MEASURE APPLICATIONS PARTNERSHIP

MAP 2016 Considerations for Implementing Measures in Federal Programs: Hospitals

FINAL REPORT

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NATIONAL QUALITY FORUM

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GUIDANCE ON CROSS-CUTTING ISSUES

Summary

- Performance measurement should foster better coordination across the care continuum.
- Patients and providers should engage in shared decisionmaking, and providers should ensure that care is delivered according to a patient's goals and preferences. These decisions should be clearly documented to ensure that subsequent care aligns with the patient's choices.
- MAP emphasized that access to care remains a key gap across the programs and expressed hope that quality measurement could help to illuminate this disparity in care.

The Measure Applications Partnership (MAP) reviewed measures under consideration for eight hospital and setting-specific programs:

- Hospital Inpatient Quality Reporting (IQR) and Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs) (Meaningful Use)
- Hospital Value-Based Purchasing (VBP)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Outpatient Quality Reporting (OQR)
- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

MAP's pre-rulemaking recommendations for measures in these programs reflect the MAP Measure Selection Criteria, how well the measures address the identified program goals, and the potential impact of a measure on the program measure set and on health and healthcare. Through the discussion of the individual measures across the eight programs, MAP identified several overarching issues. These overarching issues include: (1) measurement to improve quality across the patient-focused episode of care, (2) engaging the patients and their families as partners in care delivery, and (3) driving improvement for all. These themes are explored in more detail in the report.

OVERARCHING THEMES

Measurement to Improve Quality Across the Patient-Focused Episode of Care

As the healthcare system shifts to new payment models that promote shared accountability and responsibility for patient outcomes, performance measurement must keep pace. MAP recognized the need to encourage performance measurement to foster better coordination across the care continuum. MAP noted that current measures tend to focus on narrow clinical topics, but performance measurement needs to move beyond that to use measures that capture the "big picture" of the quality of care. A more integrated set of measures would provide consumers with that better overall picture of quality.

In particular, MAP noted the need for closer connections and better integration of hospitals with post-acute care and long-term care settings. The current post-acute and long-term care measures vary significantly by setting, creating confusion for consumers trying to assess where to seek ongoing care after a hospital discharge. The healthcare system needs measurement that can help spur better care coordination and data sharing to avoid unnecessary hospital readmissions. Better interconnectivity and information sharing could empower providers with more complete information about their patients, including vital information about a person's history, to help reduce errors and adverse treatment interactions. In particular, MAP called for improved electronic health record (EHR) interoperability and better links to information held by payers. The availability of data from other sites of care was an issue across the settings reviewed by the Hospital Workgroup.

MAP noted that access to community supports and care in the community can have significant impact on people's ability to manage their care at home and prevent readmissions. MAP also acknowledged that the degree of access to beneficial community supports and care may vary substantially by socioeconomic status and place of residence. In addition, MAP recognized that while healthcare providers have a responsibility to support their patients during their recovery, there are limits to what providers can do. MAP looks to NQF's trial period on risk adjustment for sociodemographic (SDS) factors to provide guidance on how to balance this responsibility while not unfairly penalizing providers who are providing care for the most vulnerable populations. Public comments echoed concerns about the potential impact of SDS factors on performance results and supported the need for a strong trial period. Commenters noted the impact that social determinants can have on hospital performance and stressed the need to measure hospitals on factors they can control.

MAP stressed that all providers have a responsibility to care for the whole person. Because of this, MAP pointed out that providers such as dialysis facilities and outpatient chemotherapy clinics have a responsibility to provide holistic care, not just to manage one diagnosis. Additionally, MAP emphasized the need for specialized providers to connect back with a patient's primary care provider or to help them establish a source of ongoing primary care support.

MAP underscored the importance of *strategic, cross-cutting* measurement, as having a large number of measures in each program can dilute their individual impact. More integrated measurement that assesses quality across the system could help to ensure high-value information for all stakeholders. Public commenters stressed the need for MAP to drive towards a parsimonious set of measures, within and across programs. Commenters stated that

this would help to emphasize measurement of what is most important and to reduce rewards or penalities for the same event or patient across programs.

Engaging Patients and Families as Partners in Care

Engaging patients and their families as partners in care delivery has been a critical objective for MAP and a high-priority domain across all programs. MAP noted ways in which measurement can help to address this essential issue. MAP stressed the importance of shared decisionmaking with patients and their families. It also expressed that providers should commit to supporting their patients' decisions. Subsequently, providers should clearly document a person's goals and preferences and make sure follow-up care reflects those decisions.

Patients, too, have a role in improving care delivery: MAP thus acknowledged patient accountability and the importance of helping patients take responsibility for their own healthcare. However, MAP did caution that people vary in their ability and desire to engage fully in their own care, so providers may need to adjust their approach to care accordingly. MAP stressed the need for providers to build relationships with patients and families as well as within communities to help patients manage their own care after discharge.

