NATIONAL QUALITY FORUM

MEASURE APPLICATIONS PARTNERSHIP

MAP 2015-2016 Considerations for Implementing Measures in Federal Programs

DRAFT FOR PUBLIC REPORT

December 2015

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I task order 18.

NATIONAL QUALITY FORUM

Considerations for Implementing Measures in Federal Programs: Guidance from Measure Applications Partnership Post-Acute Care and Long Term Care Workgroup

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Guidance on Cross-Cutting Issues

Summary

- **The IMPACT Act is encouraging alignment of assessments and measures across programs and the Measures Under Consideration (MUC) reflected the efforts CMS is making to implement the Act.**
- **The majority of MUCs continue to be early in development. The Workgroup appreciates the opportunity to provide advice and guidance and agrees the measures submitted are moving in the right direction to close gaps and address PAC/LTC core concepts. Ideally, however, the Workgroup would like additional opportunities for review of any emerging measures prior to final rule-making and implementation in programs.**
- **While the Home Health Quality Reporting Program (HH QRP) has numerous measures, the newer programs continue to have gaps in areas identified as high leverage, IMPACT Act Domains and PAC/LTC Core concepts. More globally, gaps remain in care coordination, actual transitions in care and areas that matter to patients and caregivers.**

The Measure Applications Partnership (MAP) reviewed measures under consideration for six setting-specific federal programs addressing post-acute care (PAC) and long-term care (LTC): the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), the Long-Term Care Hospital Quality Reporting Program (LTCH QRP), the Skilled Nursing Facility Quality Reporting Program (SNF QRP), the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP), the Home Health Quality Reporting Program (HH QRP), and the Hospice Quality Reporting Program (Hospice QRP).

The 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 NQF's prior work to identify families of measures. MAP also drew upon its Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement as a guide to inform pre-rulemaking review of measures for the PAC/LTC programs. In the PAC/LTC coordination strategy, the MAP defined high-leverage areas for performance measurement and identified 13 core measure concepts to address each of the high-leverage areas. In this year's pre-rulemaking work, MAP revisited their PAC/LTC core concepts to ensure they remain effective and meaningful in the rapidly changing work of post-acute and long-term care measurement.

MAP made a number of key revisions to the PAC/LTC core concepts. The group added quality of life as a highest-leverage area and identified symptom management, social determinants of health, autonomy and control and access to lower levels of care. The group stressed the need to move beyond concepts addressing processes to concepts that assess outcomes. For example, MAP updated the establishment of patient/family/caregiver goals to the achievement of patient/family/caregiver goals. Finally the group noted the need to ensure patients and their families are partners in their care and added education to help ensure they have the tools to be empowered as a core concept.

PAC/LTC Highest-Leverage Measurement Areas and Core Measure Concepts

Table 1.

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental health
Goal Attainment	• Achievement of patient/family/caregiver goals • Advanced care planning and treatment
Patient and Family Engagement	• Experience of care • Shared decision-making • Patient and family education
Care Coordination	• Effective transitions of care • Accurate transmission of information
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions
Quality of Life	• Symptom Management • Social determinants of health • Autonomy and control • Access to lower levels of care

Through the discussion of the individual measures across the six programs, MAP identified several overarching issues. These themes are explored below.

Overarching Themes

Implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act

The IMPACT Act was passed in September 2014 and requires PAC providers to report standardized patient assessment data as well as data on quality, resource use, and other measures. The standardized measures address several domains including functional status and changes in function, skin integrity and changes in skin integrity, medication reconciliation, incidence of major falls, and the accurate communication of health information and care preferences when a patient is transferred. Additionally, the IMPACT Act requires the implementation of measures to address resource use and efficiency such as total Medicare spending per beneficiary, discharge to community, and risk-adjusted hospitalization rates of potentially preventable admissions and readmissions. PAC programs affected by the IMPACT Act include the HH QRP, SNF QRP, IRF QRP and LTCH QRP.

Measures implemented to meet the requirements of the IMPACT Act are mandated to go through the application of the Pre-Rulemaking process. Measures reviewed by the MAP during this cycle addressed the following IMPACT Act measure domains:

- Medication reconciliation;
- Resource use measures, including total estimated Medicare spending per beneficiary;
- Discharge to community; and
- All-condition risk-adjusted potentially preventable hospital readmissions rates.

The IMPACT Act is an important step toward measurement alignment and shared accountability across the healthcare continuum which MAP has emphasized over the past several years. MAP supports the alignment of measurement across settings using standardized patient assessment data and acknowledges the importance of preventing duplicate efforts, maintaining data integrity, and reducing the burden of maintaining data on different scales. Both the MAP and the public recognized the challenging timelines required to meet IMPACT Act legislation, but also had a level of discomfort supporting measures with specifications that have not been fully defined, delineated or tested. Overall, the MUCs introduced represent significant progress toward promoting quality in PAC settings, but there was some caution in considering the costs per beneficiary measures as inclusive under quality, thus the MAP recommended ensuring cost measures would be considered under the concept of value.

Shared Accountability Across the Care Continuum

The IMPACT Act requires the implementation of measures to address risk-adjusted hospitalization rates of potentially preventable admissions and readmissions. The Act also requires the implementation of measures focused on discharge to community from the various PAC settings. The inclusion of both types of measures (e.g., admission, readmissions and discharge to community) in the PAC/LTC programs raises issues of shared accountability across the care continuum. MAP raised questions about the importance of incentivizing creative and improved connections in post-acute and long-term care with hospital care. In its guidance on the selection of avoidable readmission measures, MAP stressed the need to promote shared accountability, engage patients and caregivers as partners, ensure effective care transitions, and communicate effectively across transitions. In addition, the importance of recognizing the uniqueness and variability of care provided by the home health industry was highlighted. During this cycle of pre-rulemaking, MAP stressed the importance of hospitals and PAC/LTC settings working together to reduce avoidable admissions and readmissions and recognizing that discharge to community measures require further development to ensure they are defined appropriately for each setting and intended consequences.

MAP reiterated the importance of successful care transitions and noted the need for engagement by all providers in the care planning process. MAP noted that partnerships between hospitals and PAC/LTC providers are critical to successful transitions. As part of a successful transition of care, MAP has repeatedly noted the need for improved discharge planning, and to go beyond planning to the actual transition of care and meeting goals defined collaboratively between providers, patients and caregivers. MAP recognized the need for better data sharing and interoperability of data to facilitate discharge planning and transitions of care. MAP is hopeful that the requirement for standardized data elements

will help improve the discharge planning process and the successful exchange of information between acute care hospitals and PAC/LTC providers.

