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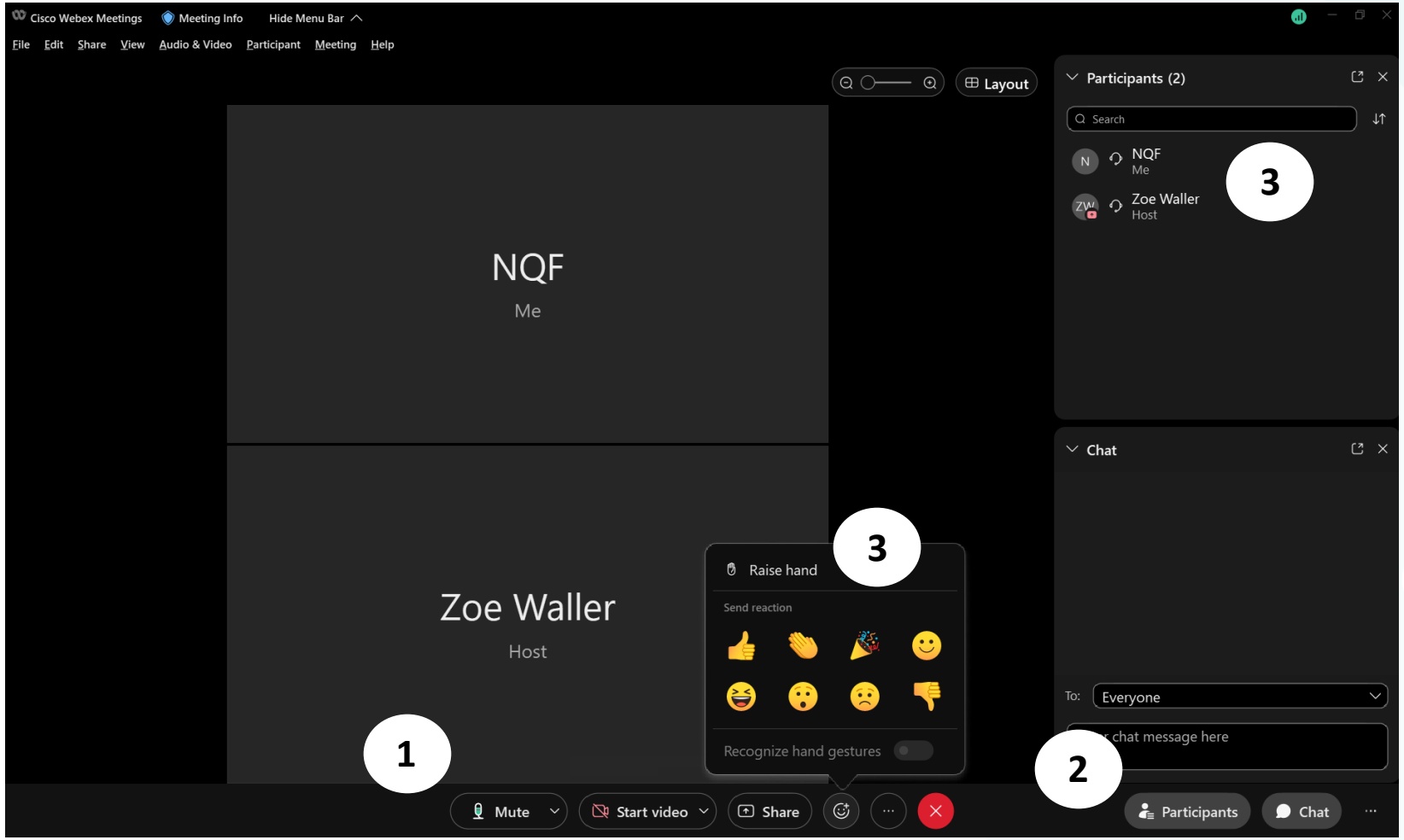

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Measure Applications Partnership (MAP) 2022 Measure Set Review (MSR) Education Meeting

April 21, 2022

Funding provided by the Centers for Medicare & Medicaid Services, Task Order HHSM-500-T0003 Option Year 3

Welcome, Introductions, and Review of Meeting Objectives

Opening Remarks

Tricia Elliott, DHA, MBA, CPHQ, FNAHQ

Senior Managing Director, Measurement Science and Application, NQF

Opening Remarks

Michelle Schreiber, MD

Deputy Director of the Centers for Clinical Standards & Quality (CCSQ) for the Centers for Medicare & Medicaid Services (CMS) and the Group Director for the Quality Measurement and Value-Based Incentives Group (QMVIG)

MAP Staff

- **Elizabeth Drye, MD, MS,** Chief Scientific Officer
- **Tricia Elliott, DHA, MBA, CPHQ, FNAHQ,** Senior Managing Director
- **Jenna Williams-Bader, MPH,** Senior Director
- **Katie Berryman, MPAP, PMP,** Director, Project Management
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- **Ashlan Ruth, BS IE,** Project Manager
- **Rebecca Payne, MPH,** Manager
- **Victoria Freire, MPH, CHES,** Analyst
- **Joelencia LeFlore,** Associate
- **Gus Zimmerman, MPP,** Associate

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- **Kimberly Rawlings,** Task Order (TO) Contracting Officer's Representative (COR), CCSQ, CMS
- **Gequincia Polk,** Indefinite Delivery/Indefinite Quantity (IDIQ) Contracting Officer's Representative (COR), Interim TO COR, CCSQ, CMS

Agenda

- Welcome, Introductions, and Review of Meeting Objectives
- MSR Pilot Review
- 2022 MSR Overview
- MSR Review Meetings and Voting/Polling Process
- CMS Program Overviews
- Opportunity for Public Comment
- Next Steps
- MSR Measure Survey

Meeting Objectives

- In preparation for the 2022 Measure Set Review (MSR), the MAP Education Meeting will:

1. Provide MAP members with an understanding of the 2022 MSR process
2. Provide brief summaries of the CMS federal programs included in the 2022 MSR process
3. Respond to MSR-related questions from MAP members

MSR Pilot Review

Measure Applications Partnership (MAP)

Statutory Authority

- The Affordable Care Act (ACA) of 2010 required the U.S. Department of Health and Human Services (HHS) Secretary to establish a pre-rulemaking process and contract with a consensus-based entity (i.e., NQF) to "convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures" for public reporting, payment, and other programs (ACA Section 3014).
- The Consolidated Appropriations Act (2021) granted the consensus-based entity the authority to provide input on the **removal of quality and efficiency measures**.
- This work is funded by the Centers for Medicare & Medicaid Services (CMS) under contract HHSM-500-T0003, Option Year 3.