Providing patients and their families with the information they need to make informed choices for their care is a priority for MAP. When reviewing measures under consideration, MAP focused on consumers and asked: What information would be truly meaningful? What would help a consumer choose a provider? What outcomes do people really care about? Guided by this consumer focus, MAP recommended a number of measures addressing outcomes, such as safety or mortality. MAP also emphasized the need to move beyond these measures and to start addressing issues such as patient activation, goals, and quality of life.

Driving Improvement for All

MAP believes that CMS has a responsibility to improve care for all Americans, not just those covered by Medicare or Medicaid. MAP noted a need to expand the populations covered by the programs reviewed by the Hospital Workgroup. In particular, there is a need for better measures of perinatal and pediatric care as these patients represent almost 25 percent of hospital discharges.[a] MAP noted that programs such as the Inpatient Quality Reporting (IQR) program and the Hospital Outpatient Quality Reporting (OQR) program do not cover key services provided by hospitals, such as obstetrical services and primary care clinics. Including broader populations could help more consumers, purchasers, and payers with related decisionmaking and could give providers information to help them improve care for all. Commenters noted the special needs of pediatric populations and the need to consider the applicability of any risk adjustment model to pediatric populations and facilities.

MAP reiterated that a key goal of publicly reporting quality information is to provide consumers with information about provider quality so they can make informed choices about where to seek care. MAP noted the need for a global measure of harm to provide better information about safety issues. An all-cause measure of harm could be more informative to consumers and more readily accessible to hospitals for improving care. However, concerns have been raised that such a measure would not support quality improvement opportunities. Finally, MAP noted its concerns that access to care remains a key gap across the programs and expressed hope that quality measurement could help to illuminate these disparities in care. Commenters noted that a holistic review of each program by MAP could help to ensure new measures add value and are useful to consumers and do not overburden providers.

a Childbirth Connection. United States maternity care facts and figures website. http://transform.childbirthconnection.org/resources/datacenter/factsandfigures/. Last accessed December 2015.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

Inpatient Quality Reporting Program (IQR)/Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (Meaningful Use)

The Hospital Inpatient Quality Reporting Program (IQR) is a pay-for-reporting and public reporting program that requires hospitals paid under the Inpatient Prospective Payment System (IPPS) to report on process, structure, outcomes, patient perspectives on care, efficiency, and costs of care measures. The program has two goals: (1) to provide an incentive for hospitals to report quality information about their services, and (2) to provide consumers information about hospital quality so they can make informed choices about their care.

In its 2015-2016 pre-rulemaking deliberations, MAP discussed key strategic issues for the IQR program including resource use versus appropriateness of care, the reliability and validity of data extracted from EHRs, measuring more meaningful outcomes in stroke patients such as impaired capacity, and the roles of hospitals within their communities to influence health, wellness, and readmissions. MAP did not support adding four clinical episode-based payment measures for aortic aneurysm procedure, cholecystectomy and common duct exploration, spinal fusion, and transurethral resection of the prostate (TURP) for benign prostatic hyperplasia. MAP agreed that resource use is important to measure but noted that data supporting variation in resource use for these procedures was not provided. MAP also noted that measuring resource use does not provide clear information on the appropriateness of care; resource use does not indicate quality care.

MAP did not support IQI-22: Vaginal Birth after Cesarean (VBAC) Delivery Rate, Uncomplicated (MUC15-1083). While MAP was pleased that a measure addressing the non-Medicare population was on the measures under consideration (MUC) list, they agreed that the measure added little value to this measure set because, for this program, VBAC rates would be calculated using CMS claims data. MAP strongly supported an all-payer and/Medicaid version of this measure for the program.

MAP conditionally supported the Risk-Standardized Acute Ischemic Stroke Mortality measure that is calculated using administrative claims only, and the version of the measure that is calculated using claims plus EHR data (hybrid). MAP did not support the version of the measure that was calculated using EHR-only data since it did not perform as well during testing as the other two versions of the measure. In addition, MAP asked CMS to consider a phased approach when implementing the hybrid version of the measure to avoid multiple versions of the same measure in the program. MAP also noted that mortality is not the most meaningful outcome for this population and suggested that CMS consider other outcomes for this population such as impaired capacity.

MAP also conditionally supported four new measures for this program. MAP recognized the importance of a community-based approach to decrease smoking, and therefore encouraged further development of the Adult Local Current Smoking Prevalence (MUC15-1013) measure, which will provide smoking prevalence rates at the city and/or county level. This type of measure indicates the need for hospital collaboration with the surrounding community to work together to provide smoking cessation. However, MAP noted that SDS factors, attribution, and community needs should be considered during the development of this measure. MAP conditionally supported the addition of INR monitoring for Individuals on Warfarin after Hospital Discharge (MUC-1015) as an optional eCQM pathway and suggested that

its performance be monitored. MAP recognized that this is an important patient safety issue, but recommended that it be optional for hospitals because, initially, not all vendors may be able to support the implementation of this measure. MAP also encouraged the development of INR control measures rather than process measures.

