Measure Applications Partnership

Coordinating Committee In-Person Meeting

January 26-27, 2015

NATIONAL QUALITY FORUM

Meeting Agenda – Day 1

- Welcome
- Overview of Pre-Rulemaking Approach
- MAP Pre-Rulemaking Strategic Deliverables: Cross-Cutting Issues
- Finalize Pre-Rulemaking Recommendations for Clinician Programs
- Finalize Pre-Rulemaking Recommendations for PAC/LTC Programs

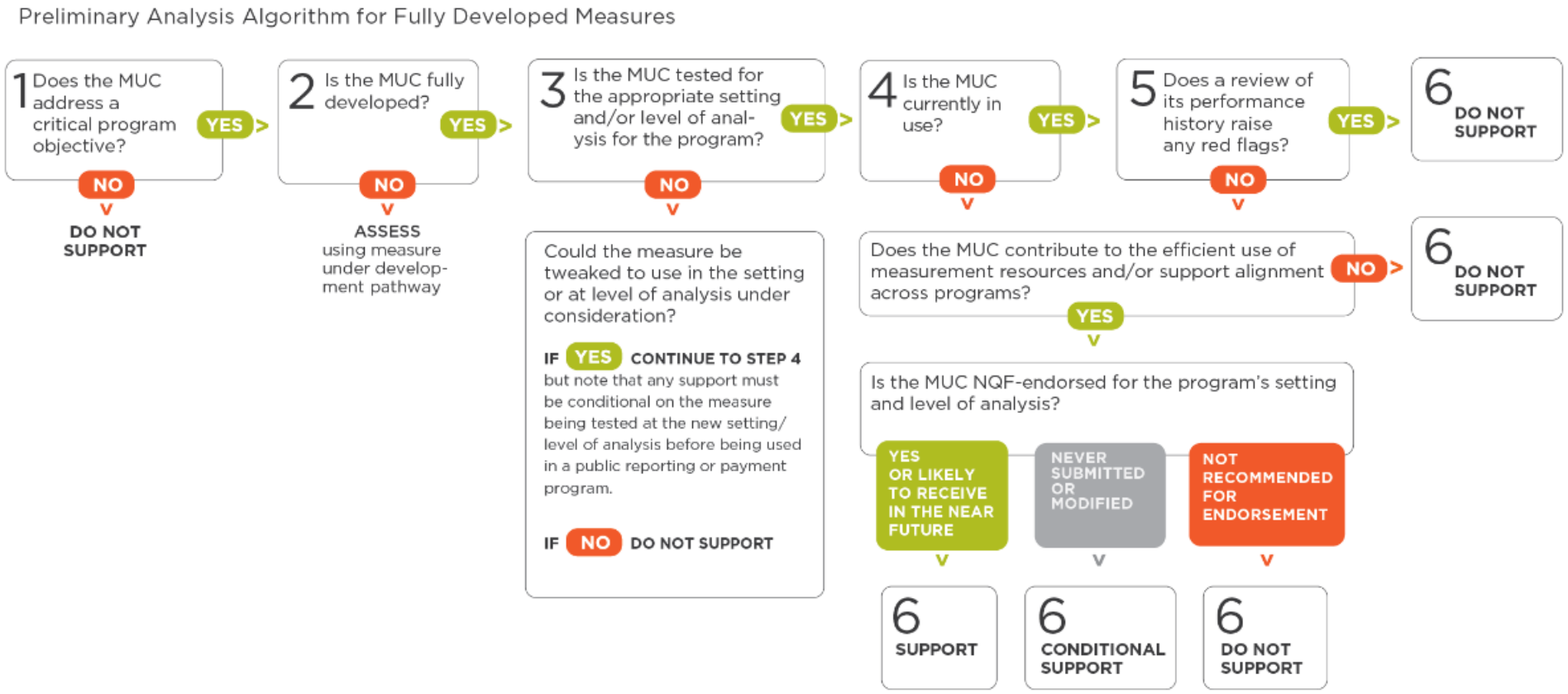
Disclosures of Interest

Overview of Pre-Rulemaking Approach

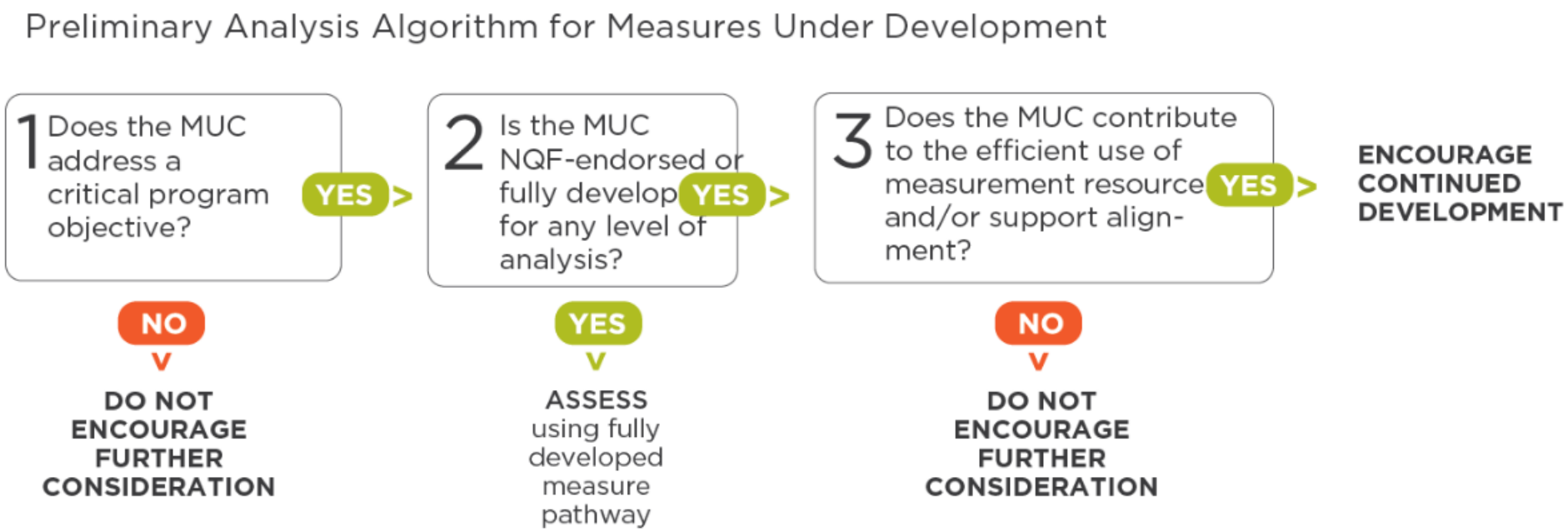
New for 2014-2015 Pre-rulemaking

- Two public comment periods
- Separated MAP products into more focused deliverables
- Began discussions by identifying critical program needs and objectives, which then drove a preliminary analysis
- Transparent decision making process, with formal votes at key points
- Electronic meeting materials with links to reference information