Considerations for Specific Programs

Inpatient Rehabilitation Facility Quality Reporting Program

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is a pay for reporting and public reporting program established under the Affordable Care Act (ACA). This program addresses the rehabilitation needs of individuals including improved functional status and return to the community post discharge. This program specifically applies to all IRF settings that receive the IRF prospective payment system (PPS) including IRF hospitals, IRF units that are co-located with affiliated acute care facilities, and IRF units affiliated with critical care access hospitals (CAH). Data sources for quality measures include Medicare Fee for Service Claims, Centers for Disease Control (CDC) National Health Safety Network (NHSN) Data, and the IRF-Patient Assessment Instrument records. As of 2014, failure to submit quality data results in a two percent reduction rate in the annual applicable IRF-PPS payment update. The data must also be made publicly available, with IRF providers having opportunity to review the data prior to its release.

In addition to the IMPACT Act domains, the Centers for Medicare and Medicaid (CMS) had identified four high priority domains and subdomains for future measure consideration to improve the IRF QRP and promote the National Quality Strategy (NQS). These high priority areas included: making care safer by reducing the rate of hospital acquired infections and conditions (i.e., catheter-associated urinary tract infections, clostridium difficile, and methicillin-resistant staphylococcus aureus), patient and family engagement with a primary focus on restoring functional status as well as measuring patient and caregiver experiences of care; making care affordable by assessing medical costs based on PAC episodes of care; and communication and care coordination. During this rule-making cycle, the focus on measurement for IRF programs was the integration of IMPACT Act requirements into the SNF QRP. In addition, CMS brought forward a measure that assesses potentially preventable within stay readmission rates. Overarching considerations raised by the MAP included encouraging CMS to ensure attribution is appropriate to the level of care that most impacts both the discharge decision and admission to the IRF.

Long-Term Care Hospital Quality Reporting Program

The Long-Term Care Hospital Quality Reporting Program (LTCH QRP) is a pay for reporting and public reporting program established under the ACA and aims to provide extended medical care to individuals with clinically complex conditions (e.g., multiple, acute, or chronic conditions needing hospital level care for periods of greater than 25 days). This program specifically applies to all LTCH facilities under the Medicare Program. As a provision of this program, LTCH providers are required to submit quality reporting data from sources such as Medicare FFS Claims, CDC NHSN data submissions, and the LTCH Continuity Assessment Record and Evaluation Data Sets (LCDS). Beginning in fiscal year 2014, failure to report quality data results in a two percent reduction in the annual PPS increase factor. The data must be made publically available with LTCHs having the opportunity to review the data prior to its release.

In addition to the IMPACT Act domains, CMS identified four high priority domains for future measure consideration to improve the LTCH QRP and align with the NQS. These domains include: effective

prevention and treatment; patient and family engagement with a primary focus on functional outcomes and patients experiences of care; making care affordable by assessing medical costs based on PAC episodes of care; and communication and care coordination. Many of these previously identified domains align with measures under consideration to meet IMPACT Act requirements. In addition to IMPACT Act focused measures, the MAP reviewed measures in development assessing ventilator weaning, compliance with spontaneous breathing trials and antipsychotic medication use in the LTCH setting. The MAP urged CMS to consider the implications of the inclusion or exclusion of patients with bipolar disorder in any of the measures focused on antipsychotic use and suggested further thought on how duration of exposure to antipsychotic medications could impact the measure specifications. The MAP recognized CMS' work on addressing the gaps in ventilator support and encouraged continued development of these measures.

Home Health Quality Reporting Program

The Home Health Quality Reporting Program (HH QRP) is a pay for reporting and public reporting program established in accordance with Section 1885 of the Social Security Act and aims to improve the quality of care provided to HH patients. The incentive structure is designed to require all HH agencies (HHA) to submit quality data from the Outcome and Assessment Information Set (OASIS) and Medicare FFS Claims. HHA's that do not comply with this incentive structure will be subject to a two percent reduction in the annual PPS increase factor. This data is made publically available through the Home Health Compare website designed to provide national ratings on the quality of HHA's.

The HH QRP is more mature as compared to other PAC settings, and while there continues to be gaps in measurement, an area of interest is ensuring a parsimonious group of measures that addresses burden to providers. While measures continue to be developed for home health, there is greater attention to retiring topped out measures and exploring opportunities to implement composite measures that utilize existing data sources. The CMS high priority domains for future measure consideration to improve the HH QRP and align with the NQS include: patient and family engagement with a focus on the quality of care in home health settings as well as functional status for home health patients; making care safer since CMS identified individuals in home based settings as high risk for major injury due to falls, new or worsened pressure ulcers, pain and functional decline; making care affordable by assessing medical costs based on PAC episodes of care; and communication and care coordination. Assessing patient care transitions and re-hospitalizations as well as infrastructure and processes for care coordination are important areas for measure development. Many of these previously identified priority domains align with the IMPACT Act and were included in the MAP deliberations for this rule-making cycle. In addition, measures assessing falls risk and improvement with dyspnea have been advancing through the development cycle for inclusion in future program iterations. Overall support for these emerging measures was received from the MAP, as well as encouragement for the strategy to continue to move toward parsimony in the QRP measure set.

Skilled Nursing Facility Quality Reporting Program

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) is a pay for reporting and public reporting program established under section 1899B of the IMPACT Act. This program requires all facilities that submit data under the SNF PPS to participate in the SNF QRP with the exception of units

affiliated with critical access hospitals. SNFs are required to submit quality data to CMS through sources including Medicare FFS Claims and the Minimum Data Set (MDS) assessment data. As of fiscal year 2018, SNFs that fail to report quality data will result in a two percent reduction in their annual payment updates.

CMS identified four high priority domains for future measure consideration for the SNF setting. These domains include: patient and family engagement with a focus on assessing functional status and functional decline for SNF residents; making care safer; making care affordable by assessing medical costs based on PAC episodes of care; and communication and care coordination. Assessing patient care transitions and re-hospitalizations as well as infrastructure and processes for care coordination continue to be important areas for measure development in the SNF QRP. The MAP had the opportunity to provide input on a number of measures under development that are intended to close gaps in the identified high priority domains in addition to the IMPACT Act. The measures considered included functional status measures aimed at assessing improvement in mobility and self-care during the SNF stay, functional status measures that assess discharge scores for mobility and self-care, antipsychotic medication utilization, pain assessment and influenza vaccination administration. Each of these measures, in addition to those in development to meet IMPACT Act requirements, promote alignment across programs as well as address high priority domains. The MAP encouraged further development of these concepts.

Skilled Nursing Facility Value-Based Purchasing Program

The Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP) was established under the Protecting Access to Medicare Act (PAMA) of 2014. Under the program, the SNF VBP per diem rate will be reduced by two percent and incentive payments will be applied to facilities based upon the readmission measure performance. The legislation mandates CMS to specify two time-limited measures:

- A SNF all-cause, all-condition hospital readmission measure, or any successor to such a measure, no later than October 1, 2015;
- A resource measure to reflect an all-condition, risk-adjusted potentially preventable hospital readmission rate for SNFs no later than October 1, 2016. This resource measure is meant to replace the all-cause all-condition readmission measure as soon as it is feasible to do so.