MAP conditionally supported the update to Excess Days in Acute Care after Hospitalization for Pneumonia (MUC15-391). This measure was expanded to include patients with a principal discharge diagnosis of aspiration pneumonia and sepsis with an accompanying secondary diagnosis of pneumonia that is present on admission. The updated measure aligns with NQF #0468 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization and NQF #0506 Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization. MAP supported the MUC15-391 measure on the condition that it be reviewed and endorsed by NQF. MAP also suggested that SDS factors that examine the hospital versus community role in readmissions be considered when the NQF Standing Committee reviews the measure. Lastly, MAP suggested that CMS consider parsimony with regard to multiple pneumonia readmission measures.

MAP conditionally supported CDC's National Healthcare Safety Network (NHSN) Antimicrobial Use Measure (MUC15-531) because they recognized the high importance of antimicrobial stewardship. The Centers for Disease Control and Prevention (CDC) stressed the need to gain more experience with the measure and that it should not yet be used for public reporting or payment. The inclusion of this measure in the IQR program will allow for the opportunity for additional testing to address feasibility issues, risk adjustment, and the issue of amount of antibiotics used versus appropriate use of antibiotics used. MAP acknowledged that this was a first step for effective antibiotic use in hospitals, and as part of their conditional support for inclusion of this measure, asked that CMS collaborate with the CDC to determine when the measure is ready to be used for public reporting and payment and bring the measure back to the MAP for discussion at that time.

Finally, MAP supported the updates to Patient Safety for Selected Indicators/AHRQ Patient Safety Indicator Composite (MUC15-604), previously known as PSI-90 and the American College of Surgeons–Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (MUC15-534). Changes were made to the Patient Safety and Adverse Events Composite to address concerns raised by the NQF Patient Safety Standing Committee. Three additional Patient Safety Indicators (PSIs) have been added to the measure. Two of the component PSIs were redesigned: PSI 12 with the removal of isolated calf deep vein thromboses (DVT) which have limited clinical relevance and PSI 15 with a greater focus on accidental punctures and lacerations that occur during abdominal/pelvic surgery and those that result in re-operation within one day which reflect events that are more likely preventable. PSIs were better linked to important changes in clinical status with "harm weights" that are based on diagnoses that were assigned after the complication. This is intended to allow the measure to reflect the impact of the events more accurately. The SSI measure was updated to change the risk-adjustment methodology from the basic standard infection ratio (SIR) to the adjusted ranking metric.

MAP noted that the measurement gaps identified by CMS in the **Program Specific Measure Priorities and Needs**[b] document as high-priority topics/areas for future measure consideration do not address the high-priority domains. Gap areas

b Center for Clinical Standards and Quality. *2015 Measures under Consideration List. Program Specific Measure Priorities and Needs.* Baltimore, MD: Centers for Medicare & Medicaid Services (CMS); 2015:25-26. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/Program-Specific-Measure-Priorities-and-Needs.pdf. Last accessed January 2016.

identified by MAP include obstetrics, pediatrics, and measures addressing the cost of drugs, particularly specialty drugs. MAP also discussed the need for an all-harm or global-harm eMeasure that would provide the public with more useful information about overall hospital care. This type of measure would provide hospitals with more readily accessible data on their performance rather than waiting for data from claims-based measures.

Overall, the majority of the comments received agreed with MAP's preliminary recommendations. However, several commenters disagreed with MAP's recommendation to encourage further development of the Adult Local Current Smoking Prevalence measure as an accountability measure in the IQR program. Commenters agreed that smoking is an ongoing public health issue and that hospitals may play a role in reducing smoking prevalence in their communities but the commenters raised several concerns. Some of these concerns include the impact of sociodemographic (SDS) factors, attribution, and factors beyond the hospital's control (e.g., excise taxes, public smoking laws, access to smoking cessation medications/counseling, etc.). Another commenter expressed concern about the development of a new measure that only addresses "smoking" status rather than "tobacco use" which includes the use of both smokeless tobacco and smoked tobacco products.

Another set of comments received expressed concern with accurately collecting and reporting data via electronic health records (EHRs) and holding hospitals accountable for INR monitoring following hospital discharge.

The majority of the comments supported MAP's recommendation to conditionally support the National Healthcare Safety Network (NHSN) Antimicrobial Use measure. A few commenters did not support the inclusion of this measure in the program because it is intended for surveillance and internal quality improvement efforts. Commenters also stated that this measure is not appropriate for accountability purposes at this time due to the limited experience with the measure.

Some commenters agreed that the changes to the Patient Safety and Adverse Events Composite (PSI-90) are an improvement over the existing measure, but an overall concern with using claims data to determine patient safety events continues. Commenters also noted that little is known about how the measure's changes will affect a hospital's performance; therefore, the measure should be implemented in IQR prior to including it in payment programs. Another commenter urged CMS to remove the measure from its programs altogether.