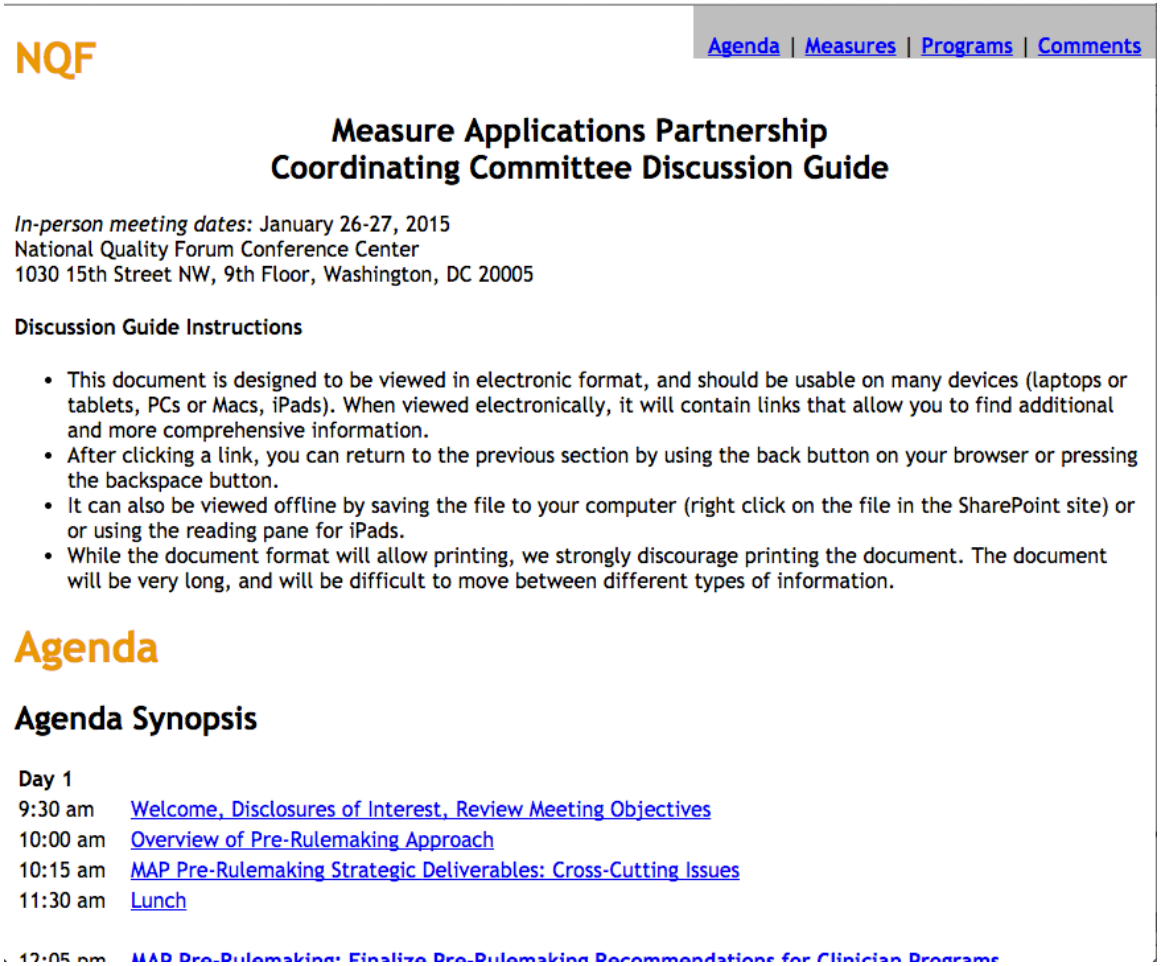
Preliminary analysis of measures with MAP measure selection criteria



Preliminary analysis of measures under development



Overview of Electronic Meeting Materials



NQF

Agenda | Measures | Programs | Comments

Measure Applications Partnership
Coordinating Committee Discussion Guide

In-person meeting dates: January 26-27, 2015
National Quality Forum Conference Center
1030 15th Street NW, 9th Floor, Washington, DC 20005

Discussion Guide Instructions

- This document is designed to be viewed in electronic format, and should be usable on many devices (laptops or tablets, PCs or Macs, iPads). When viewed electronically, it will contain links that allow you to find additional and more comprehensive information.
- After clicking a link, you can return to the previous section by using the back button on your browser or pressing the backspace button.
- It can also be viewed offline by saving the file to your computer (right click on the file in the SharePoint site) or or using the reading pane for iPads.
- While the document format will allow printing, we strongly discourage printing the document. The document will be very long, and will be difficult to move between different types of information.