CMS previously identified the sole priority domain for future measure consideration to be the specification of a readmission measure. CMS lacks the authority to implement additional measures to the program at this time. As such, the MAP considered the Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measures, as required by PAMA. It was noted that readmission from the SNF setting is not an occasional occurrence and there was support for the importance of this measure.

Hospice Quality Reporting Program

The Hospice Quality Reporting Program (HQRP) is a pay for reporting and public reporting program established in accordance with section 1814(i) of the Social Security Act and amended by section 3004 of the Affordable Care Act. The HQRP applies to all hospices, regardless of setting. Under the program, hospice providers are required to submit quality data from proposed sources such as the Hospice Item

Set and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaire through which future HQRP measures can be developed. Failure to submit quality data will result in a two percent reduction to their annual payment update.

CMS previously identified three high priority domains for future measure consideration with the overall goal of developing symptom management outcome measures. The dearth of tested and endorsed outcome measures for hospices across domains of care were noted as a major gap area and a central aspect of care. CMS also identified communication and care coordination as a high priority with a special focus on the responsiveness to patient and family preferences of care. The second high priority domain is patient and family engagement addressing the needs of the individual and their family to assess the level of quality provided by the hospice setting. The third high priority domain is making care safety through timeliness and responsiveness of care. CMS noted the responsiveness of a hospice initiation of treatment once a patient has elected hospice benefits as an important indicator of quality. In order to start addressing these measurement gaps, measures under development include a measure focusing on hospice visits when death is imminent and a composite process measure. The measures were well received by the MAP with the recognition that testing is continuing. It was stressed that an important aspect in assessing quality in hospice care is determining if visits and care provided are meaningful to both the patient and the caregiver.

Appendix A: Program Summaries

Inpatient Rehabilitation Facility Quality Reporting Program

Program Type
Pay for Reporting

Incentive Structure
The IRF QRP was established under the Affordable Care Act. Beginning in FY 2014, IRFs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable IRF Prospective Payment System (PPS) payment update.

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

CMS identified the following 4 domains as high-priority for future measure consideration:

- Patient and family engagement: restoring functional status and experience of patients and caregivers
- Making Care Safer: risk for injury due to falls, new or worsened pressure ulcers, infections (e.g., CAUTI, C. Diff. and MRSA)
- Making care affordable: efficiency-based measures
- Communication and care coordination: transitions and re-hospitalizations and medication reconciliation

Long-Term Care Hospital Quality Reporting Program

Program Type
Pay for Reporting

Incentive Structure
The LTCH QRP was established under the Affordable Care Act. Beginning in FY 2014, LTCHs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable Prospective Payment System (PPS) increase factor.

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).

CMS identified the following 4 domains as high-priority for future measure consideration:

- Patient and family engagement: functional outcomes
- Effective prevention and treatment: ventilator use, ventilator-associated event and ventilator weaning rate, and mental health status

- Making care affordable: efficiency-based measures
- Communication/care coordination: transitions and re-hospitalizations and medication reconciliation

Skilled Nursing Facility Quality Reporting Program

Program Type
Pay for Reporting

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

Program Goals
CMS identified the following 4 domains as high-priority for future measure consideration:

- Patient and family engagement: Functional status and functional decline
- Making care safer: Major injury due to falls
- New or worsened pressure ulcers Making care affordable: Efficiency-based measures
- Communication and care coordination: Transitions and re-hospitalizations
- Medication reconciliation

Skilled Nursing Facility Value-Based Purchasing Program

Program Type
Pay for Performance

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

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

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

Home Health Quality Reporting Program

Program Type

Pay for Reporting

Incentive Structure

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

Program Goals

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

CMS identified the following 4 domains as high-priority for future measure consideration:

- Patient and family engagement: care preferences; functional status and functional decline
- Making care safer: major injury due to falls and new or worsened pressure ulcers
- Making care affordable: efficiency-based measures
- Communication and care coordination: transitions and re-hospitalizations and medication reconciliation

Hospice Quality Reporting Program

Program Type

Pay for Reporting

Incentive Structure

The Hospice QRP was established under the Affordable Care Act. Beginning in FY 2014, Hospices that fail to submit quality data will be subject to a 2.0 percentage point reduction to their annual payment update.

Program Goals

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

CMS identified the following 3 domains as high-priority for future measure consideration:

- Overall Goal: Symptom management outcome measures
- Patient and family engagement: goal attainment
- Making care safer: timeliness/responsiveness of care
- Communication and care coordination: alignment of care coordination measures

Appendix B: MAP PAC/LTC Workgroup Roster

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Carol Spence, PhD

National Transitions of Care Coalition

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NATIONAL QUALITY FORUM

Considerations for Implementing Measures in Federal Programs: Guidance from Measure Applications Partnership Clinician Workgroup

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Guidance on Cross-Cutting Issues

Summary

- **The new Merit-based Incentive Payment System (MIPS) aligns all clinician measures into a single program.**
- **Further alignment of clinician measures with ACOs/APMs and hospital/facility measures is warranted.**
- **Public reporting of clinician measures on Physician Compare is ramping up.**
- **Measure gaps in both MIPS and MSSP remain.**

In the past four years MAP has provided multi-stakeholder, pre-rulemaking input to CMS on clinician-level measures for the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VBPM) and EHR Incentive programs. MAP created measure selection criteria to identify characteristics that are associated with ideal measure sets used for public reporting and payment programs. MAP's measure selection criteria complement program-specific statutory and regulatory requirements. The measure selection criteria focus on selecting high-quality measures that optimally address the National Quality Strategy's three aims; fill critical measure gaps; and increase alignment among programs. Additionally, the selection criteria emphasize the use of NQF-endorsed measures whenever possible; inclusion of a mix of measures types, i.e., outcome, composite, efficiency, patient reported outcomes, etc.; enabling measurement of person- and family-centered care and services; consideration of healthcare disparities and cultural competency; and promotion of parsimony and alignment among public and private quality programs.

MAP reviewed measures under consideration for the following clinician quality reporting programs:

- Merit-Based Incentive Payment System (MIPS) – MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program that will adjust eligible providers' Medicare payments based on performance.
- Medicare Shared Savings Program (MSSP) – MSSP is a program designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). If ACOs meet program requirements and the ACO quality performance standard, they are eligible to share in savings, if earned.

Clinician measures reported to the MSSP and PQRS/MIPS program are available for public reporting on the Physician Compare website.

Overarching Themes

New Merit-based Incentive Payment System (MIPS) consolidates all clinician programs in 2019

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR), the long-standing formula for determining Medicare payments to physicians and other eligible health professionals. To replace that formula, the MACRA legislation created a new framework for clinician payment, moving toward a system of reimbursement based on performance incentives or alternative payment models.

