MEASURE APPLICATIONS PARTNERSHIP

MAP 2019 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care

FINAL REPORT

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NATIONAL QUALITY FORUM

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CONTENTS

GUIDANCE ON CROSS-CUTTING ISSUES

Summary

- Promote improved care transitions and care coordination through bidirectional measures across the care continuum.
- Ensure the information gained from performance measurement is useful and actionable for all stakeholders.

The Measure Applications Partnership (MAP) reviewed nine measures under considerations for five setting-specific federal programs addressing post-acute care (PAC) and long-term care (LTC) and gave input on potential measure gaps. The programs that had measures under consideration are listed below.

- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Home Health Quality Reporting Program (HH QRP)
- Hospice Quality Reporting Program (Hospice QRP)

MAP's pre-rulemaking recommendations reflect the MAP Measure Selection Criteria and how well a measure under consideration addresses the identified program goals. To inform deliberations, NQF staff provided MAP with a preliminary analysis and draft recommendation on the measures under consideration (MUC). MAP also drew upon its **Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement** as a guide to inform pre-rulemaking review of measures for the PAC/LTC programs. In the PAC/LTC coordination strategy, MAP defined high-leverage areas for performance measurement and identified 13 core measurement concepts to address the high-leverage areas.

OVERARCHING THEMES

Patients requiring post-acute and long-term care are clinically complex and may frequently transition across sites of care. As such, quality of care is an essential issue for PAC and LTC patients. Performance measures are vital to understanding healthcare quality, but measures must be meaningful and actionable if they are to drive true improvement. The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) aimed to standardize PAC/LTC measurement with the goal of improving patient outcomes through shared decision making, care coordination, and enhanced discharge planning. As part of its pre-rulemaking work, MAP reviewed and made recommendations to the Centers for Medicare & Medicaid Services (CMS) on several measures designed to meet the charge of the IMPACT Act.

Improving Care Coordination and Care Transitions

In its **Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement**, MAP highlighted that patients who receive care from PAC and LTC providers frequently transition between sites of care. Patients may move among their home, the hospital, and PAC or LTC settings as their health and functional status change. Improving care coordination and the quality of care transitions is essential to improving post-acute and long-term care.

MAP reviewed eight measures under consideration for four PAC/LTC quality reporting programs addressing the transfer of health information. These measures represent important first steps towards improving care transitions. The measures assess the ability to transfer health information to either the next provider of care or to the patient and/or caregiver. MAP noted that these measures are important assessments of interoperability and the ability of providers to transfer information, specifically a medication list. MAP pointed out the potential of health information technology to improve quality and minimize the burden of measurement. MAP members noted that electronic health record adoption in PAC/LTC settings often lags behind other care settings as there have been fewer incentives to implement new technology. Enhancing and facilitating the use of technology through greater standardization could help to improve transitions and the exchange of information across providers.

When reviewing these measures, MAP noticed themes across programs. MAP members appreciated that the measures allow for the current technology limitations in PAC/LTC settings by allowing for multiple modes of transmission of the required medication list. MAP members recommended that CMS ensure that the measures appropriately consider situations such as a patient leaving against medical advice or a transfer to an emergency department. MAP also noted that the measures should ensure a timely transfer of information so that patients and receiving providers can ensure that they have the medications and equipment needed for a safe and effective transition of care. MAP also suggested that in the future the measures could be adapted to give a fuller picture of a patient's medication history, provide guidance on relevant dietary restrictions, and provide specific considerations for opioids.

MAP noted that CMS should continue to work to improve standardization and promote interoperability and recognized that the CMS Data Element Library is an important tool to promote data exchange. MAP also recommended that CMS work with vendors to improve EHR interoperability.

MAP cautioned that the medication information provided to a patient must be easy to understand. MAP noted that people have varying degrees of health literacy, and healthcare providers should ensure that patients understand the information on their medications, including proper timing

and dosages and when to discontinue use. MAP recognized that providing this information to patients could help with patient engagement and empowerment and suggested that CMS could consider including all patients in the future rather than only patients discharged to home or similar settings.

