does the measure under consideration meet a critical program objective as defined by MAP?
- Is the measure under consideration fully developed?
- Is the measure under consideration tested for the appropriate setting and/or level of analysis for the program? If no, could the measure be adjusted to use in the program's setting or level of analysis?
- Is the measure under consideration currently in use? If yes, does a review of its performance history raise any red flags?

FIGURE 1. MAP PRELIMINARY ANALYSIS ALGORITHM FOR FULLY DEVELOPED MEASURES



- Does the measure under consideration contribute to the efficient use of measurement resources for data collection and reporting and support alignment across programs?
- Is the measure under consideration NQF-endorsed for the program's setting and level of analysis?

Because early stage measures may change as they develop, MAP evaluated these measures using an abbreviated algorithm. As illustrated in Figure 2, the preliminary analysis algorithm for these types of measures asked the following questions:

- Does the measure under consideration meet a critical program objective as defined by MAP?
- Is the measure under consideration fully developed?
- Does the measure under consideration contribute to the efficient use of measurement resources and support alignment across programs?

NQF Member and Public Comment Period

To encourage stakeholder input, MAP posted the four measures for a brief commenting period that allowed stakeholders to provide feedback on the preliminary measure recommendations. Both NQF Members and any interested party can comment on the list of measures under consideration and on individual measure decisions. To provide a transparent process, all submitted comments were posted on the NQF website for public viewing. These comments were considered by the MAP Coordinating Committee when making its final decisions on measures.

Categories of MAP Decisions

MAP's measure recommendations for the off-cycle review are provided in an accompanying spreadsheet. For each measure, the spreadsheet includes the MAP recommendation along with a rationale for the decision. Table 1 outlines the different recommendation categories along with sample rationales.

FIGURE 2. MAP PRELIMINARY ANALYSIS ALGORITHM FOR EARLIER STAGE MEASURES

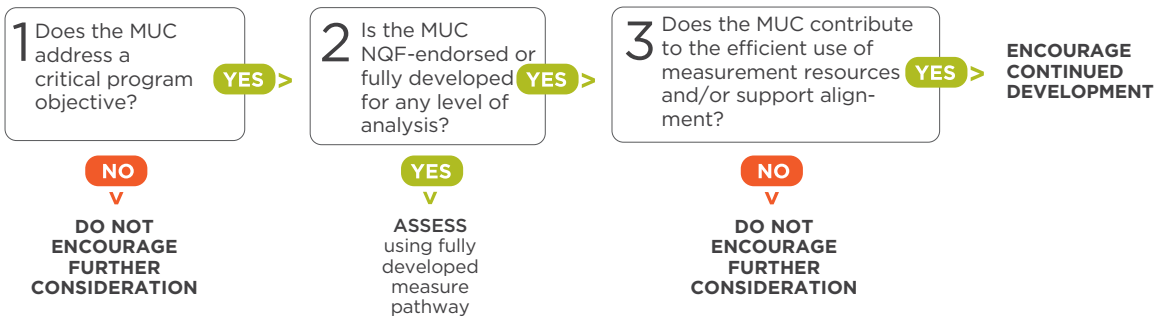


TABLE 1. MAP DECISION CATEGORIES AND EXAMPLE RATIONALES

MAP Decision Category	Rationale (Examples)
Support	• Meets a critical program objective • Addresses a previously identified measure gap • Core measure not currently included in the program measure set • Promotes alignment across programs and settings
Conditional support	• Not ready for implementation; should be submitted for and receive NQF endorsement • Not ready for implementation; measure needs further experience or testing before being used in the program
Do not support	• Overlaps with a previously finalized measure • A different NQF-endorsed measure better addresses the needs of the program • Does not meet a critical program objective
Encourage continued development	• Addresses a critical program objective, and the measure is in an earlier stage of development • Promotes alignment, and the measure is in an earlier stage of development
Do not encourage further consideration	• Overlaps with finalized measure for the program, and the measure is in an earlier stage of development • Does not address a critical objective for the program, and the measure is in an earlier stage of development
Insufficient information	• Measure numerator/denominator not provided