Importance of Multistakeholder Engagement

- The Consolidated Appropriations Act presents an opportunity for CMS to:
  - Receive additional stakeholder feedback on potential measure removals in their quality programs
  - Increase transparency about measures being considered for removal
- CMS looks forward to the robust discussion by MAP to provide meaningful feedback on measures used in federal programs.

MSR Pilot Background

- The purpose of the pilot was to establish a process for reviewing measures for potential removal from federal programs with a small set of measures.
- CMS and NQF prioritized federal programs within the Hospital setting (see next slide).
- The MSR pilot occurred in the fall with the MAP Coordinating Committee.
- NQF published the MSR pilot Final Report and Recommendations on October 1, 2021.
- NQF incorporated feedback from the Coordinating Committee into 2022 MSR processes.

Federal Programs Prioritized by CMS/NQF for MSR Pilot

Federal Programs for MAP Hospital	Number of Measures Reviewed	Measures Recommended for Removal
Hospital Inpatient Quality Reporting Program (Hospital IQR Program)	2	1
Hospital Value-Based Purchasing (VBP) Program	4	1
Hospital Readmissions Reduction Program (HRRP)	3	0
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program	10	8
Ambulatory Surgical Center Quality Reporting (ASCQR) Program	3	0

Key Takeaways From MSR Pilot

- Committee members encouraged increased representation of consumers (e.g., patient, family, and caregiver or advocate), nurses, and social workers.
- Based on Committee member feedback:
  - Advisory group volunteers will participate in workgroup review meetings
  - Workgroup co-chairs will participate in Coordinating Committee review meeting
  - NQF staff revised the measure review criteria and measure information that NQF staff will provide to MAP members before review meetings
  - NQF staff expanded the voting options from yes (remove)/no (do not remove) to four categories

2022 MSR Overview

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Summary of 2022 MSR Process

Prioritize

- Completed: CMS and NQF prioritized programs for discussion
- Completed: NQF staff refines the list of measures by program and creates survey

Survey

- Workgroup (WG) and advisory group (AG) members nominate measures for removal via survey; use measure review criteria as rationale for nomination
- NQF staff selects measures with the most votes for AG and WG discussion

Prepare

- NQF staff posts narrowed list of measures for public comment
- NQF staff prepares measure summary sheets, including summary of public comment, for review by WG/AG prior to AG and WG meetings; measures will be assessed against measure review criteria

Discuss

- AG discussion will focus on high priority measures
- Each WG to discuss 10-12 measures and vote for removal of measure or to maintain measure, based on measure review criteria; AG volunteers will be integrated into each WG
- CC to discuss 30-36 measures and vote to uphold WG recommendations or to change recommendation category

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Federal Programs Prioritized by CMS/NQF for MAP Hospital WG Review

Federal Programs for MAP Hospital	Number of Measures (2022)	Programs to be Reviewed for 2022 MSR
Hospital Outpatient Quality Reporting (HOQR) Program	**15**	**X**
Ambulatory Surgical Center Quality Reporting (ASCQR) Program	**8**	**X**
PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	**15**	**X**
Medicare Promoting Interoperability Program for Hospitals	9	**
Hospital Value-Based Purchasing (VBP) Program	13	**
Hospital Inpatient Quality Reporting Program (Hospital IQR Program)	25	**
Hospital Readmissions Reduction Program (HRRP)	6	**
Hospital-Acquired Conditions Reduction Program (HACRP)	6	**
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program	14	**
End-Stage Renal Disease Quality Improvement Program (ESRD QIP)	14	**

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Federal Programs Prioritized by CMS/NQF for MAP PAC/LTC WG Review

Federal Programs for MAP PAC/LTC	Number of Measures (2022)	Programs to be Reviewed for 2022 MSR
Home Health Quality Reporting Program (HHQRP)	**20**	**X**
Hospice Quality Reporting Program (HQRP)	**4**	**X**
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)	18	**
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)	18	**
Skilled Nursing Facility Quality Reporting Program (SNF QRP)	15	**
Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program	1	**

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Federal Programs Prioritized by CMS/NQF for MAP Clinician WG Review

Federal Programs for MAP Clinician	Number of Measures (2022)	Programs to be Reviewed for 2022 MSR
Merit-based Incentive Payment System (MIPS)	**200**	**1/3 of measures will be reviewed for 2022 MSR***
Medicare Shared Savings Program (SSP)	**13**	**X**
Medicare Part C and D Star Ratings	40 (38 unique measures)	**

**To obtain 1/3 of measures for review, measures will be grouped by clinical topic or meaningful measure area.*
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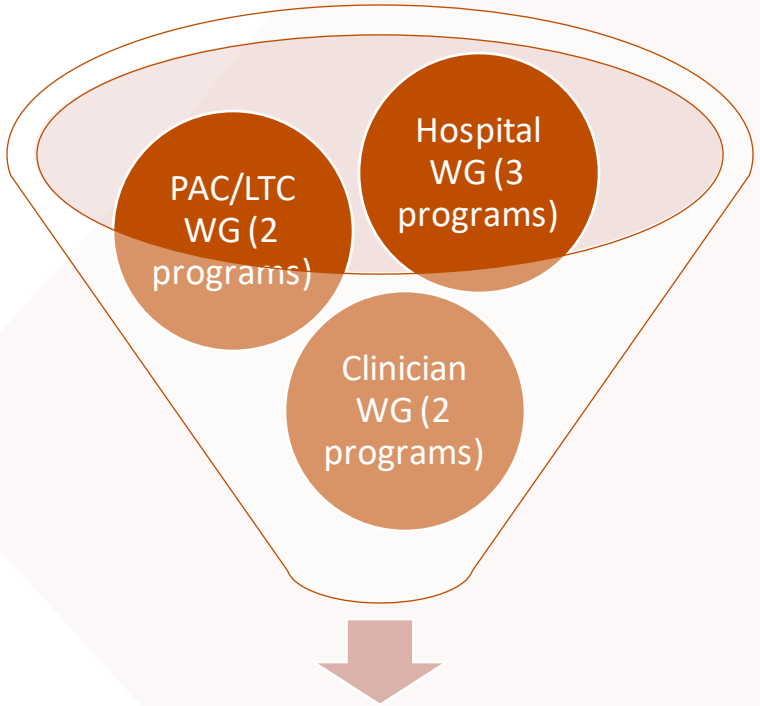
Narrowing List of Measures for Discussion



Screenshot from Advisory Group/Workgroup Survey

3. **Home Health Quality Reporting Program:** Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

	1) Does not contribute to the overall goals and objectives of the program	2) Duplicative of other measures within the same program	3) Not endorsed by a Consensus-Based Entity (CBE), or lost endorsement	4) Performance or improvement on the measure does not result in better patient outcomes	5) Does not reflect current evidence	6) Performance is topped out	7) Performance does not substantially differentiate between high and low performers	8) Measure leads to a high level of reporting burden for reporting entities	9) Not reported by entities due to low volume/entity not having data/entity not selecting to report	10) Measure has negative unintended consequences
05853-C-HHQR: Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other (please specify any additional information you would like NQF staff to know for any measure you selected)