MAP discussed several potential future directions for measurement that could improve care transitions. First, MAP noted the need for future measures to be bidirectional between the discharging and the receiving care settings. This ensures information is received and acted upon in a timely manner. MAP members also underscored the need for care providers to share information across the care continuum, not just between post-acute sites. MAP also pointed to a need to assess the transfer of information from the hospital to the post-acute site and to the patient's primary care physician. Measures that assess such transfer of information could promote shared accountability across care settings and ensure that all clinicians involved in a person's care have the information they need to provide safe, high-quality care.

MAP reviewed one measure that addresses transitions from hospice care. While MAP did not support the measure as specified, MAP recognized the impact that care transitions at the end of life can have on patients and suggested ways in which the developer could mitigate MAP's concerns with the measure.

Ensuring Meaningful Information for All Stakeholders

MAP stressed the importance of ensuring that measures produce meaningful information for all stakeholders. Measures should focus on areas that are meaningful to patients as well as clinicians and providers. MAP emphasized a need for measures that are person-centered and address aspects of care that are most meaningful to patients and families. MAP members noted the need to engage patients and families into quality improvement efforts and advised against using judgmental terms such as "adherence" and "compliance."

Measures should produce information as granular as is possible to ensure that clinicians and providers can act on that information to improve quality. As Workgroup members pointed out, facility-level information can prove challenging to act upon, while patient-level data can help identify root causes of quality issues. Additionally, Workgroup members noted that information from claims-based measures can be delayed, making it difficult to make timely improvements.

MAP emphasized the importance of ensuring correct information is communicated to all stakeholders. For example, MAP discussed that the transfer of information measures can only inform healthcare improvement efforts if the information is accurate and that it is essential that medication reconciliation is done correctly. MAP noted that the transfer of health information measures did not provide guidance on who should create the medication list. Some MAP members noted that a pharmacist may be best suited to develop the medication list but recognized that PAC/LTC settings vary in resources and that some facilities may not have the resources to employ a full-time pharmacist to conduct audits. MAP noted that CMS should provide detailed guidance on the implementation of this measure to ensure it is operationalized in a way the produces accurate medication lists. MAP also noted a need to assess if the patient understood the information provided and recommended CMS consider patient-reported measures that assess understanding in the future.

Finally, MAP perceived a need for greater consideration of how measures are implemented as part of a larger measurement system, as the way measures are scored as part of a program can influence results and create unintended consequences. For example, Workgroup members expressed a need to consider how measures are used as part of the star rating systems. MAP recognized the valuable intention of providing easy-to-understand information for consumers, but it cautioned that such information is also being used for other purposes such as network design. This can lead to an organization focusing on improving its star ratings rather than on areas that would most improve patient care.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

Skilled Nursing Facility Quality Reporting Program

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) is a quality reporting program established under section 1899B as part of the IMPACT Act. SNFs that do not submit the required data are subject to a 2 percent reduction in their annual payment rates.

MAP reviewed and conditionally supported two measures under consideration for the SNF QRP: MUC2018-138 *Transfer of Health Information to Patient—Post-Acute Care* and MUC2018-136 *Transfer of Health Information to Provider—Post-Acute Care*. The Workgroup noted that both measures could help improve the transfer of information about a patient's medication, an important aspect of care transitions. Better care transitions could improve patient outcomes, reduce complications, and lessen the risk of hospital admissions or readmissions. Additionally, the measures would meet an IMPACT Act requirement, address PAC/LTC core concepts not currently included in the program measure set, and promote alignment across programs. MAP conditionally supported both measures pending NQF endorsement.

MAP encouraged the developer to include additional payers beyond Medicare Part A since Part A alone may not capture the entire population for skilled nursing facilities, particularly in some states or regions where there is high managed care penetration. Further, for all eight PAC/LTC quality reporting measures addressing the transfer of health information, MAP suggested that the reviewing NQF standing committee ensure that there is no unintentional double-counting in the denominator in particular with individuals who are discharged home to receive home health or hospice care.