Agenda

Agenda Synopsis

Day 1	
9:30 am	Welcome, Disclosures of Interest, Review Meeting Objectives
10:00 am	Overview of Pre-Rulemaking Approach
10:15 am	MAP Pre-Rulemaking Strategic Deliverables: Cross-Cutting Issues
11:30 am	Lunch
12:05 pm	MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for Clinician Programs

Schedule of MAP Deliverables

Pre-Rulemaking Final Report Due to HHS

February 1, 2015

MAP 2015 Considerations for Implementing Measures in Federal Programs: Hospital and PAC-LTC Programs Due to HHS

February 15, 2015

MAP 2015 Considerations for Implementing Measures in Federal Programs: Clinician and Cross-Cutting Challenges Facing Measurement Due to HHS

March 15, 2015

MAP Pre-Rulemaking Approach Strategic Deliverables: Cross-Cutting Issues

Cross-Cutting Challenges Facing Measurement: Overarching Themes Raised by MAP

- Moving toward “measures that matter” in health programs
- Need to identify and fill critical measurement gaps
- Additional progress needed to further align measures between public and private programs

Moving Towards Measures that Matter: Summary of MAP Discussions this Year

- Characteristics of measures that matter, such as:
  - Assessing an important health issue
  - Addressing an opportunity for improvement
  - Potential to change performance

- Additional areas identified:
  - Moving to outcome measures
  - Patient-reported outcomes
  - Cost/resource use
  - Appropriate use
  - Care coordination
  - Patient safety

Gaps in Measures that Matter

- Historically, MAP has generated a comprehensive list of previously identified measure gaps
- This year, the list was updated with all of MAP's prior reports and recent MAP activities
- Also supplemented by discussions during this year's pre-rulemaking process

Progress on Filling Critical Measure Gaps – Gap-Filling

- MAP has helped fill gaps by recommending measures that matter in important ways
- For example, MAP recommendations contributed to CMS finalizing patient-and family-centered care measures across all programs
- Progress still remains

Progress on Filling Critical Measure Gaps: Score Card (Patient- and Family-Centered Care)

Category	Measurement Gap
Person-Centered Communication	• Information provided at appropriate times • Information is aligned with patient preferences • Patient understanding of information • Outreach to ensure ability for care self-management
Shared Decision-making, Care Planning, and Other Aspects of Person-Centered Care	• Person-centered care plan • Integration of patient/family values in care planning • Plan agreed to by the patient and provider and given to patient • Care plan shared among all involved providers • Identified primary provider responsible for the care plan • Fidelity to care plan and attainment of goals • Social care planning addressing all needs for patient & caregiver • Grief and bereavement care planning • Patient activation/engagement
Advanced Illness Care	• Symptom management • Comfort at end of life
Quality of Life and Functional Status	• Functional status • Pain and symptom management • Health-related quality of life

Progress on Filling Critical Measure Gaps: Score Card (Care Coordination)

Category	Measurement Gap
Avoidable Admissions and Readmissions	• Shared accountability and attribution across the continuum
Communication	• Bi-direction sharing of relevant/adequate information across all providers and settings • Measures of patient transition to next provider/site of care across all settings, as well as transitions to community services
System and Infrastructure	• Interoperability of EHRs to enhance communication • Structures to connect health systems and benefits • Emergency department overcrowding/wait times (focus on disproportionate use by vulnerable populations)

Progress on Filling Critical Measure Gaps: Coordinating Committee Discussion Questions

- Is a quantitative scorecard approach useful for assessing progress in filling gaps? If so, how can it be improved (such as with qualitative progress)?
- What level of information is needed to begin prioritizing gaps?
- How can we make further progress in filling these gaps?

Progress in Aligning Measurement Requirements

- Still need to make progress in alignment
  - Little alignment at state and regional levels
  - Further progress needed in public/private alignment

- One reason MAP was created was to drive alignment, and it has made progress in supporting alignment across public programs

Progress in Aligning Measurement Requirements: Coordinating Committee Discussion Question

- What level of information is needed to make further progress on alignment?
- How can MAP support further alignment efforts?

MAP Pre-Rulemaking Recommendations for Clinician Programs

Clinician Workgroup – Discussion Themes

- Include more high-value measures in federal programs
  - Noticeable increase in high value measure this year
  - Measures under consideration: 27 of 95 measures for PQRS are composites, outcomes, PROs, appropriate use/efficiency measures
- Alignment across federal programs
  - AMA: “need to synchronize and simplify”
  - Alignment of PQRS-based programs and the EHR Incentive programs
  - Alignment with the Medicare Shared Savings Program
- Participation and incentives
  - 36% participation of EPs in PQRS in 2012; 50%+ in 2013
  - PQRS measures for public reporting and payment going forward
  - PQRS non-participation penalties begin in 2015
  - No differential incentives for reporting high-value measures

Physician Quality Reporting System (PQRS)

- **Program Type:** Incentives to encourage widespread participation by EPs to report quality information.
- **Incentive Structure:** In 2015, a 2% penalty for groups >100 that don't participate. The 2% penalty extends to groups >10 in 2017, individual physicians in 2017 and non-clinician professionals in 2018.
- **Program Updates (2015 PFS final rule)**:
  - 18 cross-cutting measures – based on MAP recommendation
  - Measure turnover: 20 measures added; 50 removed for 2015
  - PQRS measures will be reported on Physician Compare and used in the quality component of the Value Modifier

PQRS and programs using PQRS measures

- 95 measures under consideration for PQRS, Physician Compare, Physician Feedback/Quality and Resource Utilization Reports; Physician Value-based Payment Modifier (quality component)
  - 42 are fully developed, tested and ready for implementation
    - 7 measures are NQF-endorsed
  - 53 are still in development
  - most MUCs have not been submitted to NQF

Value-Based Payment Modifier and Physician Feedback Programs – 6 cost measures under consideration

- **Program Type**: Feedback provides comparative performance information to physicians and payment adjustment of Medicare FFS reimbursement based on performance on quality and cost measures.
- **Incentive Structure**: A 2% Value Modifier (VM) downward payment adjustment in CY 2016, for EPs in groups of 10 or that did not satisfy the PQRS requirements as a group or as individuals in CY 2014
- **Program Updates:**
  - All physicians who participate in Fee-For-Service Medicare will be affected by the value modifier starting in 2017.
  - Measures are collected for one year to establish benchmarks prior to use in determining the payment modifier.
  - Measures reported in PQRS and several non-discretionary claims based measures are used for the quality component of the VM with cost measures.