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2022 MSR Measure Review Criteria

1. Measure does not contribute to the overall goals and objectives of the program
2. Measure is duplicative of other measures within the same program
3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
4. Performance or improvement on the measure does not result in better patient outcomes
5. Measure does not reflect current evidence
6. Measure performance is topped out, such that performance is uniformly high and lacks variation in performance overall and by subpopulation
7. Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation

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2022 MSR Measure Review Criteria (Continued)

8. Measure leads to a high level of reporting burden for reporting entities
9. Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure
10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities
    - Feedback from end users or implementers identified negative unintended consequences (e.g., premature discharges, overuse and/or inappropriate use of care or treatment)
    - The measure does not support rural health by negatively impacting issues relevant to the rural population (e.g., access, costs, data collection and/or reporting challenges)
    - The measure does not support health equity by negatively impacting disparities (e.g., race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, geographical consideration)

Types of Information Covered by the Measure Summary Sheets

- The measure summary sheets support AG, WG and CC members as they assess measures against the measure review criteria; they will cover the following types of information

Type of Information	Examples
Measure specification information	Measure description, denominator, numerator
Program use	Programs in which the measure is used
Reporting data	Number of entities reporting the measure, reporting trends
Performance data	Average performance rate, distribution, trends
Measure endorsement history	CBE endorsement status, rationale for losing endorsement
MAP history	MAP review status, MAP recommendation
Feasibility	Feasibility challenges for entities reporting the measure

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2022 MSR Decision Categories

- Support for Retaining
- Conditional Support for Retaining
- Conditional Support for Removal
- Support for Removal

2022 MSR Decision Categories (Continued)

Decision Category	Definition	Evaluation Criteria	Examples
Support for Retaining	MAP supports retaining the measure, as specified, for a particular program.	After discussion, MAP determines the measure does not meet review criteria for removal OR the measure meets at least one review criterion, but MAP thinks the benefits of retaining it in the program outweigh the met criterion. Additionally, MAP has not identified any changes for the measure.	MAP supports retaining the measure despite it meeting a review criterion; for example: • The measure is a PRO-PM that is associated with reporting burden, but it is an important measure to patients • The measure is not reported by some entities due to low volume, but it is a meaningful measure for those entities that can report it

2022 MSR Decision Categories (Continued)

Decision Category	Definition	Evaluation Criteria	Examples
Conditional Support for Retaining	MAP supports retaining the measure for a particular program but has identified certain conditions or modifications that would ideally be addressed.	The measure meets at least one review criterion but MAP thinks the benefits of retaining it in the program outweigh the met criterion. However, MAP support for retaining is based on certain conditions or modifications being addressed.	MAP supports retaining the measure if certain conditions or modifications are addressed; for example, if the measure: • Receives CBE endorsement • Is aligned to the evidence • Is respecified as an electronic clinical quality measure (eCQM) • Is modified so that it no longer meets review criteria

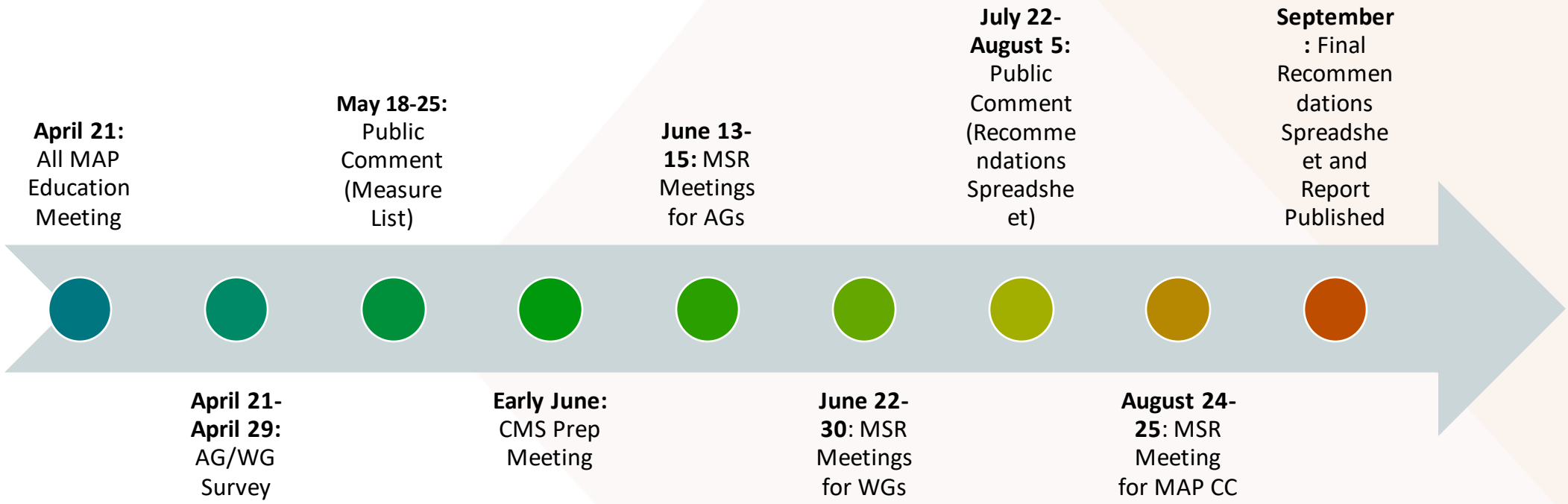
2022 MSR Decision Categories (Continued)

Decision Category	Definition	Evaluation Criteria	Examples
Conditional Support for Removal	MAP supports removal of the measure from a particular program but has identified certain conditions that would ideally be addressed before removal.	The measure meets at least two review criteria, but MAP thinks that removing the measure will create a measurement gap. Therefore, MAP does not support removal until a new measure is introduced to the program.	MAP supports removal once a new measure is introduced that can replace the existing measure; for example: • The measure is integrated into a composite • A process measure is replaced by an outcome measure or PRO-PM

2022 MSR Decision Categories (Continued)

Decision Category	Definition	Evaluation Criteria	Examples
Support for Removal	MAP supports removal of the measure from a particular program.	The measure meets at least two review criteria. MAP does not think that removal of the measure will create a measurement gap.	The workgroup determines that the measure no longer meets program priorities and removing it will not lead to a measurement gap; for example, the measure is topped out.

2022 MSR Timeline



Questions on 2022 MSR Processes?