For MUC2018-136 *Transfer of Health Information to Provider—Post-Acute Care* for the SNF QRP, MAP highlighted the need for a timely, bidirectional information exchange. MAP members appreciated the ability to use multiple modes of transmission, as many providers do not have EHRs. However, MAP members noted the need to foster and promote EHR adoption. MAP further emphasized the need for a clear definition of a reconciled medication list. CMS shared examples of the type of guidance that could accompany the measures. CMS noted that the guidance on the medication list is not intended to exhaust all of the information that could be transferred upon discharge to that patient's family, caregiver, and provider. The guidance includes a reconciled medication list that has current prescribed or over-the-counter medications, nutritional supplements, vitamins, and homeopathic or herbal products administered by any route. Additionally, the guidance consists of medications that are active and those held during the episode or planned to be continued or resumed after discharge. The list includes important information about the patient, the residents, their characteristics, their name, their date of birth information, active diagnoses, known medications, each medication that the individuals are taking or were prescribed, including the strength, the dose, the name, the route of the medication, frequency timing, and any medications held for any reason.

MAP recommended that this measure be adapted in the future to include information about supplements a person may choose to take and specific consideration for opioids. MAP encouraged CMS to consider how to properly address instances when patients see an outside specialist for a consultation or decide to leave against medical advice.

For MUC2018-138 *Transfer of Health Information to Patient—Post-Acute Care*, MAP recognized the importance of ensuring that patients have information about their medications and noted that this measure could promote patient engagement. MAP cautioned that CMS should implement this measure in a way that ensures that the information provided to patients is understandable and complete as health literacy can vary significantly and impact a person's ability to take medication as directed. MAP indicated that explaining when to stop taking a medication can be a critical safety issue. Finally, MAP suggested that this measure could be adapted in the future to promote the transfer of information to patients who are transferring to settings other than home, as this information could help protect them against medication errors while in a facility.

MAP identified several gaps in the SNF QRP measure set including the need for measures that could improve care transitions and assess the safety of the transition. MAP noted that care transitions could be improved through the bidirectional transfer of information, patient and family engagement and empowerment, improvement of interoperability, and improved communication about advance directives.

Long-Term Care Hospital Quality Reporting Program

The Long-Term Care Hospital Quality Reporting Program (LTCH QRP) was established under section 3004 of the ACA. Under this program, LTCH providers must submit quality reporting data from sources such as Medicare FFS Claims, the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) data submissions, and the LTCH Continuity Assessment Record and Evaluation Data Sets (LCDS) or be subject to a 2 percent reduction in the applicable annual payment update.

MAP reviewed and conditionally supported two measures under consideration for the LTCH QRP: MUC2018-141 *Transfer of Health Information to Patient—Post-Acute Care* and MUC2018-133 *Transfer of Health Information to Provider—Post-Acute Care*. As noted above, MAP recognized that these measures address an IMPACT Act requirement for the LTCH QRP and could help promote the transfer of important medication information. MAP also cited the potential future need for bidirectional measures. MAP conditionally supported both measures pending NQF endorsement. MAP identified that the availability of palliative care services is a potential gap in the LTCH QRP measure set.

Inpatient Rehabilitation Facility Quality Reporting Program

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) was established under section 3004 of the ACA. This program applies to all IRF settings that receive payment under the IRF Prospective Payment System (PPS) including IRF hospitals, IRF units that are co-located with affiliated acute care facilities, and IRF units affiliated with critical care access hospitals (CAHs). Under this program, IRF providers must submit quality reporting data from sources such as Medicare FFS Claims, CDC NHSN data submissions, and the IRF-Patient Assessment Instrument (PAI) or be subject to a 2 percent reduction in the applicable annual payment update.

MAP reviewed and conditionally supported two measures under consideration for the IRF QRP: MUC2018-139 *Transfer of Health Information to Patient—Post-Acute Care* and MUC2018-132 *Transfer of Health Information to Provider—Post-Acute Care*. Again, MAP noted that these measures address an IMPACT Act requirement for the IRF QRP and address an important patient safety issue. MAP noted specific issues for MUC2018-132 *Transfer of Health Information to Provider—Post-Acute Care*. First, MAP recognized that IRFs may see more acute patients than other PAC/LTC settings and suggested congruence with the definition of medication lists for acute care

hospitals. MAP also suggested that CMS consider how to address patients who leave against medical advice and clarify how the measure calculates patients who are transferred to the ED. MAP also noted the potential future need for bidirectional measures. For MUC2018-139 *Transfer of Health Information to Patient—Post-Acute Care*, MAP cautioned that information should be carefully communicated to patients.

MAP noted the appropriate prescribing and use of opioids as a potential measurement gap in the IRF QRP measure set.