APPENDIX A:
Program Summaries

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)

MAP's Suggested Critical Program Objectives
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

- Program measure set is too limited and could be enhanced by addressing core measure concepts not currently addressed in the set such as 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.[7]

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.[8] 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.[9]

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).[10]

Program Update

- Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System FY 2015 Final Rule:[11]
  - 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)

MAP's Suggested Critical Program Objectives

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).[12]
- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[13]:
  - 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.[14]
- Increased attention should be given to pain, agitation, and delirium among the ventilated population, as these factors are the biggest impediments to mobility.[15]
- Add measures to address cost, cognitive status assessment (e.g., dementia identification), medication management (e.g., use of antipsychotic medications), and advance directives.[16]

Nursing Home Quality Initiative

Program Type:
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.[17]

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).[18]

Program Update
None

MAP's Suggested Critical Program Objectives
Statutory Requirements

- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[19]:
  - 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
  - Establishes a new "SNF Quality Reporting Program" at the start of FY 2019 and 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 this 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.

- The Protecting Access to Medicare Act of 2014 (PAMA)[20]:

  - Directs the Secretary to establish a skilled nursing facility value-based purchasing (SNF VBP) program under which value-based incentive payments are made in a fiscal year to skilled nursing facilities, beginning in fiscal year 2019.

    1. Readmission measure - Not later than October 1, 2015, the Secretary shall specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such a measure).

    2. Resource use measure – Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities.

  - Directs the Secretary to: (1) provide confidential feedback reports to SNFs on their performance with respect to a measure specified for this program [under paragraph (1) or (2)], beginning October 1, 2016 and every quarter thereafter; and (2) establish procedures for making available to the public by posting on the Nursing Home Compare Medicare website (or a successor website) information on the performance of SNF with respect to a measure specified under paragraph (1) and a measure specified under paragraph (2) beginning not later than October 1, 2017.

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.[21]

- Add measures that assess discharge to the community and the quality of transition planning.[22]

- Include Nursing Home-CAHPS measures in the program to address patient experience.[23]

Home Health Quality Reporting Program

Program Type

Pay for Reporting, Public Reporting

Incentive Structure

Medicare-certified[24] 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.[25] 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.[26] 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.[27]

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.[28]

Program Update

- Updates listed in the CY 2015 Home Health Final Rule:[29]
  - 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. These measures will be added to HH Compare for public reporting in CY 2015.
  - Set a date of October 2014 for removal of the 9 episode stratified process measures in the CASPER reports. In addition, five short stay measures which had previously been reported on HH Compare were recently removed from public reporting and replaced with non-stratified "all episodes of care" versions of these measures.
  - Finalized a new pay-for-reporting performance requirement for OASIS reporting. For episodes beginning on or after July 1st, 2015 and before June 30th, 2016, HHAs must score at least 70 percent on the Quality Assessments Only (QAO) metric of pay-for-reporting performance requirement or be subject to a 2 percentage point reduction to their market basket update for CY 2017.
  - Will continue to require HHCAHPS

MAP's Suggested Critical Program Objectives

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.[30]
- Two categories of quality measures used in HH QRP are outcome measures and process measures. There are three types of outcome measures used including:[31]
  - 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[32]:
  - 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.[41]

Future Direction of the Program

- CMS will conduct a thorough analysis of the measure set to identify priority gap areas, measures that are topped out, and opportunities to improve the existing measures.

MAP Previous Recommendation

- Include measures addressing concepts such as goal attainment, patient engagement, care coordination, depression, caregiver's role, and timely referral to hospice.[33]

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.

ENDNOTES

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APPENDIX B:
Measure Applications Partnership (MAP) Rosters

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ISBN 978-1-933875-93-4

NATIONAL QUALITY FORUM
1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005

www.qualityforum.org