MSR Review Meetings and Voting/Polling Process

Measure Set Review Process

- NQF staff will create a measure summary document listing each measure selected for discussion. This summary document will be included in the meeting materials for the MSR meetings.
- NQF will assign at least two lead discussants to each measure being reviewed to present during MSR meetings.
- CMS program leads will attend MSR meetings to share any relevant information that will assist in the Committee's review of the measure.
- Committee members will discuss each measure using measure review criteria, and feedback will be captured by NQF staff.

Advisory Group Review Meetings and Polling

- Using lead discussant feedback, staff will prioritize measures with a lack of consensus for discussion. Staff will also group measures for the purposes of discussion and polling.
- The advisory groups will be polled using a **yes/no question**.
  - "Do you support retaining this measure in the program?"
- The advisory group feedback will be provided to the setting-specific workgroups through the following mechanisms:
  - Staff will include a summary of the advisory group's discussion and polling results on the measure summary sheet.
  - Advisory group volunteers will present feedback and polling results at the setting-specific workgroup meetings.

Workgroup Review Meetings and Key Voting Principles

- **Quorum** is defined as **66 percent** of the **voting members** present virtually for live voting to take place.
  - Quorum must be established prior to voting. The process to establish quorum is constituted of (1) taking roll call and (2) determining if a quorum is present. At this time, only if a member of the Committee or workgroup, questions the presence of a quorum is it necessary to reassess the presence of the quorum.
- If quorum is not established during the meeting, MAP will vote via electronic ballot after the meeting.
- MAP has established a **consensus** threshold of greater than or equal to 60 percent of voting participants voting positively AND a minimum of 60 percent of the quorum figure voting positively.
  - Abstentions do not count in the denominator.
- Every measure under review will receive a recommendation.

Workgroup Review Meetings and Key Voting Principles (Continued)

- Virtual voting will occur via Poll Everywhere. Staff will provide voting MAP members with a link prior to the meeting and will be instructed to follow the link in order to cast their vote during meetings.
- Staff will provide an overview of the process for establishing consensus through voting at the start of each MSR review meeting.
- After introductory presentations from staff and lead discussants (advisory group or workgroup representatives), the co-chairs will facilitate a discussion of the measure.
- After the discussion ends, the co-chairs will open the measure for a vote. Co-chairs will summarize the major themes of the discussion and will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions.

Coordinating Committee Review Meetings and Key Voting Principles

- The same voting principles apply to the Coordinating Committee, except the Coordinating Committee will vote on accepting the workgroup's decision.
- The Coordinating Committee will use a consent agenda for the 2022 MSR.

Break

CMS Program Overviews

Program Requirements

- Each program is developed in legislation and passed by Congress.
- Since each program is linked to different legislation, there are separate statutory requirements for all.
- Changes and updates are made on an annual basis through the rulemaking process.
  - CMS releases proposed changes in the Federal Register, followed by a 60-day public comment, and then produces a release of final rules.
  - Typically, this process runs from March thru September.
- During the rulemaking process, CMS cannot discuss any ongoing changes to the rules to avoid any undue advantages to organizations/individuals.

Clinician Programs

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Clinician Programs

Merit-based Incentive Payment System (MIPS)

Medicare Shared Savings Program (SSP)

Merit-based Incentive Program System (MIPS)

Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PROGRAM

April 21, 2022

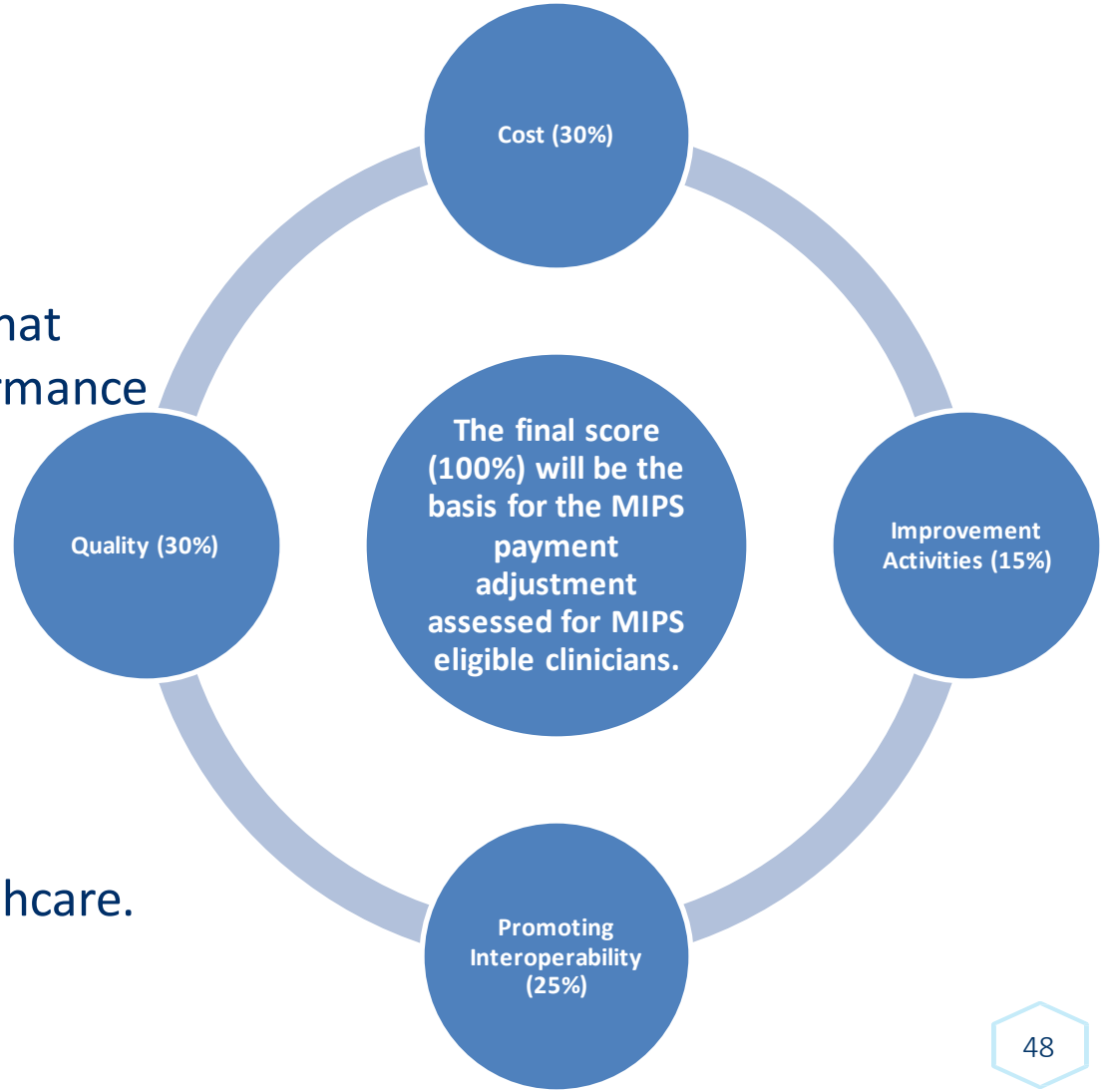
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

- **Program Type:**
  - Quality Payment Program (QPP).