As required under MACRA, the Centers for Medicare and Medicaid Services (CMS) will establish a new program through which eligible health professionals' payments will be adjusted based on performance. This program, known as the Merit-based Incentive Payment System (MIPS), will combine the previously-separate PQRS, VBPM, and EHR Incentive programs into a single payment system. The previous clinician-level quality programs will sunset after 2018, with the MIPS program taking effect in 2019. Under the MIPS program, each eligible professional or group practice will be assigned a composite performance score based on four categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health record (EHR) technology. Eligible professionals' payments will then be adjusted positively or negatively (or not at all) based on comparison of their composite scores to a performance threshold.

As part of the transition from multiple quality programs to the consolidated MIPS program, clinician-level measures under consideration in the 2015-16 pre-rulemaking cycle were proposed for potential implementation in 2017 to collect data for use in the MIPS program in 2019.

Alignment within and across programs

In pursuit of consistency, parsimony, and reducing the burden of measurement and reporting, MAP has identified alignment of measures across federal programs as one of its most important cross-cutting priorities. Alignment, or use of the same or related measures, is a critical strategy for accelerating improvement in priority areas, reducing duplicative data collection and enhancing comparability and transparency of healthcare information. MAP assesses and promotes alignment of measurement across federal programs and between public- and private-sector initiatives to streamline the costs of measurement and focus improvement efforts. One of the principles guiding MAP's work is that, to the extent possible, the same measures should be used across different programs, and should be defined in the same way (unless there are specific, justifiable reasons for differences). MAP continues to take strides toward promoting alignment and gap-filling through development of Families of Measures related to the National Quality Strategy (NQS) priority areas. MAP agreed that there remains a strong need for alignment of clinician-level measures with measures at the system level (e.g., accountable care organizations (ACOs), Alternative Payment Models (APMs), etc.) and facility level (e.g., hospitals, ambulatory care facilities, etc.).

CMS representatives noted that CMS and AHIP have been working with patients and provider groups to develop consensus around core sets of measures in particular areas, including primary care, liver disease, gastroenterology, medical oncology, and cardiology. MAP members supported these efforts

and noted that the development of such core sets is in line with MAP's goals of consistency and alignment across measurement programs.

MAP also stressed that alignment within programs remains a priority; this emerged during discussion around a number of specific measure recommendations, including measures of the quality of cardiovascular care. MAP members noted that a composite measure for optimal control of cardiovascular disease (*MUC15-275: Ischemic Vascular Disease All or None Outcome Measure (Optimal Control)*), under consideration for both the MIPS and MSSP programs, is duplicative of a set of individual measures (known as the "Million Hearts" measures) currently in use in both programs. While addition of the composite measure was recognized as a potential source of redundancy, MAP members agreed that the value of a composite measure—which can drive and incentivize improvement in ways that are different from individual measures—was sufficient justification for including such a composite in addition to the individual measures for the Million Hearts campaign. MAP was informed that MUC15- 275 will be reviewed for NQF endorsement in an upcoming project around cardiovascular care, and that this review will include a side-by-side comparison with another composite measure of optimal vascular care that is already NQF-endorsed (NQF #0076). Recognizing that the NQF review will likely result in a best-in-class decision, MAP conditionally supported MUC15-275 pending the outcome of the NQF evaluation, making it clear that the group supported inclusion of the composite measure that is considered best-in-class by the NQF review. In another instance, MAP members noted that use of the PHQ-9 tool for depression screening is promoted through measurement in private programs as well as the Adult and Child Core Measure Sets for Medicaid; fostering alignment across these programs was part of MAP's rationale for supporting a similar measure for MIPS and MSSP.

Under the MACRA legislation, clinicians may be exempted from participation in the MIPS program if they participate in an Alternative Payment Model (APM). Examples of APMs may include accountable care organizations (ACOs), patient-centered medical homes (PCMHs), shared savings programs, and bundled payment models. Like the MIPS program, APMs will also involve some form of measurement-based payment, and MAP agreed that it will be important for CMS to pursue alignment of quality measures across the MIPS program and APMs.

Public Reporting of clinician measures on Physician Compare

CMS has continued to ramp up public reporting of clinician quality information. Public reporting of eligible professionals' performance on PQRS measures through the Physician Compare website has been phased in over time, with all 2015 PQRS data becoming eligible for public reporting in December of 2016. CMS intends to continue public reporting of performance results through the Physician Compare website based on measures in the MIPS program; all measures that are included in MIPS may be reported on Physician Compare. However, measure results may be reported in one of two ways: through a clinician web page for measures that are particularly meaningful to consumers, or through a downloadable spreadsheet intended for more technical or specialized audiences. For the 2015-2016 pre-rulemaking cycle, MAP was asked to provide input on which measures would be most suitable for public reporting on the clinician web page. Measures reported in this way should be understandable for healthcare consumers and useful in decision-making. The MAP Clinician Workgroup's Guiding Principles identify a number of considerations for selecting measures that are meaningful to consumers and

purchasers. NQF-endorsed measures are preferred for public reporting, as are measures focused on outcomes (especially patient-reported outcomes), care coordination, population health, and appropriate care. In addition to making recommendations on measures proposed for the MIPS program, MAP provided additional input on which measures would be best suited for public reporting on Physician Compare clinician web pages.

Measure gaps remain

During both measure-specific deliberations and overarching discussions, MAP continued to highlight measure gaps across clinician-level programs. In particular, MAP members noted the need for patient-centered measures, including patient-reported outcome measures, functional status measures, care coordination measures, and measures that incorporate patient values and preferences. MAP noted that the principle of patient preference could apply not only to new measures, but also to existing measures, which could potentially be modified to include outcomes or processes that reflect patient preferences and shared decision-making. Measures around end-of-life care, for example, would lend themselves especially well to such considerations. With regard to patient-reported measures, MAP noted that such measures should go beyond patients' experiences with the healthcare system and focus on the impact of healthcare on patients' health and well-being—it was noted that measures can sometimes focus on clinical success as defined by providers, while potentially losing sight of what success looks like to patients.

MAP also suggested that the impact of patients' sociodemographic status (SDS) on measure results should continue to be explored. MAP members noted that taking account of whether providers are caring for high-risk populations—from both a clinical and sociodemographic standpoint—is important to providers, who want to ensure a level playing field for performance measurement, but also to patients, who want to know which providers are taking good care of high-risk populations. This may become an increasingly important consideration in the context of patient-reported outcomes.

MAP expressed appreciation for the increase in measures of appropriate use or overuse that have been submitted for consideration, while recognizing that this remains a gap area and a priority for development; many suggested looking to the Choosing Wisely campaign for direction in this area. MAP members also noted that overuse measures should be paired with measures of quality and of the total cost of care so that people can better understand the value they are getting from their investment.