Commenters agreed that mortality is not the most meaningful outcome for stroke patients and noted a preference for measures assessing cognitive and functional outcomes. Commenters also supported the developer's efforts to improve the Hospital 30-Day Mortality Following Acute Ischemic Stroke Hospitalization measure by adjusting for stroke severity. Concerns with the measure as proposed state that the use of 30-day mortality measures can inhibit the use of palliative care services and fail to accommodate the wishes of patients who prefer death over prolonged life-sustaining treatment. There were also concerns with the ability to accurately obtain data from an electronic health record (EHR).

Commenters disagreed with the inclusion of Excess Days in Acute Care after Hospitalization for Pneumonia and Hospital-Level, Risk-Standardized 30-Day Episode-of-Care Payment Measure for Pneumonia in IQR. In general, the commenters expressed concerns about these measures overlapping with the pneumonia readmissions measure and the Medicare Spending Per Beneficiary measure, thereby penalizing hospitals twice for the same admission.

Hospital Value-Based Purchasing (VBP)

The Hospital Value-Based Purchasing (VBP) program is a pay-for-reporting program. A portion of hospital reimbursement is withheld and used to fund a pool of incentive payments that hospitals can earn back over time. The goals of this program are to improve quality by realigning financial incentives and to provide incentive payments to providers that meet or exceed performance standards.

In its 2015-2016 pre-rulemaking deliberations, MAP discussed key strategic issues for the VBP program, including whether to support the addition of condition-specific cost-of-care measures, how to make updates to the methodology of measures in a pay-for-performance program, and the appropriateness of mortality measures for the program. MAP did not support adding seven measures addressing cost of care, noting that they overlapped with the statutorily required Medicare Spending Per Beneficiary (MSBP) measure currently in the program. MAP agreed that only reporting the overarching measure prevents rewarding or penalizing a hospital multiple times for the same episode, while maintaining parsimony in the measure set. MAP also raised concerns that variation in performance on these measures may be driven by post-acute care costs.

Public comments supported MAP's recommendations on these measures. Commenters shared a number of the concerns that MAP raised. First, commenters noted that many of of the cost measures reviewed by MAP were not fully tested or specified, making it challenging for MAP to make a sound recommendation. Additionally, commenters shared MAP's rationale that the cost measures under consideration overlap with the MSPB measure and would create unnecessary duplication.

MAP discussed the updates to the ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure and the Patient Safety and Adverse Events Composite (formerly known as PSI 90) (see previous section). MAP noted that the updated versions of both measures were improvements over the version currently in the program. However, MAP cautioned that revisions to measures in payment programs should be done carefully and that CMS should work with providers and the public to help them understand the inevitable shifts in performance that will come from the use of the revised measures. MAP also noted the importance of safety measures for the VBP program, as progress in reducing hospital-acquired conditions has been slow, and reiterated the need to move beyond the current safety measures.

Public commenters raised a number of concerns about the use of the Patient Safety and Adverse Events Composite in the VBP program. Commenters noted that performance of the new measure is unknown, and more information is needed before it is used in payment programs. Commenters raised concerns about the limits of claims data, in particular around the calculation of PSI-15, one of the component measures in the composite. The majority of commenters agreed with MAP's recommendation that the updated measure be implemented in payment programs after being included in the IQR program. However, some commenters expressed concerns with the updates to the measure and requested that CMS remove this measure from its quality initiative programs.

The majority of commenters supported MAP's recommendation that the updated version of the ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure be implemented in the VBP program after successful NQF review. Commenters noted that the measure should only be included in VBP after one year of successful reporting in IQR. One commenter did not agree with MAP's recommendation noting that this measure uses self-reported data and may be too variable for accountability programs.

Finally, MAP supported a measure addressing Hospital 30-Day, All-Cause, Risk-Standardized

Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery. MAP recognized that mortality after heart surgery is an extremely important metric but raised concerns with the measure. MAP cautioned that this measure could cause providers to hesitate to refer patients to palliative care and that the end point of 30 days could create perverse incentives. Ultimately, MAP decided that the benefits of this measure outweighed the risk of these potential negative consequences.

Public comments were split on this measure. Some commenters supported MAP's decision and rationale. However, others raised concerns that the use of 30-day mortality measures can inhibit the use of palliative care services and may fail to accommodate the wishes of the patient, noting that including this measure in a payment program may exacerbate these issues. Commenters stressed that if the measure is included in the program, there should be an exclusion for both hospice patients and those who opt to receive primarily palliative care. Commenters also noted that this measure should be risk-adjusted for socioeconomic factors before being included in VBP.