- **Incentive Structure:**
  - Pay-for-performance.
  - There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight.

- **Program Goals:**
  - Improve quality of patient care and outcomes. for Medicare fee-for-service (FFS).
  - Reward clinicians for innovative patient care.
  - Drive fundamental movement toward value in healthcare.



History and Structure

- MIPS is one way to participate in the QPP. Under MIPS, eligible clinicians are reimbursed for Medicare Part B covered professional services and rewarded for improving the quality of patient care and outcomes.
- MIPS combines three Medicare "legacy" programs – the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals – into a single program.
- Under MIPS, the four performance categories affect a clinician's future Medicare payments.
  - Each category with a specific weight, will result in a MIPS final score of 0 to 100 points.
  - MIPS final score will determine whether the eligible clinician receives a negative, neutral, or positive MIPS payment adjustment.
  - Payment adjustment is based on performance during the 2022 performance year and applied to payments for covered professional services beginning on January 1, 2024.

2022 MIPS Current Measures by Meaningful Measure Area

2022 MIPS Current Measures Divided by Meaningful Measure Area

Healthcare Priority	# of Measures
Person-Centered Care	34
Safety	35
Chronic Conditions	35
Seamless Care Coordination	18
Equity	0
Affordability and Efficiency	35
Wellness and Prevention	22
Behavioral Health	21
TOTAL	200

High Priorities for Future Measure Consideration

- The following specialties, clinical conditions and topics have been identified as gaps within the MIPS quality performance category and are considered priority areas for future measure consideration.

Specialties:
- Interventional Cardiology
- Non-patient facing (e.g., Pathology, Radiology)
- Dentistry
- Podiatry
- Nutrition/Dietician
- Pain Management
- Plastic Surgery

Clinical Conditions:
- Opioid Epidemic
- Maternal Health
- Mental Health
- Chronic Conditions
- Avoidance of Amputation for Diabetes

Topics:
- Outcome measures [outcome, intermediate outcome, and patient reported outcome measures (PRO-PMs)(patient voice)]
- Coordination/Communication/Team-based Care
- Digital measures (e.g., quality measures with sources from administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, wearable/medical instruments, patient portals or applications, health information exchanges (HIEs) or registries, and other sources)
- Measures that provide new measure options within a topped-out specialty area
- Health equity
- COVID-19
- Shared-decision Making (Patient Voice)
- Experience of care (patient voice)

Program Changes and Updates for 2022

- Revised the definition of MIPS eligible clinician to include clinical social workers and certified nurse-midwives.
- Set MIPS performance threshold at 75 points and exceptional performance threshold at 89 points.
- Weighted cost and quality performance categories equally (as statutorily required) at 30%.
- Revised quality scoring policies, including introduction of a floor for new measures (7 points for first year, 5 points for second year) and removal of outcome/high priority measure bonus points and end-to-end electronic reporting bonus points.

Measures Previously Identified for Removal in 2022

In the Calendar Year 2022 Physician Fee Schedule Final Rule, the following measures are identified for removal starting with the 2022 performance year.

Quality Number	Measure Title
021	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin
023	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
044	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
067	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
070	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
154	Falls: Risk Assessment
195	Radiology: Stenosis Measurement in Carotid Imaging Reports
225	Radiology: Reminder System for Screening Mammograms
337	Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier
342	Pain Brought Under Control Within 48 Hours
429	Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy
434	Proportion of Patients Sustaining a Ureter Injury at the Time of Pelvic Organ Prolapse Repair
444	Medication Management for People with Asthma

Questions on the Merit-based Incentive Payment System (MIPS) Program?

Medicare Shared Savings Program (MSSP)

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Medicare Shared Savings Program (Shared Savings Program)

- **Program Type:** Shared Savings Program - Mandated by section 3022 of the Affordable Care Act
- **Incentive Structure:**

  CMS assesses Shared Savings Program Accountable Care Organization (ACO) performance annually based on quality and financial performance to determine share savings and losses.

  - Beginning with performance year 2021, ACOs are required to report their quality data to CMS via the Alternative Payment Model (APM) Performance Pathway (APP).
  - Performance categories and weights under the APP used to calculate an ACO's MIPS Quality performance category score:
    - Quality (50%)
    - Cost – (0%)*
    - Improvement Activities (IA) (20%)**
    - Promoting Interoperability (30%)
- **Program Goals:**
  - Promote accountability for a patient population
  - Coordinate items and services for the ACOs' patient population Medicare fee-for-service beneficiaries
  - Encourage investment in high quality and efficient services

*APMs are already responsible for costs

** All MIPS APM participants who report through the APP will receive a full score for the IA category for performance year 2022, and would not need to submit additional IA activity information

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History and Structure

- Section 3022 of the Affordable Care Act (ACA) amended Title XVIII of the Act by adding section 1899 to the Act establishing the Medicare Shared Savings Program (Shared Savings Program).
  - Facilitate coordination and cooperation among healthcare providers to improve the quality of care for Medicare fee-for-service (FFS) beneficiaries, and
  - Reduce the rate of growth in expenditures under Medicare Parts A and B.
- The Shared Savings Program is Medicare's national value-based payment program for ACOs.
  - Eligible clinicians, hospitals, and other health care providers can voluntarily join or form an ACO.
- ACOs share in savings by meeting the quality performance standard for the performance year and lowering the growth in Medicare spending.
  - ACOs participating under a two-sided shared savings/losses model may owe losses if they increase costs and the amount owed is based on their quality performance depending on track.

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APM Performance Pathway (APP) Measure Set for PY 2022 and Subsequent Years
CMS Web Interface Measures/eCQM/MIPS CQMs

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area	Measure Type
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Chronic Conditions	Intermediate Outcome
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Behavioral Health	Process
Quality ID#:236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface*	APM Entity/Third Party Intermediary	Chronic Conditions	Intermediate Outcome
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface*	APM Entity/Third Party Intermediary	Safety	Process
Quality ID#: 110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface*	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
Quality ID#: 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface*	APM Entity/Third Party Intermediary	Behavioral Health	Process
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface*	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
Quality ID#: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface*	APM Entity/Third Party Intermediary	Chronic Conditions	Process
Quality ID#: 370	Depression Remission at Twelve Months	CMS Web Interface*	APM Entity/Third Party Intermediary	Behavioral Health	Outcome

*ACOs will have the option to report via the Web Interface for the 2022, 2023 and 2024 performance years only

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APM Performance Pathway (APP) Measure Set for PY 2022 and Subsequent Years CAHPS for MIPS Survey and Administrative Claims Measures

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area	Measure Type
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Person-Centered Care	PRO-PM
Measure # 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Affordability and Efficiency	Outcome
Measure # 484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	N/A	Affordability and Efficiency	Outcome

2022 Medicare Shared Savings Program Measures
(Divided by Meaningful Measure Area)

Healthcare Priority	# of Measures
Person-Centered Care	1
Safety	1
Chronic Conditions	3
Seamless Care Coordination	0
Equity	0
Affordability and Efficiency	2
Wellness and Prevention	3
Behavioral Health	3
TOTAL	13

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High Priorities for Future Measure Consideration

- Shared Savings Program goals include identification of measures of success in the delivery of high-quality health care at the individual and population levels and align with HHS and CMS priorities, with a focus on outcomes.
- Measures that promote health equity and address social determinants of health.