The importance of developing measures of team-based care was also a recurring theme. MAP members suggested that the healthcare system needs to do a better job of identifying patients that are in need of good care, defining what good care looks like for them, and leveraging both team-based approaches and the overall resources of the health system to provide that care.

Considerations for Specific Programs

Merit-based Incentive Payment System (MIPS)

CMS has identified key program needs and priorities for the MIPS program, including outcome measures, measures relevant to specialty providers, domains of person and caregiver experience and outcomes, communication and care coordination, and appropriate use and resource use. CMS also noted a preference for electronic clinical quality measures (eCQMs or eMeasures), measures that are not duplicative of existing clinician measures, and measures with an opportunity for improvement, i.e., those that are not "topped out." The measures under consideration addressed these needs and priorities:

- Outcome measures 24
    - Patient-reported outcome measures 2
- Fully developed measures 5
    - NQF-endorsed measures 2
- eCQMs/eMeasures 2
- Measures relevant for specialty providers 52
- Identified opportunity for improvement 11

MAP has also identified priorities for clinician measures, including outcomes and PROs, composite measures, cost and resource measures, appropriate use measures, care coordination measures, and patient safety measures. While a number of measures under consideration address key program needs identified by MAP, measure gaps in priority areas remain. Currently, outcome measures represent approximately 25 percent of the measures available for reporting under the PQRS program. While there is an increase in the proportion of outcome measures under consideration for the 2015-2016 pre-rulemaking cycle (roughly 37 percent of proposed measures are outcomes), the large majority of measures available for clinician quality programs remain process measures.

Specificity vs. generalizability in measurement

Many of the measures under consideration for the MIPS program are narrowly-focused on specific procedures or conditions, and are applicable only to particular specialty or subspecialty providers. MAP discussed the relative benefits and drawbacks of a large array of specialized measures compared to a smaller set of generalizable measures that can be applied across a wide range of conditions and providers. MAP members agreed that having a limited set of broadly-applicable measures is an important goal for federal programs, helping to ensure alignment, reduce measurement burden for providers, and increase the comparability of performance across contexts (e.g., different providers and settings). However, MAP members acknowledged that the practices of some physicians (e.g., ophthalmologists, oncologists) can be very highly specialized, and that correspondingly-specialized measures are needed to appropriately evaluate the quality of care being provided. This tension was highlighted, for example, during discussion of a measure of biopsy reporting time for non-melanoma skin cancer. MAP members questioned why the measure was limited only to non-melanoma skin

cancer, noting that patients should expect a timely report on the results of any biopsy or critical laboratory test.

MAP members also recognized that consumers of healthcare can benefit from both highly-specific and more general measures. While measures around broader aspects of care may help patients select their primary care physicians or other clinicians they will be seeing for routine care, more granular measures of performance for specific procedures or treatment of specific conditions may help patients in selecting providers when they are in need of more specialized services. MAP recognizes that there is a need for balance on this issue, while noting that the goals of parsimony and alignment should be pursued unless there is a compelling reason for multiple similar or narrowly-focused measures.

Opportunity for improvement

MAP agreed that an important consideration in recommending measures for use in federal programs is whether there is an opportunity for improvement—i.e., variation in performance or overall low performance—warranting measurement in a given area. It was noted that, particularly for measures still under development, there was very limited information available to MAP on gaps in care or performance in general. This made it challenging for MAP members to make truly informed decisions on the appropriateness of some measures for use in accountability programs such as MIPS.

Notable measure discussions

MAP held extensive discussion on measure MUC15-1019, *Non-Recommended PSA-Based Screening*, which is intended to reduce the use of prostate-specific antigen (PSA)-based screening for prostate cancer. A 2012 recommendation from the United States Preventive Services Task Force (USPSTF) discouraged the use of PSA screening due to a lack of evidence supporting its benefits, giving the service a grade D recommendation. The USPSTF recommendation has been heavily criticized by the urology community, and more than 33 public comments to MAP on this measure strongly opposed its adoption as part of the MIPS program, citing concern about the measure's potential to inhibit shared decision-making by dissuading providers from informing patients of PSA screening as an option.

MAP noted that overtreatment in this area is a legitimate concern and that measurement could address more narrow aspects of screening or treatment specifically until the controversy over general PSA screening has been resolved and an evidence-based standard of care is established.

Two composite measures under consideration, MUC15-577 and MUC15-576 (*PQI 91: Prevention Quality Acute Composite* and *PQI 92: Prevention Quality Chronic Composite*, respectively) were also the subjects of MAP discussion. PQI 91, the acute composite, measures the number of people per 100,000 who are admitted to the hospital for selected acute conditions, including dehydration, bacterial pneumonia, and urinary tract infection. PQI 92, the chronic composite, measures the number of people per 100,000 who are admitted to the hospital for selected chronic conditions, including diabetes with short or long-term complications, chronic obstructive pulmonary disease, asthma, and heart failure. Both composite measures are intended to encourage care coordination and efficient use of healthcare services. MAP members discussed the limitations and potential unintended consequences these measures, noting, for example, that the acute composite's measurement of hospital admissions for urinary tract infections

could result in providers misusing or overusing antibiotics in an attempt to achieve higher performance on the measure. With regard to the chronic composite measure, MAP members suggested that sociodemographic factors may have a significant impact on outcomes addressed by this measure, and that adjustment for these factors should be considered.

MAP also noted that these measures were designed to be applied at a population level, and discussed whether use of the measures at the clinician level would be appropriate, given the much smaller number of patients treated by individual clinicians or practice groups.

Medicare Shared Savings Program (MSSP)

MAP considered five measures for addition to the Medicare Shared Savings Program (MSSP); discussion centered on several composite measures that are proposed for use in MSSP. Each of these measures (*Ischemic Vascular Disease All or None Outcome Measure (Optimal Control)*, *PQI 91: Prevention Quality Acute Composite* and *PQI 92: Prevention Quality Chronic Composite*) were proposed for use in both the MIPS program and the MSSP, and issues addressed by MAP were similar across both programs.

As noted above, discussion of the IVD Optimal Control composite focused on concerns around alignment and duplication of measures. Discussion of the acute and chronic population health composites mirrored the discussion of these measures for the MIPS program, with similar concerns raised about incentives for overuse of antibiotics and the potential need for sociodemographic status adjustment. While MSSP applies to accountable care organizations (ACOs), which may serve larger patient populations than individual clinicians or group practices, MAP members suggested that there are similar concerns about population-level measures being applied at the ACO level.

Alignment of measures both within MSSP and between MSSP and other programs was also recognized by MAP as a remaining need.

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.