Home Health Quality Reporting Program

The Home Health Quality Reporting Program (HH QRP) was established in accordance with Section 1895 of the Social Security Act. Under this program, home health agencies (HHAs) must submit quality reporting data from sources such as Medicare FFS Claims, the Outcome and Assessment Information Set (OASIS), and the Home Health Care Consumer Assessment of Healthcare Providers and Systems survey (HH CAHPS), or be subject to a 2 percent reduction in the annual PPS increase factor.

MAP reviewed and conditionally supported two measures under consideration for the HH QRP: MUC2018-135 *Transfer of Health Information to Patient—Post-Acute Care* and MUC2018-131 *Transfer of Health Information to Provider—Post-Acute Care*. MAP recognized the importance of these measures in addressing improved care transitions and noted that they would address an IMPACT Act requirement. MAP conditionally supported both measures pending NQF endorsement. MAP suggested that CMS should consider how MUC2018-131 *Transfer of Health Information to Provider—Post-Acute Care* addresses patients who choose to discontinue home healthcare. MAP also noted the potential future need for bidirectional measures and that the measure could be adapted in the future to address specific concerns around opioids.

MAP identified potential gaps in the HH QRP measure set. MAP members identified the need for additional measures addressing the stabilization and/or improvement in activities of daily living not currently addressed in the program measure set. MAP also suggested a need to measure instrumental activities of daily living addressing outcomes that are more distal to the time of treatment than those currently assessed in the HH QRP. MAP also noted a potential gap for a patient-reported outcome measure addressing functional status or quality of life. Finally, MAP members recommended a measure that offers a more holistic view of wound care.

Hospice Quality Reporting Program

The Hospice Quality Reporting Program (HQRP) was established under section 3004 of the ACA. The HQRP applies to all hospices, regardless of setting. Under this program, hospice providers must submit quality reporting data from sources such as the Hospice Item Set (HIS) data collection tool and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, or be subject to a 2 percent reduction in the applicable annual payment update.

MAP reviewed one measure under consideration for the HQRP: MUC2018-101 *Transitions from Hospice Care, Followed by Death or Acute Care*. MAP did not support this measure for rulemaking as currently specified with a potential for mitigation. MAP recognized the need to address a potentially serious quality problem for patients if they are inappropriately discharged from hospice. MAP noted that transitions of care at the end of a person's life can be associated with adverse health outcomes, lower patient and family satisfaction, and higher costs. In a March 2018 report, the Medicare Payment Advisory Commission (MedPAC) found that in 2016 25 percent of providers had live discharge rates greater than 31 percent and that 10 percent of providers had rates greater than 53 percent. MedPAC noted that while

some live discharges from hospice are acceptable and expected, higher than normal rates may indicate a quality problem, such as a provider not being able to meet a patient's or caregiver's needs.

While CMS rightly wishes to identify areas of low quality hospice care delivery that result in negative outcomes for patients, MAP members raised concerns that the measure under consideration is not garnering this information from claims data in a way that is fair to hospice care providers. MAP agrees that a certain portion of the measure will contain the signal for quality that CMS is interested in, and that this signal is important. However, MAP raised concerns that conceptually there is too much noise in the measure stemming from items that MAP suggests should be criteria for exclusions from the denominator. As the measure stands, the unequal distribution of patients with these exclusions across hospice providers leads to a measure that would not be suitable for accountability purposes. Because of variability implicit in the data, it is not possible to say unequivocally that one provider has done better than another, nor that an individual provider has improved over time.

MAP identified ways in which the developer could potentially mitigate the concerns raised. First, MAP recommended that the measure developer reconsider the exclusion criteria for the measure. Specifically, the developer should review the exclusion for Medicare Advantage patients, as this may be excluding too many patients. Additionally, the developer should consider adding an exclusion to allow for patient choice, as a patient may choose to transition from hospice for many reasons. For example, a patient may choose to pursue additional curative treatment, have cultural beliefs that influence the definition of a good death, have limited access to primary care, or may need to revoke the hospice benefit to avoid a financial penalty for seeking more acute care. The developer could also clarify how the measure addresses patients transferred to palliative care or another hospice. MAP recommended that the developer examine the use of a predicted to expected ratio to score this measure and provide guidance on how the measure will address hospices with a small volume of patients. MAP also noted that the measure may provide more useful information if the developer were to separate out the concepts addressed in the measure, as the measure may be trying to address different concepts by including both death within 30 days and acute care use within seven days. Finally, MAP recommended the developer examine the impact of shortening the timeframes for capturing the post-discharge events.