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Program Changes and Updates

We finalized the following policies for Shared Savings Program ACOs in the CY 2022 Medicare Physician Fee Schedule (PFS) final rule:

Quality Reporting Requirements

- For performance years 2022 through 2024, ACOs will be required to report quality data via the Alternative Payment Model (APM) Performance Pathway (APP).
  - ACOs can choose to report either the 10 measures under the CMS Web Interface or the 3 eCQM/MIPS CQM measures.
  - ACOs must field the CAHPS for MIPS survey.
  - CMS will calculate 2 measures using administrative claims data: the Hospital Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure and the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) measure.
- For performance year 2025 and subsequent performance years, ACOs will be required to report the 3 eCQM/MIPS CQM measures, field the CAHPS for MIPS survey, and CMS will continue to calculate the 2 measures using administrative claims data as noted above.

Quality Performance Standard

- For performance years 2022 and 2023, ACOs will meet the quality performance standard if they achieve a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring.
  - For performance years 2022 and 2023, if an ACO reports the 3 eCQMs/MIPS CQMs, the ACO will meet the quality performance standard if it achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of the 4 outcome measures in the APP measure set and a quality performance score that is equivalent to or higher than the 30th percentile of the performance benchmark on at least 1 of the 5 remaining measures in the APP measure set.
- For performance year 2024 and subsequent performance years, ACOs will meet the quality performance standard if they achieve a quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring.
- An ACO will not meet the quality performance standard if the ACO (1) doesn't report any of the 10 CMS Web Interface measures or any of the 3 eCQMs/MIPS CQMs and (2) doesn't administer a CAHPS for MIPS survey.

Measures Required by Statute

Section 1899 (b)(3)(A) of the Act requires the Secretary to determine appropriate measures to assess the quality of care furnished by the ACO, such as:

- 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).

Specific measure requirements include:

- Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients.
- Measures that are targeted to the needs and gaps in care of Medicare fee-for-service patients and their caregivers.
- Measures that align with CMS quality reporting and value based initiatives, including the Quality Payment Program.
- Measures that support improved population health.
- Measures addressing high-priority healthcare issues, such as health equity and opioid use.
- Measures that align with recommendations from the Core Quality Measures Collaborative.

Measures Previously Identified for Removal

- In the CY 2019 PFS final rule (83 FR 59713), we stated that seek to align the Shared Savings Program quality measure set with changes made to the CMS Web Interface measures under the Quality Payment Program.
  - Changes made in the CY 2019 PFS final rule reduced the Shared Savings Program quality measure set from 31 to 23 measures.
- In the CY 2020 PFS final rule, we finalized required reporting of quality data via the Alternative Payment Model Performance Pathway (APP).
  - One set of quality metrics
    - » May report either the 10 CMS Web Interface measures or the 3 eCQM/MIPS CQMs, and
    - » Administer a CAHPS for MIPS survey, and
    - » CMS will calculate 2 claims-based measures included under the APP

Questions on the Medicare Shared Savings (MSSP) Program?

Hospital Programs

NATIONAL QUALITY FORUM

Hospital Programs

Hospital Outpatient Quality Reporting (OQR)

Ambulatory Surgical Center Quality Reporting (ASCQR)

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

Hospital Outpatient Quality Reporting (OQR) Program

Hospital Outpatient Quality Reporting (OQR) Program

- Program Type: Pay for Reporting and Public Reporting
- Incentive Structure: Hospitals outpatient departments (HOPDs) that do not participate, or participate but fail to meet program requirements, receive a two-percentage point (2%) reduction of their annual payment update (APU) under the OPPS for not meeting program requirements
- Goals: Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about HOPD quality so they can make informed choices about their care.

NATIONAL QUALITY FORUM

History and Structure

- Established by Section 109 of the Tax Relief and Health Care Act (TRHCA) of 2006
- The program requires subsection (d) hospitals providing outpatient services paid under the Outpatient Prospective Payment System (OPPS) to report on process, structure, outcomes, efficiency, costs of care, and patient experience of care
- Pay-for-Reporting Program
- Facilities receive a two-percentage point (2%) reduction of their annual payment update (APU) under the OPPS for not meeting program requirements
- Data publicly reported on the CMS *Hospital Compare* website

CY2022 Current Measures
Divided by Meaningful Measure Area

Healthcare Priority	# of Measures
Person-Centered Care	2
Safety	4
Chronic Conditions	1
Seamless Care Coordination	0
Equity	0
Affordability and Efficiency	8
Wellness and Prevention	0
Behavioral Health	0
TOTAL	15

High Priorities for Future Measure Consideration

As care moves more toward the ambulatory side, it is important to ensure that procedures and clinical care in hospital settings are of equal high quality and that consumers can compare care across facilities, including ASCs.

- Equity
- Person-Centered Care
- Behavioral Health
- PRO-PM
- Outcome eCQMs

CY 2022 OPPS/ASC Final Rule Program Changes and Updates

- Adoption of the COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) Measure Beginning With the CY 2022 Reporting Period/CY 2024 Payment Determination (Via NHSN)
- Adoption of the Breast Cancer Screening Recall Rates Measure Beginning With the CY 2023 Payment Determination (Claims-based)
- Adoption of the ST-Segment Elevation Myocardial Infarction (STEMI) eCQM Beginning With Voluntary Reporting for the CY 2023 Reporting Period and Mandatory for the CY 2024 Reporting Period/CY 2026 Payment Determination and Subsequent Years (Replacement for two Chart-abstracted Measures)
- Requiring OP-37a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures Beginning With Voluntary Reporting for the CY 2023 Reporting Period and Mandatory Reporting Beginning With the CY 2024 Reporting Period/CY 2026 Payment Determination and for Subsequent Years

Statutory Requirements

- Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1833(t)(17)(C)(i) of the Social Security Act
- The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed, by the entity with a contract under Section 1833(t)(17)(C)(i) of the Social Security Act, if endorsed measures have been given due consideration.