Medicare Shared Savings Program

Program History and Structure: Section 3022 of the Affordable Care Act (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Shared Savings Program that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery. The Medicare Shared Savings Program (Shared Savings Program) was designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). If ACOs meet program requirements and the ACO quality performance standard, they are eligible to share in savings, if earned. There are two shared savings options: 1) one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) and 2) two-sided risk model (sharing of savings and losses for all three years).

Current Program Measure Information: The Affordable Care Act specifies appropriate measures of clinical processes and outcomes; patient, and, wherever practicable, caregiver experience of care; and utilization (such as rates of hospital admission for ambulatory sensitive conditions) and that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
- Hospitals employing ACO professionals, and
- Other Medicare providers and suppliers as determined by the Secretary.

The Shared Savings Program quality reporting requirements are aligned with PQRS. Quality measure data for the Shared Savings Program is collected via claims and administrative data, CG-CAHPS, and the PQRS GPRO web interface.

Specific measure requirements include:

1. Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients.
2. Measures that are targeted to the needs and gaps in care of Medicare fee-for-service patients and their caregivers.
3. Measures that align with CMS quality reporting initiatives, such as PQRS and the VM.
4. Measures that support improved individual and population health.

Merit-Based Incentive Payment System (MIPS)

Program History and Structure: The Merit-Based Incentive Payment System (MIPS) is established by H.R. 2 Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repeals the Medicare sustainable growth rate (SGR) and improves Medicare payment for physician services. The MACRA consolidates the current programs of the Physician Quality Reporting System (PQRS), The Value-Based Modifier (VM), and the Electronic Health Records (EHR) Incentive Program into one program (MIPS) that streamlines and improves on the three distinct incentive programs. MIPS will apply to doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in 2019. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2021, provided there are viable performance metrics available. Positive and negative adjustments will be applied to items and services furnished beginning January 1, 2019 based on providers meeting a performance threshold four performance categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology. Adjustments will be capped at 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and future years.

High Priority Domains for Future Measure Consideration: In the CY 2016 PFS Rule, CMS will not propose the implementation of measures that do not meet the MIPS criteria of performance and measure set gaps. MIPS has a priority focus on outcome measures and measures that are relevant for specialty providers. CMS identifies the following domains as high-priority for future measure consideration:

1. Person and caregiver-centered Experience and Outcomes
    a. CMS wants to specifically focus on patient reported outcome measures (PROMs)
2. Communication and Care Coordination
    a. Measures addressing coordination of care and treatment with other providers
3. Appropriate Use and Resource Use

Measure Requirements: CMS applies criteria for measures that may be considered for potential inclusion in the MIPS. At a minimum, the following criteria and requirements must be met for selection in the MIPS:

CMS is statutorily required to select measures that reflect consensus among affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.

To the extent practicable, quality measures selected for inclusion on the final list will address at least one of the following quality domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention.

- Measures implemented in MIPS may be available for public reporting on Physician Compare.
    - Preference will be given to electronically specified measures (eCQMs)
- eCQMs must meet EHR system infrastructure requirements, as defined by the future MIPS regulation.

    - The data collection mechanisms must be able to transmit and receive requirements as identified in future MIPS regulation. For example, eCQMs must meet QRDA standards.
- Measures must be fully developed and tested.
    - Reliability and validity testing must be conducted for measures.
    - Feasibility testing must be conducted for eCQMs.
- Measures should not duplicate other measures currently in the MIPS. Duplicative measures are assessed to see which would be the better measure for the MIPS measure set.
- Measure performance and evidence should identify opportunities for improvement. CMS does not intend to implement measures in which evidence identifies high levels of performance with little variation or opportunity for improvement, e.g. measures that are "topped out."

Physician Compare

Program History and Structure: Section 10331 of the 2010 Patient Protection & Affordable Care Act (ACA) requires CMS to establish the Physician Compare website to publicly report physician performance data. The goal of the Physician Compare website is to provide reliable information for consumers to encourage informed health care decisions; and to create explicit incentives for physicians to maximize performance. To meet the statutory mandate, CMS repurposed the Medicare.gov Healthcare Provider Directory into Physician Compare. On December 30, 2010, CMS officially launched the Physician Compare website using the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) as its underlying data source. Based on stakeholder feedback and understanding the Affordable Care Act (ACA) requirements for the site, CMS redesigned Physician Compare in June 2013. Since that time, CMS has been working continually to enhance the site and its functionality, improve the information available, and include more and increasingly useful information about the physicians and other health care professionals who are on the website.

The 2012 Physician Fee Schedule final rule indicated that the first measures available for public reporting on Physician Compare would be a sub-set of the 2012 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) measures collected via the Web Interface. CMS publicly reported this first set of measure data in February 2014 for the 66 group practices and 141 ACOs. In December 2014, the next phase of public reporting was accomplished with the posting of a sub-set of the 2013 PQRS GPRO Diabetes Mellitus (DM) and Coronary Artery Disease (CAD) measures collected via the Web Interface for 139 group practices and 214 Shared Savings Program and 23 Pioneer ACOS. In addition, CAHPS for ACO summary survey measures were added to Physician Compare. The following quality measures were publicly reported in December 2014:

2013 PQRS GPRO and ACO measures

- A sub-set of 3 DM and 1 CAD Web Interface measures.
    - Diabetes: High Blood Pressure Control
    - Diabetes: Hemoglobin A1c Control (<8%)
    - Diabetes: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease
    - Coronary Artery Disease (CAD): ACE-I/ARB Therapy – Diabetes or LVSD

2013 CAHPS for ACOs measures

- 4 CAHPS for ACOs summary survey measures.
    - Getting timely care, appointments, and information
    - How well providers Communicate
    - Patient's Rating of Provider
    - Health Promotion & Education

For 2014 data, all PQRS GPRO measures collected via the Web Interface, as well as a sub-set of measures reported via registry and EHR are available for public reporting on Physician Compare. All measures reported by Shared Savings Program and Pioneer ACOs are also available for public reporting. CMS will continue to publicly report 2014 CAHPS for ACOs and will publish the first set of CAHPS for PQRS measures for groups of 100 or more EPs who participate in PQRS GPRO and for group practices of 25-99 EPs reporting via a certified CAHPS vendor. In addition, twenty individual measures reported by EPs under the 2014 PQRS via claims, EHR, or registry are available for public reporting. All 2014 data are targeted for publication in late 2015.

For 2015 data, at the group practice level, all 2015 PQRS GPRO measures reported via the Web Interface, registry, or EHR are available for public reporting. In addition, the 12 summary survey 2015 CAHPS for PQRS and CAHPS for ACO measures are available for public reporting for group practices of 2 or more EPs and ACOs reporting via a CMS-approved certified survey vendor. At the individual EP level, all 2015 PQRS measures reported via registry, EHR, or claims are available for public reporting. In addition, individual EP-level 2015 Qualified Clinical Data Registry (QCDR) measures, which include PQRS and non-PQRS data, will be available for public reporting on Physician Compare in late 2016.