Consensus Not Reached by Clinician Workgroup

PQRS and PQRS-based programs:

- **X3776 Consideration of Non-Pharmacologic Interventions**
- **X3792 Controlling High Blood Pressure**

Cost measures for the Value Based Payment Modifier:

- **X0351 Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure**
- **X0355 Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure**

Measures Identified for Discussion: PQRS and PQRS-based programs

- **X3283 Closing the Referral Loop - Critical Information Communicated with Request for Referral**
- **X3053 Functional Status Assessments and Goal Setting for Chronic Pain Due to Osteoarthritis**
- **X3475 Substance Use Screening and Intervention Composite**
- **X3482 Functional Status Outcomes for Patients Receiving Primary Total Knee Replacements**
- **X3773 Optimal Asthma Care 2014**
- **X3802 Appropriate follow-up imaging for non-traumatic knee pain**
- **X3803 Appropriate use of imaging for non-traumatic shoulder pain**

Measures Identified for Discussion: Physician feedback/ QRURs

- **X0354 Cellulitis Clinical Episode-Based Payment Measure**
- **X0355 Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure**
- **X0351 Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure**
- **X0356 Hip Replacement/ Revision Clinical Episode-Based Payment Measure**
- **X0352 Knee Replacement/ Revision Clinical Episode-Based Payment Measure**
- **X0353 Spine Fusion/ Refusion Clinical Episode-Based Payment Measure**

Measures Identified for Discussion: Physician Value Based Payment Modifier

- **X0354 Cellulitis Clinical Episode-Based Payment Measure**
- **X0356 Hip Replacement/ Revision Clinical Episode-Based Payment Measure**
- **X0352 Knee Replacement/ Revision Clinical Episode-Based Payment Measure**
- **X0353 Spine Fusion/ Refusion Clinical Episode-Based Payment Measure**

Medicare and Medicaid EHR Incentive Program

- **Program Type**: Incentive program to promote widespread adoption of CEHRT by providers and incentivize "meaningful use" of EHRs by providers.
  - For Stage 2 (2014 and beyond): EPs must report on 9 total clinical quality measures that cover 3 of the National Quality Strategy Domains (selected from a set of 64 clinical quality measures).
  - All eMeasures are being updated to conform with newest standards for EHR measures. CMS directed MAP to consider all 32 EHR measures as "under development."
  - Alignment: 27 of the 32 eMeasures are also under consideration for PQRS

Measures Identified for Discussion: EHR Incentive Programs (Meaningful Use)

- **X3283 Closing the Referral Loop - Critical Information Communicated with Request for Referral**
- **X3053 Functional Status Assessments and Goal Setting for Chronic Pain Due to Osteoarthritis**
- **X3482 Functional Status Outcomes for Patients Receiving Primary Total Knee Replacements**

MAP Pre-Rulemaking Recommendations for Post Acute Care/Long-Term Care Programs

Medicare Shared Savings – PAC-LTC Workgroup Discussion Themes

- Identification of measures that promote primary care and care coordination among providers and support shared accountability.
- Standardization across settings for patients with multiple chronic conditions as they transition from the hospital setting to a post acute setting.

Review and Finalize Broader Guidance About Programmatic Issues

Implementation of the IMPACT Act of 2014

- The IMPACT Act is a bipartisan bill under section 1899 (B) Title XVIII of the Social Security Act.
  - Requires PAC providers to report standardized assessment data of new quality and resource use measures (e.g., total Medicare spending per beneficiary, discharge to community, and risk-adjusted hospitalization rates of potentially preventable admissions and readmissions).
  - The data is required to be interoperable to allow for its exchange among PAC and other providers to facilitate care coordination and improve Medicare beneficiary outcomes.
  - The IMPACT ACT affects PAC programs including:
    - HHA Quality Reporting Program
    - Skilled Nursing Facility Quality Reporting Program
    - IRF Quality Reporting Program
    - LTCH Quality Reporting Program

Implementation of the IMPACT Act of 2014

- The new 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
  - Proper and accurate communication of health information and care preferences when a patient is transferred.
- The Secretary of the U.S. DHHS is directed to provide confidential feedback reports to PAC providers on their performance with respect to required measures as well as to arrange for public reporting of performance results.
- The IMPACT Act is an important step toward measurement alignment and shared accountability across the healthcare continuum previously emphasized by MAP.
- MAP supported the standardizing of patient assessment data across PAC settings; however, it noted the importance of aligning measurement with other settings such as long-term care and home- and community-based services.
- MAP also recommended coordinating efforts between existing patient assessment instruments such as the IRF-Patient Assessment Instrument and the CARE tool to avoid duplication of efforts, maintain integrity of data, and reduce burden of maintaining data on different scales.

Ensuring a Person-Centered Approach to PAC/LTC Care

- MAP emphasized harmonization of measures to promote patient-centered care across PAC/LTC programs.
- Due to the heterogeneity of populations served in each setting, MAP recommended that measures be specified and applicable to specific populations.
- MAP stressed that following a person across the care continuum from facility to home-based care or beyond will allow for a better assessment of a person's outcomes and experience across time and settings.

Aligning Across Settings

- MAP continues to highlight the need to align performance measurement across PAC/LTC settings as well as with other settings to ensure comparability of performance and to facilitate information exchange.
- Shared accountability and care coordination among PAC/LTC and other care settings would allow for a better assessment of a person's outcomes and experience across time and settings.

Coordinating Committee Discussion Questions

- Does the Coordinating Committee agree with the PAC/LTC Workgroup's focus on shared accountability and alignment?
- What can MAP do to ensure the harmonization of measures across PAC/LTC settings?
- What can MAP do to promote care coordination and shared accountability?
- How can MAP encourage greater alignment across PAC/LTC programs?

Program Specific Themes

Inpatient Rehabilitation Facility Quality Reporting Program

- **Program Type:** Pay for Reporting, Public Reporting
- **Incentive Structure:** Must submit data on quality measures to receive annual payment updates, starting in FY 2014; failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year.
- **Program Goals:** Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.

Centers for Medicare and Medicaid Services. IRF Quality Reporting Program Details. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Details.html Last accessed October 2014

IPFQR Themes

- The PAC/LTC Workgroup reviewed and conditionally supported five measures addressing patient safety and functional status.
- The group conditionally supported four functional outcome measures noting they are actionable and meaningful to patients.
- The group raised concerns about potential duplicity between the CARE tool and the IRF-PAI and the burden of maintaining data on two scales.

Long-Term Care Hospital Quality Reporting Program

- **Program Type**: Pay for Reporting, Public Reporting
- **Incentive Structure**: Must submit data on quality measures in order to receive annual payment updates starting in FY 2014 ; failure to report quality data will result in a 2 percent reduction in the annual payment update.
- **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).