CY 2022 OPPS/ASC Final Rule Measures Identified for Removal

- Measure Removals Beginning With the CY 2023 Reporting Period/CY 2025 Payment Determination: OP-02 (Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival) and OP-03 (Median Time To Transfer to Another Facility for Acute Coronary Intervention)

Questions on the Hospital Outpatient Quality Reporting (OQR) Program?

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

- Program Type: Quality Payment Program & Public Reporting
- Incentive Structure: Ambulatory Surgical Centers (ASCs) that do not participate, or participate but fail to meet program requirements, receive a two-percentage point (2%) reduction of their annual payment update (APU) under the ASC Fee Schedule (ASCFS) for not meeting program requirements
- Goals: Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about ASC quality so they can make informed choices about their care.

History and Structure

- The Ambulatory Surgical Center Quality Reporting Program (ASCQR) was established under the authority provided by Section 109(b) of the Medicare Improvements and Extension Act of 2006, Division B, Title I of the Tax Relief and Health Care Act (TRHCA) of 2006
- The statute provides the authority for requiring Ambulatory Surgical Centers (ASCs) paid under the ASC fee schedule (ASCFS) to report on process, structure, outcomes, patient experience of care, efficiency, and costs of care measures
- ASCs receive a two-percentage point (2%) payment penalty to their ASCFS annual payment update for not meeting program requirements. CMS implemented this program so that payment determinations were effective beginning with the Calendar Year (CY) 2014 payment update

NATIONAL QUALITY FORUM

2022 ASCQR Measures
Divided by Meaningful Measure Area

Healthcare Priority	# of Measures
Person-Centered Care	1
Safety	6
Chronic Conditions	0
Seamless Care Coordination	0
Equity	0
Affordability and Efficiency	1
Wellness and Prevention	0
Behavioral Health	0
TOTAL	**8**

High Priorities for Future Measure Consideration

The key strategy for ASCQR is to ensure that procedures done in any type of facility have equivalent quality. As such, measures of quality of procedures in hospital settings should extend to ASCs, to the extent feasible and appropriate, so that consumers can compare quality of a specific procedure across different facility types.

- Safety and Patient Experience
- Person and Family Engagement
- Best Practices of Healthy Living
- Effective Prevention and Treatment
- Making Care Affordable
- Communication/Care Coordination

CY2022 OPP/ASC Final Rule Program Changes and Updates

- Adoption of the COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) Measure (ASC-20) Beginning With the CY 2022 Reporting Period/CY 2024 Payment Determination (Via NHSN)
- Requirement of Previously Suspended ASC-1, ASC-2, ASC-3, and ASC-4 Patient Safety Measures Beginning With the CY 2023 Reporting Period/CY 2025 Payment Determination and Subsequent Years (Via CMS Web-based Tool)
- Requirement of ASC-15a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-Based Measures Beginning With Voluntary Reporting in CY 2023 Reporting Period and Mandatory Reporting Beginning With the CY 2024 Reporting Period/CY 2026 Payment Determination and for Subsequent Years

NATIONAL QUALITY FORUM

Statutory Requirements

- Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act
- The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed, by the entity with a contract under Section 1890(a) of the Social Security Act, if endorsed measures have been given due consideration

Questions on the Ambulatory Surgical Center Quality Reporting (ASCQR) Program?

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

- Program Type: Quality Reporting
- Incentive Structure: PCHQR is a voluntary reporting program. Data are reporting on Provider Data Catalog (PDC)
- 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 and 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.

History and Structure

- Section 3005 of the Affordable Care Act added subsections (a)(1)(W) and (k) to section 1866 of the Social Security Act • Section 1866(k) of the Social Security Act established a quality reporting program for hospitals described in section 1886(d)(1)(B)(v), referred to as a "PPS-Exempt Cancer Hospitals," or: PCHs – These hospitals are excluded from payment under the inpatient prospective payment system (IPPS)

- PCHQR is a voluntary quality reporting program, in which data will be publicly reported on the Provider Data Catalog website (PDC). – If a PCH participates in the program, the facility is required to submit data for selected quality measures to CMS. – There are no payment implications for PCHs related to the PCHQR program.

2022 PCHQR Current Measures
Divided by Meaningful Measure Area

Healthcare Priority	# of Measures
Person-Centered Care	5
Safety	5
Chronic Conditions	2
Seamless Care Coordination	
Equity	
Affordability and Efficiency	
Wellness and Prevention	2
Behavioral Health	1
TOTAL	15

High Priorities for Future Measure Consideration

- PRO-PM
- Care Coordination
- Behavioral Health

Questions on the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program?

Post-Acute Care/Long-Term Care (PAC/LTC) Programs

NATIONAL QUALITY FORUM

PAC/LTC Programs

Home Health Quality Reporting Program (HH QRP)

Hospice Quality Reporting Program (HQRP)

Home Health Quality Reporting Program (HH QRP)

Home Health Quality Reporting Program (HHQRP)

- Program Type: Pay for Performing & Public Reporting

- Incentive Structure: Section 484.225(i) of Part 42 of the Code of Federal Regulations (C.F.R.) provides that HHAs that meet the quality data reporting requirements are eligible to receive the full home health (HH) market basket percentage increase. HHAs that do not meet the reporting requirements are subject to a two (2%) percentage point reduction to the HH market basket increase.

- Program Goals: Alignment with the mission of the National Academy of Medicine (NAM) which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness.

History and Structure

- The Home Health Quality Reporting Program (HH QRP) was established in accordance with section 1895 (b)(3)(B)(v)(II) of the Social Security Act.

- Home Health Agencies (HHAs) are required by the Act to submit quality data for use in evaluating quality for Home Health agencies.

- HHAs that do not submit quality data to the Secretary are subject to a 2 percent reduction in the annual payment update (Section 1895(b) (3)(B)(v)(I)).

CY 2022, HH QRP Current Measures
Displayed by Meaningful Measure Area

Healthcare Priority	# of Measures
Person-Centered Care	6
Safety	4
Chronic Conditions	0
Seamless Care Coordination	3
Equity	0
Affordability and Efficiency	6
Wellness and Prevention	1
Behavioral Health	0
TOTAL	20

High Priorities for Future Measure Consideration

- HH QRP identified the following as high priorities for future measure consideration:
  - Measure (s) that would address health equity.
  - Develop and adopt a cross-setting function measure which focuses on functional ability at discharge.
  - Patient Healthcare Associated Infections (HAIs) – CMS plans to evaluate the appropriateness of adoption within HHAs.
  - Patient COVID-19 Vaccination – This measure would be a cross-setting measure. CMS is currently evaluating the feasibility and appropriateness of this measure concept.