MAP has previously argued for a parsimonious measure set for the VBP to ensure that performance on each measure weighs heavily into the program's payment incentives. However, MAP agreed with the measure gaps identified by CMS, including adverse drug events, behavioral health, cancer, care transitions, palliative and end-of-life care, and medication reconciliation. MAP noted the importance of balancing the needs of all stakeholders while maintaining the impact of the measures in the program.

Hospital-Acquired Condition Reduction Program (HACRP)

The Hospital-Acquired Condition Reduction Program (HACRP) is a pay-for-performance and public reporting program that aims to provide an incentive to reduce the incidence of hospital-acquired conditions (HACs) to improve both the cost of care and patient outcomes. Since December 2014, HAC scores have been reported on the Hospital Compare website. Hospitals with the highest rates of HACs will have their Medicare payments reduced by 1 percent.

In its 2015-2016 pre-rulemaking deliberations, MAP discussed updates to two measures currently in the program, the ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure and the Patient Safety and Adverse Events Composite. While MAP acknowledged that the updated versions of both measures were improvements over the versions currently in the program, it cautioned that revisions to measures in payment programs should be done carefully. Additionally, MAP encouraged CMS to provide information to both providers and the public on the changes in measure specifications and how these differences may affect performance scores. This would help users understand that changes in performance may be partially related to revisions in the specifications, rather than just provider performance changes.

MAP agreed with the measure gaps identified by CMS and emphasized a few additional gap areas for the program. These include measures on what hospitals are doing to prevent adverse drug events, pressure ulcers, falls with harm, and acute renal failure in the hospital. A few members also expressed the importance of a general surgical site infection measure instead of procedure-specific measures.

While some public commenters supported MAP's recommendations, others dissented due to their concerns regarding the Patient Safety and Adverse Events Composite. Commenters expressed that not enough is known about the measure changes and their ability to alter hospital performance. One commenter did not favor MAP's recommendation on the SSI measure due to the variability in the NHSN data set, thus expressing that the measure should not be used for accountability purposes.

Hospital Outpatient Quality Reporting (OQR)

The Hospital Outpatient Quality Reporting Program (OQR) is a pay-for-reporting program that aims to establish a system for collecting and providing quality data to hospitals providing outpatient services, and help consumers make informed decisions by providing quality-of-care information.

In the 2015-2016 pre-rulemaking deliberations, MAP supported two new admissions measures for inclusion in OQR, targeted to fill the communication and care coordination measurement gap. MAP advised that the measure of admissions and emergency department visits for patients receiving outpatient chemotherapy must undergo review and endorsement by NQF, with a special consideration for the Committee to consider the exclusion and risk-adjustment choices made in development. MAP cautioned that while this measure is appropriate in a pay-for-reporting program, the measure may not yet be appropriate for inclusion in a pay-for-performance program where providers may be penalized, as performance on this measure may not always be definitively attributed to a single provider.

The measure of risk-standardized hospital visits within seven days of hospital outpatient surgery underwent endorsement in 2015, and the measure developer provided a rationale for excluding sociodemographic adjustment from the measure. MAP supported this measure, although some advised that the rationale for sociodemographic adjustment be re-examined as part of the measure maintenance process. MAP noted the potential for both measures to drive efforts to increase patient activation, and suggested that NQF consider offering performance guidance to nonmedical providers of transition or other care coordination services.

MAP agreed with gaps in the OQR measure set identified by CMS, placing a particular emphasis on patient and family engagement and communication and care coordination among multiple providers. MAP also cited the importance of measures of high-volume outpatient services, including screening and primary care visits. MAP noted the importance of recognizing patients and families as care partners to drive shared decisionmaking and support for patients as they navigate multiple providers. MAP encouraged new measure development to assess the success of that partnership, citing the Patient Activation Measure (PAM) developed at the University of Oregon as an example. The PAM was recommended for NQF endorsement in December 2015 by the Person- and Family-Centered Care Committee during its off-cycle review phase.

Public comments on MAP's recommendations cautioned that admissions measures may affect treatment decisions, particularly for cancer patients. Public comments concurred with MAP's recommendation that risk-adjustment strategies be carefully considered prior to implementation.

Ambulatory Surgical Center Quality Reporting (ASCQR)

The Ambulatory Surgical Center Quality Reporting (ASCQR) program is a pay-for-reporting program that aims to promote higher-quality, more efficient care for Medicare beneficiaries, to establish a system for collecting and providing quality data to ambulatory surgical centers, and to provide consumers with quality-of-care information that will help them make informed decisions about their healthcare.

The measure under consideration for the 2015-2016 pre-rulemaking cycle targeted the gap in measures of surgical complications. The measure, Toxic Anterior Segment Syndrome (TASS) Outcome, reports rates of a complication of surgery performed on the anterior segment of the eye (typically to repair cataracts). MAP noted that the millions of cataracts surgeries performed annually, combined with the clustering outbreak-type incidence of TASS and the emergence of new providers in the space, lended urgency to

implementing the measure in the ASCQR program. However, MAP cautioned that the measure should first undergo the NQF Consensus Development Process (CDP) to ensure that it meets the criteria of scientific validity and reliability before being resubmitted to MAP for evaluation.