Centers for Medicare and Medicaid. LTCH Quality Reporting. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/ Last accessed October 2014.
FY 2012 IPPS/LTCH PPS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1 Last accessed October 2014

LTCHQR Themes

- The PAC/LTC Workgroup reviewed three measures addressing patient safety priorities for LTCHs:
  - Conditionally supported a measure addressing VTE prophylaxis
  - Encouraged further development of two measures addressing ventilator issues
    - » The group emphasized the importance of ventilator care and successful weaning to improve quality of life, decrease morbidity and mortality, and resource use

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. Payment reductions will be on a sliding scale, which could amount to a maximum of two percent per year.
- **Program Goals:** Improve the quality of dialysis care and produce better outcomes for beneficiaries.

Centers for Medicare and Medicaid Services. End Stage Renal Disease (ESRD) Center. http://www.cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center.html Last accessed October 2014.

ESRD QIP Themes

- MAP has previously recommended expanding the program measure set to include cross-cutting and person-centered measurement areas such as:
  - Care coordination
  - Medication reconciliation
  - Functional status
  - Patient engagement
- The PAC/LTC Workgroup was unable to come to consensus on a number of measures addressing medication documentation and cultural competency

Skilled Nursing Facilities Value-Based Purchasing Program

- **Protecting Access to Medicare Act (PAMA)-** Requires establishment of SNF value-based purchasing program, starting in FY 2019.
- **The Protecting Access to Medicare Act of 2014 (PAMA)-** Requires that a SNF VBP is established so that value-based incentive payments are made beginning FY 2019.
  - *A SNF all-cause and condition readmission measure shall be specified by FY 2015;*
  - *An all-cause risk adjusted resource use measure shall be specified by FY 2016.*

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 2014
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 .

SNF Value-Based Purchasing Program Themes

- This is the first year MAP has reviewed measures for this newly established program.
- The PAC/LTC Workgroup supported adding a measure addressing hospital readmissions.
  - The group noted this measure is well aligned with readmission measures used in other settings
- Some members raised concerns about potential unintended consequences such as discouraging needed hospitalizations and the exclusion of cancer patients from this measure.

Home Health Quality Reporting Program

- **Program Type:** Pay for Reporting, Public Reporting
- **Incentive Structure:** Home health agencies (HHAs) that do not submit data will receive a 2 percentage point reduction in their annual HH market basket percentage increase. Subsets of the quality measures generated from OASIS are reported on the HH Compare website.
- **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.

Centers for Medicare and Medicaid Services. Home Health Quality Reporting Requirements. July 14. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html. Last accessed October 2014.

HHQR Themes

- The PAC/LTC Workgroup reviewed one measure addressing pressure ulcers
  - This is a required domain under the IMPACT Act.
  - The group conditionally supported this measure as its harmonized with measures used in other settings.
- The group offered recommendations to enhance this measure including focusing on the consequences of not detecting a pressure ulcer and excluding hospice patients with ulcers that are unlikely to heal.

Hospice Quality Reporting Program

- **Program Type:** Pay for Reporting, Public Reporting
- **Incentive Structure:** Failure to submit required quality data, beginning in FY 2014, shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.
- **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.
- **Program Update:**
  - CMS finalized the Hospice Item Set (HIS) in last year's rule to meet the quality reporting requirement for hospices for the FY 2016 payment determination and each subsequent year.
  - CAHPS Hospice Survey has a January 1, 2015 implementation date.

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

Hospice Quality Reporting Program Themes

- There were no measures under consideration for this program this year.
- The PAC/LTC Workgroup reiterated its priorities for this program including an appropriate outcome measure for pain and measures that address timeliness/responsiveness of care, access to the healthcare team, and composite measures on communication, access, and care coordination.
- The PAC/LTC Workgroup emphasized the need to include family and caregivers in the hospice survey.

PAC/LTC Measures Requiring Vote by Coordinating Committee: Consensus not Reached by Workgroup

Consensus Not Reached: End Stage Renal Disease Quality Incentive Program

- The PAC/LTC Workgroup was unable to come to consensus on four measures under consideration for the ESRD QIP program.
- Two measures address cultural competency:
  - The group recognized the importance of cultural competency but raised concerns that the measures have limited testing in the dialysis facility setting.
  - Some members raised concerns about the burden of these measures; data would be collected through a survey administered once per year
  - Other members noted that culturally competent care improves patient engagement.
- Two measures address medication documentation:
  - The group noted the importance of medication documentation but raised concerns about the feasibility of this measure.
  - Some members felt this is a “check the box” measure but others argued it addresses an important safety priority.

End Stage Renal Disease Quality Incentive Program Consensus Not Reached

ID	Title	Decision
E0419	Documentation of Current Medications in the Medical Record	Consensus Not Reached
X3721	Medications Documentation Reporting Measure	Consensus Not Reached
E1919	Cultural Competency Implementation Measure	Consensus Not Reached
X3716	Cultural Competency Reporting Measure	Consensus Not Reached

Finalizing Workgroup Recommendations for All PAC/LTC Programs

End Stage Renal Disease Quality Incentive Program Measures Under Consideration and Recommendations

ID	Title	Decision
X2051	Delivered Dose of Dialysis Above Minimum-Composite Score	Conditional Support
X3717	Delivered Dose of Hemodialysis Above Minimum	Conditional Support
X3718	Delivered Dose of Peritoneal Dialysis Above Minimum	Conditional Support

Inpatient Rehabilitation Facility Quality Reporting Program Measures Under Consideration and Recommendations

ID	Title	Decision
S2633	IRF Functional Outcome Measure: Change in Self Care Score for Medical Rehabilitation Patients	Conditional Support
S2634	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	Conditional Support
S2635	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	Conditional Support
S2636	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	Conditional Support
E0371	Venous Thromboembolism Prophylaxis	Conditional Support

Long Term Care Hospital Quality Reporting Program Measures Under Consideration and Recommendations

ID	Title	Decision
E0371	Venous Thromboembolism Prophylaxis	Conditional Support
X3705	Compliance with Ventilator Process Elements during LTCH Stay	Encourage Continued Development
X3706	Ventilator Weaning Rate	Encourage Continued Development

Skilled Nursing Facilities Value Based Purchasing Program Measures Under Consideration and Recommendations

