NATIONAL QUALITY FORUM

Welcome to Today's Meeting!

- Housekeeping reminders:
  - Please mute your computer when not speaking
  - The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
  - We encourage you to keep the video on throughout the event
  - Please ensure your first and last name is listed correctly in your video
  - We will do a full roll call once the meeting begins
  - Feel free to use the chat feature to communicate with NQF staff
  - We will be using the hand raising feature during open discussion

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MAPCoordinatingCommittee@qualityforum.org

Measure Applications Partnership (MAP) Education Meeting

August 9, 2021

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

Welcome, Opening Remarks, and Agenda

Opening Remarks

Kathleen Giblin, RN, Senior Vice President, Quality Innovation, and Acting Senior Vice President, Quality Measurement, NQF

Agenda

- Welcome and Opening Remarks

- Introductions and Roll Call

- Centers for Medicare and Medicaid Services (CMS) Presentation

- Scope of Work and Timeline for Measure Set Review (MSR) Pilot

- MAP Coordinating Committee Discussion

- Opportunity for Public Comment

- Next Steps

Introductions and Roll Call

Coordinating Committee Membership

Workgroup Co-Chairs: *Charles Kahn, III, MPH; Misty Roberts, MSN*

Organizational Members (Voting)

- American Academy of Hospice and Palliative Medicine
- American Association on Health and Disability
- American College of Physicians
- American Health Care Association
- American Medical Association
- American Nurses Association
- America's Health Insurance Plans
- AmeriHealth Caritas
- Blue Cross Blue Shield Association

- Covered California
- HCA Healthcare
- The Joint Commission
- The Leapfrog Group
- National Committee for Quality Assurance
- National Patient Advocate Foundation
- Network for Regional Healthcare Improvement
- Patient & Family Centered Care Partners
- Purchaser Business Group on Health

Individual Subject Matter Experts (Voting)

- Dan Culica, MD, PhD
- Janice Tufte
- Ronald Walters, MD, MBA, MHA

Federal Government Liaisons (Nonvoting)

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Office of the National Coordinator for Health Information Technology (ONC)

Committee Staff

- **Amy Moyer, MS, PMP,** Senior Director

- **Katie Berryman, MPAP, PMP,** Senior Project Manager

- **Udara Perera, DrPHc, MPH,** Senior Manager

- **Ivory Harding, MS,** Manager

- **Ashlan Ruth, BS IE,** Project Manager

- **Rebecca Payne, MPH,** Senior Analyst

- **Victoria Freire, MPH, CHES,** Analyst

- **Joelencia LeFlore,** Coordinator

- **Tricia Elliot, MBA, CPHQ, FNAHQ,** Senior Managing Director

CMS Presentation

CMS Vision for Quality Measures

Use impactful quality measures to improve health outcomes and deliver value by empowering people to make informed care decisions while reducing burden on providers, healthcare organizations, health plans, states, and managed care organizations and driving outcome improvement through public reporting and payment programs.

Role of Quality Measurement

- Quality measures allow for comparison of quality performance through a standardized method, using standard definitions and measure specifications (to compare "apples to apples")

- Measures must meet clear goals for scientific evidence, validity, reliability, feasibility, and impact (NQF endorsement)

- Measures are the backbone of performance evaluation and used in multiple CMS value based programs.

- Same or similar measures often used across the healthcare industry (commercial payers, ratings agencies)

- Many quality measures are developed by CMS, however most developed by other measure developers/stewards

CMS Goals for Quality Measurement

Use Meaningful Measures Framework to Streamline and Align Quality Measurement

Leverage Measures to Drive Outcome Improvement through Public Reporting and Payment Programs

Improve Quality Measures Efficiency by a Transition to Digital Measures and Use of Advanced Data Analytics