Program Changes and Updates

- The following were finalized in the CY 2022 HH PPS Final rule:
  - Public Reporting of Application of Percent of Residents Experiencing One or More Major Falls with Injury and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
  - Implementation of OASIS E on January 1, 2023 to start the collection of data on:
    - The Transfer of Health Information to Provider-Post-Acute Care and the Transfer of Health Information to Patient-Post-Acute Care measures
    - Certain Standardized Patient Assessment Data Elements (such as the collection of items related to Social Determinants of Health).

Program Changes and Updates

- The expansion of the HHVBP model to include Medicare-certified HHAs in all fifty (50) states, District of Columbia, and the U.S. territories.
  - When the expanded HHVBP Model adds measures in the future, there will be measures that have been in use in the HH QRP.
  - CY 2022 is a pre-implementation year. CY 2023 will be the first year in which performance will be tied to payment in CY 2025.

Measures Required by Statute

The following measures are statutorily required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

- Quality Measure Domain:
  - Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
  - Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
  - Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF# 0674)
  - Drug Regimen Review
  - Transfer of Health Information to the Provider-Post-Acute Care (PAC)
  - Transfer of Health Information to the Patient-Post-Acute Care (PAC)
- Resource Use and Other Measures:
  - Discharge to Community (NQF #3477)
  - Total estimated Medicare Spending Per Beneficiary (MSPB)
  - Potentially Preventable 30-Day Post-Discharge Readmission

Measures Previously Identified for Removal

- The following measures were finalized for removal/replacement in the FY 2022 HH QRP Rule:
  - Removal of the Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care.
  - Replacement of the Acute Care Hospitalization During the First 60 Days of Home Health (NQF #0171) and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (NQF #0173) measures with the Home Health Within Stay Potentially Preventable measure.

Questions on the Home Health Quality Reporting Program (HH QRP)?

Hospice Quality Reporting Program (HQRP)

Hospice Quality Reporting Program (HQRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** Starting in FY 2024 (CY 2022 data), Hospices that fail to submit quality data will have their annual payment update (APU) reduced by 4%; prior to FY 2024, the APU payment penalty was 2%.
- **Program Goal:** Identify and close the gaps in quality measurement for hospice care and ensure alignment between the HQRP and the latest practices in hospice care, including improvements in pain and symptom management for patients regardless of where hospice care is provided.

History and Structure

- The Hospice Quality Reporting Program (HQRP) was established in accordance with Section 1814(i)(5) of the Social Security Act, as amended by section 3004(c) of the Affordable Care Act.
- The HQRP applies to all patients in Medicare-certified hospices, regardless of payer source.
- QRP measure development and selection activities takes into consideration input from numerous stakeholders, including the Measures Application Partnership (MAP), the Medicare Payment Advisory Commission (MedPAC), Technical Expert Panels, and national priorities, such as those established by the National Priorities Partnership, the HHS Strategic Plan, the National Strategy for Quality Improvement in Healthcare, and the CMS Quality Strategy.
- Measures adopted into the HQRP are expected to address a Meaningful Measure area. The Meaningful Measure Initiative was initiated as means reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care.

FY 2022, HQRP Current Measures
Displayed by Meaningful Measure Area

Healthcare Priority	# of Measures
Person-Centered Care	4
Safety	0
Chronic Conditions	0
Seamless Care Coordination	0
Equity	0
Affordability and Efficiency	0
Wellness and Prevention	0
Behavioral Health	0
TOTAL	4

High Priorities for Future Measure Consideration

- The following are high priorities for future HQRP measure consideration:
  - The Hospice Outcome & Patient Evaluations (HOPE) tool Measure Concepts
    - Outcome Measures
    - Pain and symptom impact measures
    - Hybrid Measures: Develop hybrid measures which would combine data from different sources, such as claims, assessments (HOPE), or other data sources
  - Health Equity: Measure(s) that address health equity
  - Hospice Access

Program Changes and Updates

- Finalized in the FY 2022 Hospice Final Rule:
  - Adopted two claims-based measures; Hospice Care Index (HCI) and Hospice Visits in the Last Days of Life (HVLDL) measure and their public reporting starts May 2022.
    - The HVLDL measure received NQF Endorsement in February, 2022.
  - Removed the Seven Hospice Item Set (HIS) measures from HQRP and Public Reporting, because a more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available and already publicly reported.
    - These 7 HIS measures continue to be collected to calculate the NQF# 3235 composite, HIS-Comprehensive Assessment at Admission Measure that is publicly reported. Therefore, the 7 HIS measures are publicly available on the Provider Data Catalog.
  - Begin public reporting of CAHPS Hospice Survey Star Ratings August 2022.
  - Developing and national testing of HOPE to propose in future rulemaking.

Measures Required by Statute

- There are no measures required by Statute in the Hospice Quality Reporting Program

Measures Previously Identified for Removal

- The following measures were finalized for removal in the FY 2022 Hospice QRP Final Rule:
  - Removed the seven HIS process measures because a more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available and already publicly reported:
    - Hospice and Palliative Care Treatment Preferences
    - Beliefs & Values Addressed (if desired by the patient)
    - Hospice and Palliative Care Pain Screening
    - Hospice and Palliative Care Pain Assessment
    - Hospice and Palliative Care Dyspnea Screening
    - Hospice and Palliative Care Dyspnea Treatment
    - Patient Treated with an Opioid Who Are Given a Bowel Regimen
  - Replaced the HIS-based Hospice Visit When Death Is Imminent measure pair with the claims-based Hospice Visits In the Last Days of Life (HVLDL).

Questions on the Hospice Quality Reporting Program (HQRP)?

Opportunity for Public Comment

Next Steps

Timeline of Upcoming Activities

- Public Comment on Measure List : May 18 – May 25, 2022
- Advisory Group Meetings
  - Rural Health Advisory Group – June 13, 2022
  - Health Equity Advisory Group – June 15, 2022
- Workgroup Review Meetings
  - Hospital Workgroup – June 22, 2022
  - Clinician Workgroup – June 27, 2022
  - Post-Acute/Long-Term Care (PAC/LTC) Workgroup – June 30, 2022
  - Coordinating Committee – August 24-25, 2022
- Public Comment on Measure Removal Recommendations: July 22 – August 05, 2022
- Final Recommendations Report to CMS – September 22, 2022

Contact Information – Coordinating Committee and Workgroups

- **Project page:** Coordinating Committee
- **Email:** MAPCoordinatingCommittee@qualityforum.org

- **Project page:** Clinician Workgroup
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- **Project page:** Hospital Workgroup
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- **Project page:** PAC/LTC Workgroup
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Contact Information – Advisory Groups

- **Project page:** Rural Health Advisory Group
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- **Project page:** Health Equity Advisory Group
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MSR Measure Survey

THANK YOU.

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