ID	Title	Decision
S2510	Skilled Nursing Facility All-Cause 30 Day Post Discharge Readmission Measure	Support

Home Health Quality Reporting Program
Measures Under Consideration and Recommendations

ID	Title	Decision
X3704	Percent of Patients with Pressure Ulcers That Are New or Worsened	Conditional Support

Review and Finalize Remaining Recommendations

Meeting Agenda – Day 2

- Day 1 Recap
- MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for:
  - Hospital Programs
  - Medicare Shared savings Program
- Discussion on MAP *ad hoc* review
- Round-Robin Discussion: Improving MAP's Process

MAP Pre-Rulemaking Recommendations for Hospital Programs

Review and Finalize Broader Guidance About Programmatic Issues

High-Value Measures

- Include measures that get consumers the information they need to:
  - make informed decisions about their care
  - direct them to facilities with the highest quality care
- Allow facilities to focus on the high priority aspects of healthcare where performance varies or is less than optimal
- Reduce measurement burden from data collection and reporting of performance measures

Alignment Across Programs

- Align measures across programs by focusing on comparable performance across settings and data types.
  - Care for particular conditions can be provided in settings covered by different programs, thus making it difficult to compare providers across settings if measures are not aligned.
  - Care traditionally provided in one particular care setting is now increasingly being provided in multiple care settings
- Expand existing programs to close reporting gaps for small and rural hospitals
- Align measure elements such as timelines and reporting periods
- Align results across data types

Coordinating Committee Discussion Questions

- Does the Coordinating Committee agree with the Hospital Workgroup's focus on high-value measures and alignment?
- What can MAP do to facilitate the adoption of high-value measures?
- How can MAP encourage greater alignment across hospital programs?

Program Specific Themes

Hospital Inpatient Quality Reporting Program Overview

- **Program Type:**
  - Pay-for-Reporting and Public Reporting
- **Incentive Structure:**
  - Hospitals that do not report data on the required measures will receive a 2 percent reduction in their annual Medicare payment update.
- **Program Goals:**
  - To provide an incentive for hospitals to report quality information about their services
  - To provide consumers information about hospital quality so they can make informed choices about their care

IQR Themes

- Measures under consideration begin to fill a number of previously identified gaps including maternal/child health, affordability/cost, safety culture, and adverse drug events
- HHS could look to existing measures and measures under consideration for the PPS-Exempt Cancer Hospital Quality Reporting Program, the Inpatient Psychiatric Facility Quality Reporting Program, and the Hospice Quality Reporting program to fill additional gaps in IQR and encourage alignment

IQR Themes

- There are a number of challenges in the current measurement environment:
  - Several outcome measures in the IQR program should be reviewed in the upcoming NQF trial period to determine if socio-demographic adjustment is appropriate
  - There is a need to continue to explore issues of shared accountability and attribution, particularly for measures addressing cost of care and care transitions
  - CMS should help simplify reporting through registries. For hospitals that do participate in a registry, CMS should collect data directly from the registry. For those that do not, CMS should create a pathway to allow them to submit this data directly to CMS without the cost of participation in the registry.

Hospital Value-Based Purchasing Program Overview

- **Program Type:**
  - Pay for Performance
- **Incentive Structure:**
  - Medicare bases a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing Program (VBP). Medicare began by withholding 1 percent of its regular hospital reimbursements from all hospitals paid under its inpatient prospective payment system (IPPS) to fund a pool of VBP incentive payments. The amount withheld from reimbursements increases over time:
    - FY 2015: 1.5%
    - FY 2016: 1.75%
    - FY 2017 and future fiscal years: 2%
  - Hospitals are scored based on their performance on each measure within the program relative to other hospitals as well as on how their performance on each measure has improved over time. The higher of these scores on each measure is used in determining incentive payments.
- **Program Goals:**
  - Improve healthcare quality by realigning hospitals' financial incentives.
  - Provide incentive payments to hospitals that meet or exceed performance standards.

VBP Themes

- The Workgroup recognized that measurement is a constantly changing and improving field but the group expressed caution on how revised measures are phased into the program.
  - The group reiterated the importance of public reporting before use in pay for performance programs
  - CMS should consider how updated measures are phased in to minimize confusion for providers, consumers, and purchasers trying to interpret the results of the measures

Hospital Readmissions Reduction Program Overview

- **Program Type:**
  - Pay for Performance and Public Reporting – Payments are based on information publicly reported on the Hospital Compare website.
- **Incentive Structure:**
  - Diagnosis-related group (DRG) payment rates will be reduced based on a hospital's ratio of actual to expected readmissions. The maximum payment reduction is 3 percent.
- **Program Goals:**
  - Reducing readmissions in hospitals paid under the Inpatient Prospective Payment System (IPPS), which includes more than three-quarters of all hospitals.
  - Providing consumers with information to help them make informed decisions about their health care.

HRRP Themes

- The Hospital Workgroup recommended that measures included in the HRRP should be considered in the upcoming NQF SDS trial period to review whether there is a conceptual and empirical relationship between the outcomes and SDS factors.
- The group highlighted that if measures are updated they should be evaluated through the NQF endorsement process and carefully phased into programs.

HAC Reduction Program Overview

- **Program Type:**
  - Pay-for-Performance and Public Reporting
- **Incentive Structure:**
  - The 25% of hospitals that have the highest rates of HACs (as determined by the measures in the program) will have their Medicare payments reduced by 1%.
  - The measures in the program are classified into two domains: Domain 1 includes the Patient Safety Indicator (PSI) 90 measure, a composite of eight administrative claims based measures and Domain 2 includes infection measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network (CDC NHSN).
- **Program Goals:**
  - To provide an incentive to reduce the incidence of HACs to improve both patient outcomes and the cost of care
  - To heighten awareness of HACs and eliminate the incidence of HACs that could be reasonably prevented by applying evidence-based clinical guidelines.
  - To support a broader public health imperative by helping to raise awareness and action by prompting a national discussion on this important quality problem.
  - To drive improvement for the care of Medicare beneficiaries, but also privately insured and Medicaid patients, through spill over benefits of improved care processes within hospitals.

HAC Reduction Program Themes

- The Hospital Workgroup supported updates to the NHSN CLABSI and CAUTI Measures. The group applauded improvements to the measures but cautioned that they should be implemented carefully to minimize burden and confusion.