MAP concurred with the priority measure gap areas for the ASCQR program identified by CMS, and stressed its support for adding measures of surgical quality, including both site infections and complications, and measures of patient and family engagement.

Public comments supported MAP's recommendation, noting the concordance of the measure with recently published professional guidelines and the potential to better understand the prevalence of TASS.

Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)

The Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) program is a voluntary quality data reporting program. These data are published on Hospital Compare. The goal is to provide information about the quality of care that is provided in cancer hospitals, specifically the 11 facilities that are exempt from the inpatient prospective payment system and the inpatient quality reporting program.

In its 2015-2016 pre-rulemaking deliberations, MAP conditionally supported five measures, of which four are updates to measures for continued inclusion in the PCHQR program. These four measures include:

- ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure,
- National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium Difficile Infection (CDI) Outcome Measure,
- NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure, and
- Oncology: Radiation Dose Limits to Normal Tissues.

More detail on each update can be found in the **MAP 2016 Final Recommendations to HHS and CMS (XLSX)**. Additionally, MAP advised and conditionally supported that the measure of admissions and emergency department visits for patients receiving outpatient chemotherapy must undergo review and endorsement by NQF, with a special consideration from the CDP Standing Committee of the exclusions and risk-adjustment methods.

MAP agreed with the priority measure gap areas identified by CMS for the PCHQR program. One additional gap area that MAP recommended was quality-of-life measures for patients with cancer, which could help improve the care provided. The measures reviewed in this pre-rulemaking cycle would help to fill the care coordination and quality-of-life measurement gap. MAP emphasized that many cancer patients are treated in general hospitals, and not in cancer-specialty hospitals. For this reason, MAP encouraged better symmetry between this program and the IQR program to help improve the overall quality of care for cancer patients in all settings.

MAP received a number of public comments supporting its recommendations for measures in the PCHQR program. A few commenters indicated their concerns about the absence of detailed measure specifications on the Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy measure. Commenters expressed that there could be potential unintended consequences if the measure were implemented without proper testing and validation and encouraged MAP not to support the measure.

Inpatient Psychiatric Facility Quality Reporting (IPFQR)

The Inpatient Psychiatric Facility Quality Reporting Program is a pay-for-reporting program established to provide information on the quality of care provided in psychiatric hospitals or inpatient psychiatric units. This program aims to provide consumers with information to help inform their decisions, to improve quality of care by ensuring that providers are aware of and are reporting on best practices, and to establish a system for collecting and providing quality data for inpatient psychiatric hospitals and inpatient psychiatric units.

In its 2015-2016 pre-rulemaking deliberations, MAP reviewed two measures for the IPFQR program. MAP supported the addition of the Substance Use Core Measure Set (SUB)-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge. In doing so, MAP indicated that this measure addresses a critical area that is often overlooked. MAP noted that substance use issues are often accepted as part of mental illness and can be a key driver of readmissions for patients with psychiatric disorders. MAP also recognized the need to move quickly from addressing processes to assessing outcomes. MAP noted that this measure could help to fill a key gap area in the IQR program.

MAP received a number of public comments about its recommendations on this measure. The majority of commenters supported MAP's recommendation to support the addition of this measure. Comments received from the measure steward clarified that the measure should not be expanded to patients under 18 years of age because the evidence base does not support the use of pharmacological agents for younger patients as these medications have not been approved for use with these patients. Commenters also suggested some potential updates to the measure noting that patients who do not have active substance use issues or who are discharged to home or another healthcare facility for hospice care should be excluded from the measure.

Additionally, MAP conditionally supported the Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF). MAP noted that this measure should be submitted to NQF for review and endorsement with particular attention paid to issues related to sociodemographic status, especially access to community-based support. Public commenters agreed with these recommendations, but stressed the need to consider the impact of sociodemographic factors, particularly access to community resources. One commenter also noted that the unplanned readmission algorithm should be refined to include additional conditions.

MAP found gaps in the current set of measures used in the IPFQR program. MAP stressed the need for better measures addressing substance abuse, in particular abuse of alcohol, tobacco, and opioids. MAP also recognized the need for measures assessing connections to care in the community, especially measures that assess if a patient is connected to a primary care provider. MAP noted that psychiatric care is an area where there is a particular need to break down care silos and better integrate inpatient and outpatient care. MAP stressed the need to align psychiatric care with the rest of the care continuum. Finally, MAP noted the need for measures addressing avoidable and readmissions as well as emergency department visits.

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

The End-Stage Renal Disease Quality Incentive Program (ESRD QIP) is a pay-for-performance and public reporting program established to promote high-quality services in outpatient dialysis facilities treating patients with ESRD.