Current Program Measure Information: Table 1 below provides the number of quality measures under each domain of measurement from the National Quality Strategy (NQS) priorities that were finalized in the 2012, 2013, 2014 and 2015 PFS final rules as available for public reporting. Only those measures that are comparable, valid, reliable, and suitable for public reporting will be publicly reported on Physician Compare (see "Measure Requirements" below).

Table 1: Quality Measures Finalized for Public Reporting by the 2012, 2013, 2014, & 2015 PFS Final Rules

	Number of Measures Finalized for Potential Reporting on Physician Compare									
	2012 PFS Final Rule		2013 PFS Final Rule		2014 PFS Final Rule			2015 PFS Final Rule		
NQS Priority Domains	Groups	ACOs	Groups	ACOs	EPs	Groups	ACOs	EPs	Groups	ACOs
Effective Clinical Care	27	20	20	20	13	14	14	110	138	8
Patient Safety	1	1	1	1	2	2	2	26	34	2
Communication/Care Coordination	1	1	1	1	0	0	29	37	0	

Community/Population Health	0	0	0	0	5	5	5	14	15	5
Efficiency and Cost Reduction	0	0	0	0	0	0	0	15	16	0
Person and Caregiver-CenteredExperience and Outcomes	0	0	25	35	0	12	12	12	14	12
Effective Clinical Care	27	20	20	20	13	14	14	110	138	8

High Priority Domains for Future Measure Consideration: As we move more toward expanded public reporting, it is critical to include consumer-friendly measures. This means that measure development needs to focus on creating measures that look at the types of information consumers need to know to make informed health care decisions. PQRS was originally a pay-for-reporting program without explicit intent to publicly report quality measures. However, starting with 2015 data, all PQRS measures are available for public reporting on Physician Compare. Based on this expansion of public reporting and the changing use of PQRS measures, it is critical to consider public reporting and the consumer perspective during measure development. CMS identified the key areas to consider when developing consumer-friendly measures.

- Outcome measures
- Composite measures
- Risk adjusted measures

Consumer testing has also shown that users prefer outcome measures over process measures. In order for quality measures to be meaningful to consumers, they must resonate with consumers. We often hear that consumers do not think process measures are useful. They want to understand if patients like them better or if a procedure was successful. This is the information that will help them make informed decisions.

Composite measures can help consumers accurately interpret measures in a way that is meaningful to them while also removing the burden of interpretation from them. Composite measures help make data more digestible. It is much easier for a consumer to understand that a doctor is good at diabetes care, for instance, than it is to understand why it is important for a doctor to perform well across a series of technical measures about glucose levels and treatment best practices. Similarly, risk adjustment can ensure that consumers are more accurately comparing health care professionals and group practices.

Consumers can provide valuable feedback when engaged early in the measure development process. They can determine if measures are understandable and useful in decision making. We understand that all measures are not intended for public reporting. However, the continued growth of public reporting makes the consumer perspective increasingly important. Moving towards more consumer-friendly measures, specifically outcome measures, composite measures, and risk-adjusted measures, will be

instrumental toward achieving Physician Compare's goal, as defined by the Affordable Care Act, of providing consumers useful quality data to inform health care decisions.

Measure Requirements: Although CMS has finalized the quality measures listed in Table 1 for public reporting, not all of these quality measures may ultimately be suitable for public reporting. Only comparable, valid, reliable, and accurate data will be publicly reported. For example, the performance results for certain measures may not be statistically reliable if the total number of patients reported on is low. Hence, to select a sub-set of quality measures finalized for public reporting, CMS will need to analyze the actual measure performance results collected for each program year. At minimum, any quality measures selected for public reporting must meet the following criteria:

- As statutorily mandated, quality measures must be statistically valid and reliable, and risk adjustment should be considered for outcome measures as appropriate.
- They must be readily comprehensible to users so that users can leverage the performance information to inform their health care decisions.
- They should enable users to make meaningful and valid comparisons of performance results across health care professionals and group practices by having the following properties:
    - There should be sufficient variation in the performance rates, since comparisons would be difficult if the majority of providers are clustered at one or two performance rates.
    - There should be room for improvement in the measure performance.
    - There should be a sufficient number of cases in the measure denominator, since performance rates that are based only on a handful of cases may result in unreliable rates and make statistically valid comparisons difficult.
    - There should be a sufficient number of health care professionals or group practices in each peer group comparison.

In addition, CMS will not publish any measures that are in their first year and only those measures that prove to resonate with consumers and are deemed to be relevant to consumers will be included on the profile pages of the website. All other comparable, valid, reliable, and accurate measures would be included in a publicly available downloadable database, similar to the databases currently available on data.medicare.gov.

Appendix B: MAP Clinician Rosters

MAP Clinician Workgroup

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NATIONAL QUALITY FORUM

Considerations for Implementing Measures in Federal Programs: Guidance from Measure Applications Partnership Hospital Workgroup

DRAFT FOR PUBLIC REPORT

December 2015

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I task order 18.

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Summary

- **Performance measurement should encourage and foster better coordination across the care continuum.**
- **Patients and providers should engage in shared-decision making and providers should ensure care is delivered according to a patient's goals and preferences. These decisions should be clearly documented to ensure subsequent care is aligned 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 these disparities in care.**

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

- Hospital Value-Based Purchasing (VBP)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Outpatient Quality Reporting (OQR)
- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Hospital Inpatient Quality Reporting (IQR) and Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs) (Meaningful Use)
- 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 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 patient and their families as partners in care delivery, and (3) driving improvement for all. These themes are explored in more detail below.

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, there is a need for performance measurement to 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 there is a need to move beyond that to measures that capture the "big picture" of the quality of care. In particular, consumers are looking for a more integrated set of measures that they can use to see an overall picture of quality.

In particular, the group 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. There is a need for measurement that can help spur better care coordination and data sharing to avoid unnecessary hospital readmissions. Better interconnectivity and information sharing could help providers have more complete information about their patients, including vital information about a person's history, helping to reduce errors and adverse treatment interactions. In particular, MAP called for improved EHR interoperability and better links to information held by payers. The availability of data and the ability to get 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 impacts on a person's ability to manage their care at home and prevent readmissions. However, MAP recognized that these factors can be greatly impacted by a person's socioeconomic status and where they live. MAP also recognized that while healthcare providers have a responsibility to support their patients during their recovery, there are limits to what they 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.

MAP stressed that all providers have a responsibility to care for the whole person. The group also noted the need to recognize that patients may consider their primary care provider differently than the healthcare system does. Because of this, MAP recognized 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 these providers to connect back with a patient's primary care provider or to help them establish a source of ongoing primary care support.