Hospital Outpatient Quality Reporting Program Overview

- **Program Type:**
  - Pay for Reporting – Information is reported on the Hospital Compare website.
- **Incentive Structure:**
  - Hospitals that do not report data on the required measures will receive a 2 percent reduction in their annual Medicare payment update.
- **Program Goals:**
  - Establish a system for collecting and providing quality data to hospitals providing outpatient services such as clinic visits, emergency department visits, and critical care services
  - Provide consumers with quality of care information that will help them make informed decisions about their health care.

OQR Themes

- The measures under consideration begin to fill a number of previously identified gaps, especially an outpatient CAHPS module, patient reported outcomes, patient and family engagement measures, care coordination measures, and measures of ED care.
- The Workgroup expressed caution that survey measures be aligned to reduce undue burden on providers and patients.

Ambulatory Surgery Center Quality Reporting Program Overview

- **Program Type:**
  - Pay for Reporting – Performance information is current reported to the Centers for Medicare & Medicaid Services (CMS) but it is expected to be publicly available in the future.
- **Incentive Structure:**
  - Ambulatory surgical centers (ACSs) that treat Medicare beneficiaries and fail to report data will receive a 2.0 percent reduction in their annual payment update.
- **Program Goals:**
  - Promote higher quality, more efficient care for Medicare beneficiaries.
  - Establish a system for collecting and providing quality data to ASCs.
  - Provide consumers with quality of care information that will help them make informed decisions about their health care.

ASCQR Themes

- The Hospital Workgroup supported a number of measures that could begin to fill a previously identified gap around complications from procedures.
- The group encouraged continuing the development of the Outpatient/Ambulatory Surgery Patient Experience of Care Survey to begin to fill the gap around patient and family engagement.

Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs) Program Overview

- **Program Type:**
  - Pay for Reporting. The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.
- **Incentive Structure:**
  - For the Medicare Incentive program (hospitals), incentive payments began in 2011 and are comprised of an Initial Amount, Medicare Share, and Transition Factor. The CAH EHR Incentive payment is based on a formula for Allowable Costs and the Medicare Share. The Medicaid Incentive program includes an Overall EHR Amount and Medicaid Share. Medicare payment penalties will take effect in 2015 for providers who are eligible but do not participate. Payment penalties do not apply to Medicaid.
- **Program Goals:**
  - Promote widespread adoption of certified EHR technology by providers.
  - Incentivize "meaningful use" of EHRs by hospitals to:
    - Improve quality, safety, efficiency, and reduce health disparities
    - Engage patients and family
    - Improve care coordination, and population and public health
    - Maintain privacy and security of patient health information

Meaningful Use Themes

- The Hospital Workgroup supported the direction of a number of encouraging measure concepts during its 2014-2015 pre-rulemaking work.
- The group was hopeful that the collection of reliable clinical data could be enhance the existing measures to better capture patient severity as well as improve the measure reliability.

PPS-Exempt Cancer Hospital Quality Reporting Program Overview

- **Program Type:**
  - Data Reporting
- **Incentive Structure:**
  - There is currently no financial incentive for the 11 hospitals in this program to report quality measures. CMS plans to create an incentive structure in the future.
- **Program Goals:**
  - The Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program is intended to provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the inpatient prospective payment system and the Inpatient Quality Reporting Program.
  - It is also intended to encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices

PCHQR Themes

- The Hospital Workgroup conditionally supported a number of measures where the dedicated cancer centers have uniformly high rates of performance.
  - The group recognized the role these centers could play as benchmarks for general acute care hospitals providing cancer care and recommended CMS consider the adoption of these measures in the IQR program as well.
- The Hospital Workgroup noted that measures in the PCHQR set should move beyond measurement of cancer care to include cross-cutting measures as well to allow for alignment across care settings and programs.

Program Overview

- **Program Type:**
  - Pay for Reporting
- **Incentive Structure:**
  - Inpatient psychiatric hospitals or psychiatric units that do not report data on the required measures will receive a 2 percent reduction in their annual federal payment update.
- **Program Goals:**
  - Provide consumers with quality information to help inform their decisions about their healthcare options.
  - Improve the quality of inpatient psychiatric care by ensuring providers are aware of and reporting on best practices.
  - Establish a system for collecting and providing quality data for inpatient psychiatric hospitals or psychiatric units.

IPFQR Themes

- The Workgroup strongly supported the need to move beyond the measurement of psychiatric care in inpatient psychiatric facilities into measurement of other important general medical conditions that affect patients with psychiatric conditions.
- The group noted that measurement of psychiatric treatment quality should not be limited to inpatient psychiatric hospitals or psychiatric units, but rather be expanded to general medical facilities that are treating these patients as well.

Hospital Measures Requiring Vote by Coordinating Committee: Consensus not Reached by Workgroup

Consensus Not Reached: Hospital Outpatient Quality Reporting Program

- The Hospital Workgroup was unable to come to consensus on one measure under consideration for the OQR Program: E0326 Advance Care Plan
- Workgroup members broadly agreed on the importance of an advanced care plan.
  - Some members noted that all providers have a responsibility to discuss advance directives, including outpatient facilities
  - Others argued that these conversations require an ongoing provider and patient relationship . Additionally others argued this is a check the box measure and will not drive toward improved performance.
- The Workgroup did take a straw poll on this measure:
  - 39% Support; 17% Conditional Support; 43% Do Not Support.