In its 2015-2016 pre-rulemaking deliberations, MAP considered seven measures for the ESRD

QIP program. MAP supported the inclusion of Avoidance of Utilization of High Ultrafiltration Rate (≥ 13 ml/kg/hour)(NQF #2701) (MUC 15-758). MAP also supported updates to two additional measures, Standardized Hospitalization Ratio – Modified (NQF #1463) (MUC15-693) and Standardized Readmission Ratio (SRR) for Dialysis Facilities (NQF #2496) (MUC15-1167) with the condition that NQF review and endorse the measure updates and examine SDS factors as part of the review.

MAP did not support the inclusion of ESRD Vaccination: Full-Season Influenza Vaccination (MUC15-761) because there is already an NQF-endorsed influenza vaccination claims-based measure available. MAP did not support the inclusion of Proportion of Patients with Hypercalcemia (NQF #1454) (MUC15-1165) and Measurement of Phosphorous Concentration (NQF #0255) (MUC15-1136) because these measures were recently reviewed by the NQF Renal Standing Committee and were recommended for reserve status because the measures have "topped out." MAP determined that measuring hypercalcemia in this population for a pay-for-performance and public reporting program may not be as meaningful to patients, because almost all dialysis patients have calcium levels below the target level. MAP also noted that the phosphorous measure does not align with the guidelines that recommend measuring phosphorous levels every one to three months rather than monthly. Finally, MAP did not support Standardized Mortality Ratio – Modified (MUC15-575). Some members noted that reporting mortality rates, rather than ratios, would be more meaningful to consumers and actionable for facilities. MAP also discussed the need to include hospice after the start of dialysis as an exclusion in the future, because patients sometimes undergo a trial period of three to four months of dialysis before deciding to stop treatment.

MAP identified several gap areas including fluid management, infection, vascular access, patient-centered care, and medical therapy management.

MAP also discussed reviewing the list of quality measures used in the ESRD Seamless Care Organization (ESCO) to determine if measures from that program should be considered for ESRD QIP. The ESRD ESCO measures focus on patient safety, person- and caregiver-centered experience and outcomes, communication and care coordination, clinical quality care, and population health.

Overall, the majority of the commenters supported MAP's recommendations. A few commenters disagreed with MAP's decision to conditionally support the Standardized Readmission Ratio for Dialysis Facilities measure because the information provided lacked the specificity required to evaluate the measure fully. Another commenter expressed concern with measuring readmissions without considering the risk of death. Another set of comments expressed concerns with the quality of the studies that informed the Measurement of Phosphorous Concentration measure and the Avoidance of Utilization of High Ultrafiltration measure.

APPENDIX A:
Program Summaries

The material in this appendix was drawn from the CMS Program Specific Measure Priorities and Needs document, which was released in May 2015.

Inpatient Quality Reporting Program (IQR) and Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs

Program Type

Pay for Reporting and Public Reporting. A subset of the measures in the program is publicly reported on the Hospital Compare website. 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

CMS is aligning the Hospital IQR with the EHR Incentive Programs to allow hospitals to submit unified measures through a single submission method. Hospitals receive one-quarter of the applicable percentage point of the annual market basket (AMB) payment update. Hospitals that choose not to participate in the program also receive a reduction by that same amount. Hospitals that do not report data on the required measures will receive a 2 percent reduction in their annual Medicare payment update.

Eligible hospitals and CAHs are required to report on electronically specified clinical quality measures (eCQMs) using certified electronic health record (EHR) technology (CEHRT) in order to qualify for incentive payments. As of 2015, eligible hospitals that do not demonstrate meaningful use will be subject to a payment reduction of three-quarters of the applicable percentage point of the annual market basket (AMB) payment update.

Program Goals

- Provide an incentive for hospitals to publicly report quality information about their services.
- Provide consumers information about hospital quality so they can make informed choices about their care.
- 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

Hospital Value-Based Purchasing Program

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 2016: 1.75 percent
- FY 2017 and future fiscal years: 2 percent

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.

Measures selected for the VBP program must be included in IQR and reported on the Hospital Compare website for at least 1 year prior to use in the VBP program.

Program Goals

- Improve healthcare quality by realigning hospitals' financial incentives.
- Provide incentive payments to hospitals that meet or exceed performance standards.

Hospital-Acquired Condition (HAC) Reduction Program

Program Type

Pay for Performance and Public Reporting. HAC scores are reported on the Hospital Compare website as of December 2014.

Incentive Structure

- The 25 percent 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 percent.
- The measures in the program are classified into two domains: Domain 1 includes the Patient Safety Indicator (PSI) 90 measure, a composite of 10 administrative claims-based measures, and domain 2 includes infection measures developed by the Centers for Disease Control and Prevention's National Health Safety Network (CDC NHSN).