MAP also suggested that CMS consider a dry run of the measure before publicly reporting results and explore the need for a survey of patients with a live discharge from hospice to better understand their reason for discharge and the potential scope of the problem.

On a more global level, the MAP questioned whether or not a claims-based measure is the best mechanism to capture whether patients' and their families' wishes were respected upon the transfer from hospice. MAP suggested that a patient-reported outcome could be a more effective form of measurement.

MAP reviewed the Hospice QRP measure set, noting a gap in measures addressing if care was delivered in line with the patient's goals.

APPENDIX A:
Program Summaries

Inpatient Rehabilitation Facility Quality Reporting Program

Program Type

Penalty for failure to report

Incentive Structure

The IRF QRP was established under the Affordable Care Act. Beginning in FY 2014, IRFs that fail to submit data will be subject to a 2 percentage point reduction of the applicable IRF Prospective Payment System (PPS) payment update.

Program Goals

Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.

CMS identified the following domains as high-priority for future measure consideration:

- Communication/Care Coordination: Transfer of Health Information and Interoperability

Long-Term Care Hospital Quality Reporting Program

Program Type

Penalty for failure to report

Incentive Structure

The LTCH QRP was established under the Affordable Care Act. Beginning in FY 2014, LTCHs that fail to submit data will be subject to a 2 percentage point reduction of the applicable annual payment update (APU).

Program Goals

Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for periods of greater than 25 days).

CMS identified the following domain as high-priority for future measure consideration:

- Communication/Care Coordination: Transfer of Health Information and Interoperability

Skilled Nursing Facility Quality Reporting Program

Program Type

Penalty for failure to report

Incentive Structure

The IMPACT Act added Section 1899B to the Social Security Act establishing the SNF QRP. Beginning in FY 2018, providers [SNFs] that do not submit required quality reporting data to CMS will have their annual update reduced by 2 percentage points.

Program Goals

CMS identified the following domains as high-priority for future measure consideration:

- Communication/Care Coordination: Transfer of Health Information and Interoperability

Skilled Nursing Facility Value-Based Purchasing Program (not reviewed in 2018-2019)

Program Type

Pay for performance

Incentive Structure

Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) authorizes establishing a SNF VBP Program beginning with FY 2019 under which value-based incentive payments are made to SNFs in a fiscal year based on performance.

CMS identified the following domain as high-priority for future measure consideration:

- The PAMA legislation mandates that CMS specify:
  - An SNF all-cause, all-condition hospital readmission measure by no later than October 1, 2015
  - A resource use measure that reflects resource use by measuring all-condition, risk-adjusted potentially preventable hospital readmission rates for SNFs by no later than October 1, 2016 (This measure will replace the all-cause, all-condition measure)

Home Health Quality Reporting Program

Program Type

Penalty for failure to report

Incentive Structure

The HH QRP was established in accordance with section 1895 of the Social Security Act. Home health agencies (HHAs) that do not submit data receive a 2 percentage point reduction in their annual HH market basket percentage increase.

Program Goals

Alignment with the mission of the IOM which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness.

CMS identified the following domain as high-priority for future measure consideration:

- Patient and Family Engagement: Care is Personalized and Aligned with the Patient's Goals

Hospice Quality Reporting Program

Program Type

Penalty for failure to report

Incentive Structure

The Hospice QRP was established under the Affordable Care Act. Beginning in FY 2014, hospices that fail to submit quality data will be subject to a 2 percentage point reduction to their annual payment update.

Program Goals

Make the hospice patient as physically and emotionally comfortable as possible, with minimal disruption to normal activities, while remaining primarily in the home environment.

CMS identified the following three domains as high-priority for future measure consideration:

- Effective Prevention and Treatment: symptom management outcome measures
- Making care safer: timeliness/responsiveness of care
- Communication and care coordination: alignment of care coordination measures

APPENDIX B:
MAP PAC/LTC Workgroup Roster and NQF Staff

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