MAP recognized the need for measurement to be strategic and cross-cutting, as having a large number of measures in each program can dilute their individual impact and importance. More integrated measurement that assesses quality across the system could help to ensure high value information for all stakeholders.

Engaging Patients and Families as Partners in Care

MAP recognized the need to engage the patient and their families as partners and collaborators in the care delivery process. Better engagement of patients has been a critical objective for MAP and a high-priority domain across all programs. MAP noted a number of ways measurement can help to address this essential issue. MAP stressed the importance of shared decision making with patients and their families and that providers need to be committed to support the patient's decision. Subsequently, providers need to help ensure a person's goals and preferences are clearly documented and that subsequent care is reflective of those decisions.

MAP acknowledged the importance of patient accountability and helping them assume responsibility for their care in order to improve care delivery. MAP did caution that there is a need to balance this with a patient and their caregivers' ability and desire to be fully engaged in their care. MAP stressed the need

for providers to build relationships with patients and their families as well as within communities to help patients manage their 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 what information would be truly meaningful to help a consumer choose a provider and give information about the outcomes that are important to patients. To support this goal, MAP recommended a number of measures addressing outcomes such as safety or mortality. MAP also stressed 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 (HOQR) 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 this decision-making and could give providers information to help them improve care for all.

MAP reiterated 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.

MAP Core Concepts

MAP described a need for a framework to guide measure selection for CMS programs while uniting the efforts of a variety of providers and stakeholders. The 2015 Institute of Medicine report "Vital Signs: Core Metrics for Health and Health Care Progress", along with the CMS Quality Strategy, was cited by MAP as one of several possible resources to support the development of this framework. The MAP Coordinating Committee took up this charge, and has committed to articulating a set of MAP Core Concepts.

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[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

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) report on process, structure, outcomes, patient perspectives on care, efficiency, and costs of care measures. The goals of this program are to provide an incentive for hospitals to report quality information about their services and provide consumers information about hospital quality so they can make informed choices about their care.

In its 2015-2016 pre-rulemaking deliberations, MAP discussed a number of 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 impact 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 data supporting variation in resource use for these procedures was not provided. The group also noted that measuring resource use does not provide clear information on the appropriateness of care; resource use is not indicative of quality care.

MAP did not support IQI-22: Vaginal Birth after Cesarean (VBAC) Delivery Rate, Uncomplicated (MUC15 - 1083). While the group 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 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. The group recognized the importance of a community-based approach to decrease smoking, 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. 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 it be optional for hospitals because initially not all vendors may be able to support the implementation of this measure.

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 principle 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 this 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 measure is reviewed by the NQF Standing Committee. 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). The 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 group 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.

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-Center for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (MUC15-534). A number of changes were made to the Patient Safety and Adverse Events Composite to address a number of concerns raised by the NQF Safety Standing Committee. Three additional PSIs have been added to the measure. Two of the component PSIs were redesigned; specifically 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 more accurately reflect the impact of the events. 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 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 e-measure that would provide the public with more useful information about overall hospital care.

[b] Center for Clinical Standards and Quality. 2015 Measures under Consideration List. Program Specific Measure Priorities and Needs. Centers for Medicare and Medicaid Services; 2015:25-26.

This type of measure would provide hospitals with more readily accessible data on their performance rather than waiting for data from claims-based measures.

Hospital Value-Based Purchasing (VBP)

The Hospital Value-Based Purchasing (VBP) 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 that meet or exceed performance standards.

In its 2015-2016 pre-rulemaking deliberations, MAP discussed a number of 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. The group did not support adding seven measures addressing cost of care noting that they overlapped with the statutorily required Medicare Spending Per Beneficiary 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.

The group discussed the updates, described in the previous section, to the American College of Surgeons-Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure and the Patient Safety and Adverse Events Composite (formerly known as Patient Safety Indicator (PSI) 90. The group noted that the updated versions of both measures were improvements over the version currently in the program. However, the group cautioned that revisions to measures in payment programs should be done carefully and 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. The group 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.

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 a number of concerns with the measure. The group 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, the group decided that the benefits of this measure outweighed the risk of these potential negative consequences.

Although MAP has stressed the importance of keeping the measure set parsimonious to avoid diluting the incentive payments, 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 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 American College of Surgeons-Centers for Disease Control and Prevention (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 version currently in the program, they cautioned that revisions to measures in payment programs should be done carefully. Additionally, they encouraged CMS to provide information to both providers and the public on the changes in measure specifications and how these differences may shift performance from the revised measures. 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.

Hospital Outpatient Quality Reporting (HOQR)

The Hospital Outpatient Quality Reporting Program (HOQR) 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 positively noted the potential for both measures to drive efforts to increase

patient activation, and suggested that NQF consider offering performance guidance to non-medical providers of transition or other care coordination services.

MAP agreed with gaps in the HOQR 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 decision-making 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 developed at the University of Oregon as an example.

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 health care.

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

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

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. This data is 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. The updates are all measures currently in the PCHQR program and include: American College of Surgeons-Centers for Disease Control and Prevention (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, National Healthcare Safety Network (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 excel spreadsheet noting the MAP recommendations on measures under consideration. 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 Consensus Development Process 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 would help measure and improve the care that is provided. The measures reviewed in this pre-rulemaking cycle would help to support the care coordination and quality of life measurement gap. MAP emphasized that many cancer patients are treated in general hospitals, and not only in cancer-specialty hospitals. As a result, 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.

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 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. The group 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 noting 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 yet 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.

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 of sociodemographic status, especially access to community-based support.

MAP found a number of 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 access 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 two measures, Avoidance of Utilization of High Ultrafiltration Rate (≥ 13 ml/kg/hour) (MUC 15-758) and Measurement of Phosphorus Concentration (MUC15-1136). MAP also supported updates to two additional measures with the condition that NQF review 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 also agreed not to support Proportion of Patients with Hypercalcemia (NQF #1454) (MUC15-1165) because this measure was recently reviewed by the NQF Renal Standing Committee and was recommended for reserve status because the measure has "topped out". MAP also 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. Instead, MAP supported the inclusion of Measurement of Phosphorus Concentration (MUC15-1136) because the minimum performance rate for this measure is 0 percent with a mean performance of 87 percent, suggesting that some facilities are not following the process at all. 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 determining 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.

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.

Ambulatory Surgical Centers 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 2.1 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 health care.

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% 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 ten 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

- 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 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%
- 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.
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.

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 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.

Inpatient Quality Reporting Program (IQR) and Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs (Meaningful Use or MU)

Program Type

Pay-for-Reporting and Public Reporting. A subset of the measures in the program is publicly reported on the Hospital Compare web site. 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 2.0 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 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 health care.

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

Program Type

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.

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

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 two 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.[1c]

Program Goals

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

Appendix B: MAP Hospital Workgroup Roster

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