Hospital Measures Identified for Discussion

IQR Measures Identified for Discussion

- Episode-Based Payment Measures
  - Cellulitis Clinical Episode-Based Payment Measure (MUC ID: X0354)
  - Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure (MUC ID: X0351)
  - Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure (MUC ID: X0355)
  - Spine Fusion/ Refusion Clinical Episode-Based Payment Measure (MUC ID: X0353)
- Participation in a Patient Safety Culture Survey (MUC ID: X3689)

IQR/Meaningful Use Measures for Discussion

- Adverse Drug Events: - Inappropriate Renal Dosing of Anticoagulants (MUC ID X3323)
- Timely Evaluation of High-Risk Individuals in the Emergency Department (MUC ID X1234)
- Perinatal Care Cesarean section (PC O2) Nulliparous women with a term, singleton baby in vertex position delivered by cesarean section (MUC ID: X1970)

OQR Measures Identified for Discussion

- Emergency Department Transfer Communication Measure Set
  - Administrative Communication (MUC ID: E0291)
  - Vital Signs (MUC ID: E0292)
  - Medication Information (MUC ID: E0293)
  - Patient Information (MUC ID: E0294)
  - Physician Information (MUC ID: E0295)
  - Nursing Information (MUC ID: E0296)
  - Procedures and Tests (MUC ID: E0297)

HACRP, VBP and HRRP Measures for Discussion: Updates to Measures in Payment Programs

- HACRP and VBP Measures:
  - National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome (MUC ID: S0138)
  - National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome (MUC ID: S0139)
  - Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization
- HRRP Measures:
  - Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization (MUC ID: E0506)

PCHQR Measures for Discussion

- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcusaureus (MRSA) Bacteremia Outcome Measure (MUC ID E1716)

IPFQR Measures for Discussion

- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (MUC ID: E0648)

- ***Finalizing Workgroup Recommendations for All Hospital Programs***

IQR Fully Developed MUCs and Recommendations

ID	Title	Decision
S0138	NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome	Support
S0139	NHSN Central line-associated Bloodstream Infection (CLABSI) Outcome	Support
X3689	Participation in a Patient Safety Culture Survey	Support
E0141	Patient Fall Rate	Conditional support
E0202	Falls with injury	Conditional support
E0204	Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract)	Conditional support
E0205	Nursing Hours per Patient Day	Conditional support
E0468	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization	Conditional support
E0506	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization	Conditional support
E0642	Cardiac Rehabilitation Patient Referral From an Inpatient Setting	Conditional support
E0704	Proportion of Patients Hospitalized with AMI that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Conditional support
E0705	Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Conditional support
E0708	Proportion of Patients Hospitalized with Pneumonia that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Conditional support
X0351	Kidney/Urinary Tract Infection Clinical Episode-Based Payment Measure	Conditional support
X0353	Spine Fusion/Refusion Clinical Episode-Based Payment Measure	Conditional support
X0354	Cellulitis Clinical Episode-Based Payment Measure	Conditional support
X0355	Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure	Conditional support
X3620	Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip and/or total knee arthroplasty (THA/TKA)	Conditional support
X3722	Hospital 30-day, all-cause, unplanned risk-standardized days in acute care following heart failure hospitalization	Conditional support
X3727	Hospital 30-day, all-cause, unplanned risk-standardized days in acute care following pneumonia hospitalization	Conditional support
X3728	Hospital 30-day, all-cause, unplanned risk-standardized days in acute care following acute myocardial infarction (AMI) hospitalization	Conditional support

IQR Measures Under Development and Recommendations

ID	Title	Decision
X3701	Hospital-Wide All-Cause Unplanned Readmission Hybrid eMeasure	Encourage continued development

VBP Measures Under Consideration and Recommendations

ID	Title	Decision
E1893	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Support
E0351	Death among surgical inpatients with serious, treatable complications (PSI 4)	Conditional support

OQR Measures Under Consideration and Recommendations

ID	Title	Decision
E1822	External Beam Radiotherapy for Bone Metastases	Support
E1898	Health literacy measure derived from the health literacy domain of the C-CAT	Support
X607	Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache	Conditional support
X3697	O/ASPECS Discharge and Recovery	Encourage continued development
X3698	O/ASPECS About Facility and Staff	Encourage continued development
X3699	O/ASPECS Communication	Encourage continued development
X3702	O/ASPECS Overall Facility Rating	Encourage continued development
X3703	O/ASPECS Recommend	Encourage continued development

ASCQR Measures Under Consideration and Recommendations

ID	Title	Decision
X3719	Normothermia Outcome	Conditional support
X3720	Unplanned Anterior Vitrectomy	Conditional support
E0326	Advance Care Plan	Do not support
X3697	O/ASPECS Discharge and Recovery	Encourage continued development
X3698	O/ASPECS About Facility and Staff	Encourage continued development
X3699	O/ASPECS Communication	Encourage continued development
X3702	O/ASPECS Overall Facility Rating	Encourage continued development
X3703	O/ASPECS Recommend	Encourage continued development

Meaningful Use Measures Under Development and Recommendations

ID	Title	Decision
X3701	Hospital-Wide All-Cause Unplanned Readmission Hybrid eMeasure	Encourage continued development

PCHQR Measures Under Consideration and Recommendations

ID	Title	Decision
E0431	INFLUENZA VACCINATION COVERAGE AMONG HEALTHCARE PERSONNEL	Support
E1659	Influenza Immunization	Support
E1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Support
E0219	Post breast conservation surgery irradiation	Conditional support
E0221	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	Conditional support
E0225	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	Conditional support
E1641	Hospice and Palliative Care – Treatment Preferences	Conditional support
X3629	30 Day Unplanned Readmissions for Cancer Patients	Conditional support

IPFQR Measures Under Consideration and Recommendations

ID	Title	Decision
E0647	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Support
E1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Support
E1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered. SUB-2a Alcohol Use Brief Intervention Received.	Support

MAP Pre-Rulemaking Recommendations for Medicare Shared Savings Program

Medicare Shared Savings Program- Clinician Workgroup Discussion Themes

- 107 measures reviewed by Clinician WG
- General themes:
  - Move toward a few outcome measures
  - Additional cost measures are not needed as cost incentives are embedded in the program structure
  - Measures should be broadly applicable with a population focus
  - Condition specific measures should be rolled up into composites

Medicare Shared Savings – Hospital Workgroup Discussion Themes

- MSSP measures should focus on underuse to ensure providers are not underutilizing appropriate care.
- Measures in this program should seek to improve care coordination and decrease fragmentation across the system.

Measures Identified for Discussion: Medicare Shared Savings Program

- X3283 Closing the Referral Loop - Critical Information Communicated with Request for Referral
- E2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB)
- X3482 Functional Status Outcomes for Patients Receiving Primary Total Knee Replacements
- X3053 Functional Status Assessments and Goal Setting for Chronic Pain Due to Osteoarthritis

Finalizing Workgroup Recommendations for MSSP

Discussion on Potential MAP Ad Hoc Review

Round Robin on MAP Process

Adjourn