Program Goals

- Provide an incentive to reduce the incidence of HACs to both improve patient outcomes and reduce the cost of care.
- Heighten awareness of HACs and eliminate the incidence of HACs that could be reasonably prevented by applying evidence-based clinical guidelines.
- Support a broader public health imperative by helping to raise awareness and action by prompting a national discussion on this important quality problem.
- 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.

Hospital Outpatient Quality Reporting Program

Program Type

Pay for Reporting. Information on measures 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 healthcare.

Ambulatory Surgical Center Quality Reporting Program

Program Type

Pay for Reporting. Performance information is currently reported to the Centers for Medicare & Medicaid Services (CMS), but it is expected to be publicly reported on Hospital Compare in Spring 2016.

Incentive Structure

Ambulatory surgical centers (ACSs) that treat Medicare beneficiaries and fail to report data will receive a 2 percent reduction in their annual payment update. The program includes ASCs operating exclusively to provide surgical services to patients not requiring hospitalization.

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 healthcare.

Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program

Program Type

Public Reporting. Information was publicly reported beginning in 2014.

Incentive Structure

PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare.

Program Goals

- 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.
- 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.

Inpatient Psychiatric Facilities Quality Reporting Program

Program Type

Pay for Reporting. Information is reported on the Hospital Compare website.

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.
- The IPFQR Program applies to freestanding psychiatric hospitals, government-operated psychiatric hospitals, and distinct psychiatric units of acute-care hospitals and critical access hospitals. This program does not apply to children's hospitals, which are paid under a different system.

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 that providers are aware of and are reporting on best practices.
- Establish a system for collecting and providing quality data for inpatient psychiatric hospitals or psychiatric units.

End-Stage Renal Disease Quality Incentive Program

Program Type

Pay for Performance, Public Reporting

Incentive Structure

Under this program, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions are on a sliding scale, which could amount to a maximum of 2 percent per year. Facility performance in the End-Stage Renal Disease Quality Incentive Program (ESRD QIP) is publicly reported through three mechanisms: Performance Score Certificate (which the facility must display in a public area), the Dialysis Facility Compare website, and ESRD QIP Dialysis Facility Performance Information.

Program Goals

- Improve the quality of dialysis care and produce better outcomes for beneficiaries.

APPENDIX B:
MAP Hospital Workgroup Roster and NQF Staff

COMMITTEE CHAIRS (VOTING)

Christie Upshaw Travis, MSHHA (Co-Chair)

Ronald S. Walters, MD, MBA, MHA, MS (Co-Chair)

ORGANIZATIONAL MEMBERS (VOTING)

American Federation of Teachers Healthcare
Kelly Trautner

American Hospital Association
Nancy Foster

America's Essential Hospitals
David Engler, PhD

ASC Quality Collaboration
Donna Slosburg, BSN, LHRM, CASC

Blue Cross Blue Shield of Massachusetts
Wei Ying, MD, MS, MBA

Children's Hospital Association
Andrea Benin, MD

Geisinger Health Systems
Heather Lewis, RN

Mothers against Medical Error
Helen Haskell, MA

National Coalition for Cancer Survivorship
Shelley Fuld Nasso

National Rural Health Association
Brock Slabach, MPH, FACHE

Pharmacy Quality Alliance
Shekhar Mehta, PharmD, MS

Premier, Inc.
Leslie Schultz, PhD, RN, NEA-BC, CPHQ

Project Patient Care
Martin Hatlie, JD

Service Employees International Union
LaDawna Howard

The Society of Thoracic Surgeons
Jeff Jacobs, MD

St. Louis Area Business Health Coalition
Karen Roth, RN, MBA, CPA

INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

Gregory Alexander, PhD, RN, FAAN

Elizabeth Evans, DNP

Jack Fowler, Jr., PhD

Mitchell Levy, MD, FCCM, FCCP

Dolores L. Mitchell, BA

R. Sean Morrison, MD

Michael P. Phelan, MD, FACEP

Ann Marie Sullivan, MD

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

Agency for Healthcare Research and Quality (AHRQ)
Pamela Owens, PhD

Centers for Disease Control and Prevention (CDC)
Daniel Pollock, MD

Centers for Medicare & Medicaid Services (CMS)
Pierre Yong, MD, MPH

DUAL ELIGIBLE BENEFICIARIES WORKGROUP LIAISON (NON-VOTING)

iCare
Thomas H. Lutzow, PhD, MBA

NATIONAL QUALITY FORUM STAFF

Helen Burstin, MD, MPH
Chief Scientific Officer

Marcia Wilson, PhD, MBA
Senior Vice Present, Quality Measurement

Elisa Munthali, MPH
Vice President, Quality Measurement

Melissa Marinelarena, RN, MPA
Senior Director, Quality Measurement

Erin O'Rourke
Senior Director, Quality Measurement

Zehra Shahab, MPH
Project Manager, Quality Measurement

Jean-Luc Tilly
Project Analyst, Quality Measurement

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

www.qualityforum.org