Empower Consumers to Make Best Healthcare Choices through Person-Centered Quality Measures and Public Transparency
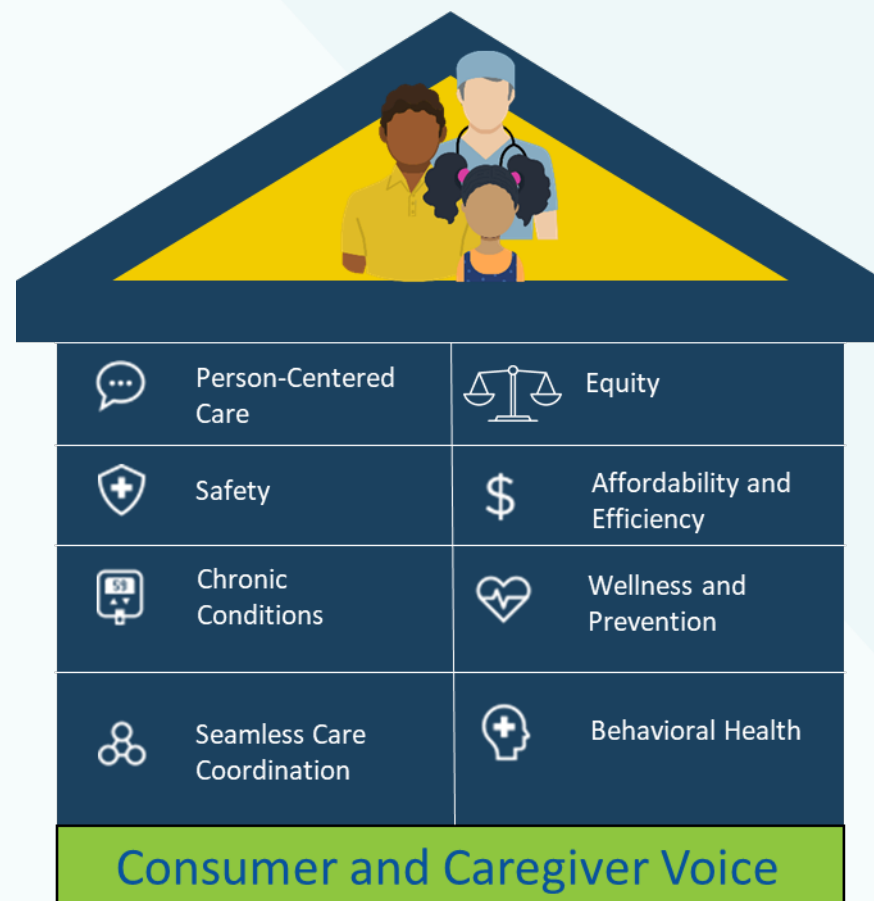
Leverage Quality Measures to Promote Equity and Close Gaps in Care

Alignment Efforts: Ongoing Evaluation

- Increased emphasis at CMS on evaluating the measure portfolio to identify opportunities for improved alignment across programs

  – High value measures identified for use across programs

  – Low value measures identified for potential removal pending stakeholder input

- Alignment opportunities exist at multiple levels:

  – Agency-wide (Internal Alignment Workgroup)

  – Cross-agency (CMS/VA/DoD Workgroup)

  – Public/private (Core Quality Measures Collaborative [CQMC])

Evaluation Criteria

Evaluation Criterion	Question to Consider when Addressing the Criterion
Importance	Is this measure meaningful and important to patients? Does it address an aspect of healthcare where there is a gap in performance or measurement?
Feasibility	Do the benefits of this measure outweigh the potential burdens associated with reporting on it?
Scientific Adaptability	Does the measure produce consistent results that accurately distinguish good care from poor quality care? Does it measure what it purports to measure?
Usability and Use	To what extent can patients, clinicians, hospitals, or other stakeholders use information from the measure to inform performance or improve accountability in care delivery?
Harmonization (Comparison to related or competing measures)	Are there existing measures that have data elements in common with this measure? To what extent can this measure leverage those data elements to reduce the burden associated with implementation and reporting?

Learn more about these measure evaluation criteria on the **_NQF website_**

Stakeholder Engagement

Stakeholder input helps ensure that measurement is

- **transparent**
- **patient-centered**
- **well-informed**

Includes feedback from:

Technical Expert Panels

Patient groups

Public comments

Interviews/workflow assessments

MAP
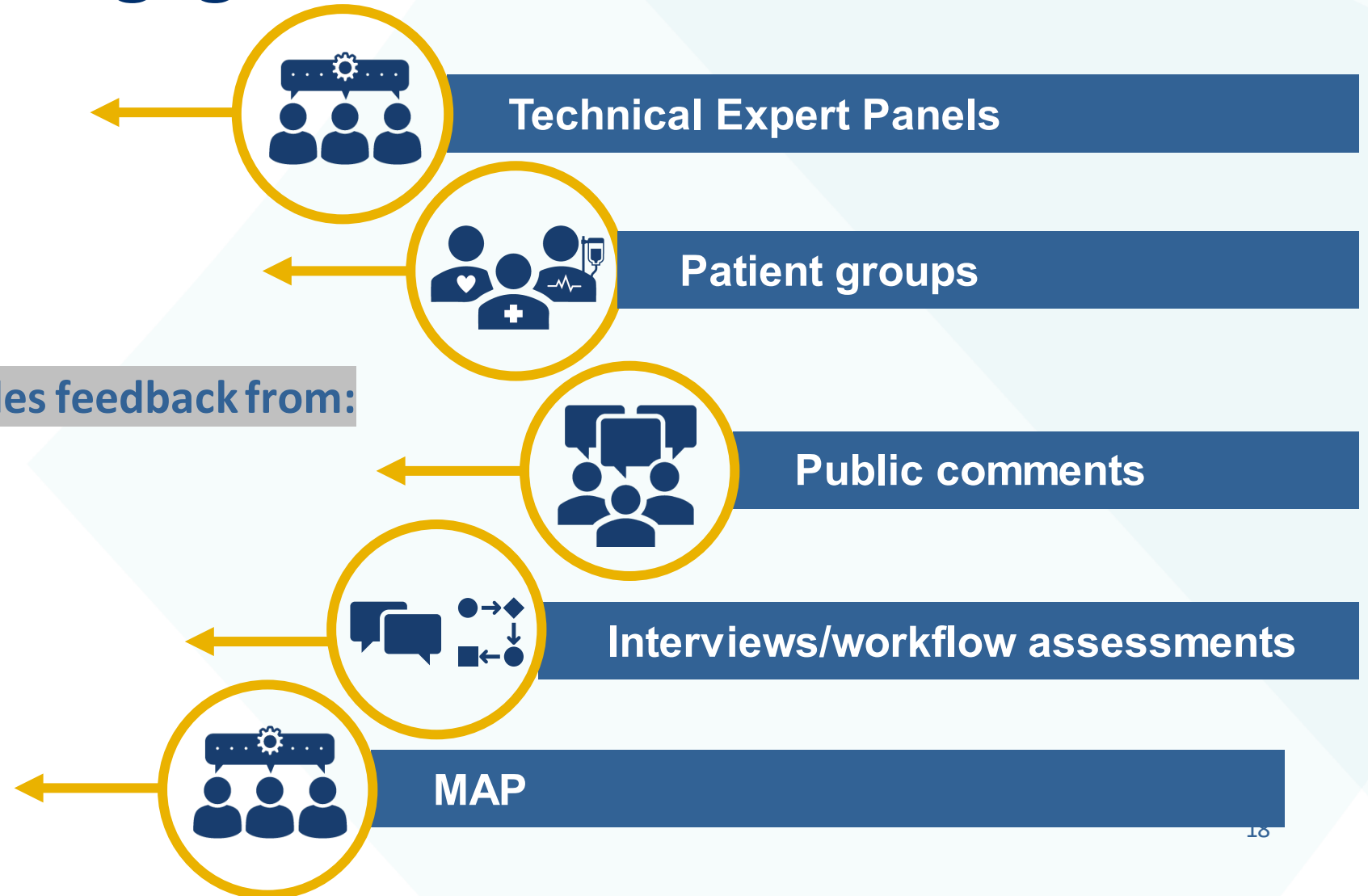
Role of MAP

To promote healthcare improvement priorities, MAP:

- Informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all
- Provides input to HHS during pre-rulemaking on the selection of performance measures for use in public reporting, performance-based payment, and other federal programs
- Identifies gaps for measure development, testing, and endorsement
- Encourages measurement alignment across public and private programs, settings, levels of analysis, and populations to:
  » Promote coordination of care delivery
  » Reduce data collection burden

Value of MAP Feedback

- Facilitates multi-stakeholder dialogue that includes HHS representatives

- Allows for a consensus-building process among stakeholders in a transparent open forum

- Proposed rules are "closer to the mark" because the main provisions related to performance measurement have already been vetted by the affected stakeholders in advance of implementation

- Reduces the effort required by individual stakeholder groups to submit official comments on proposed rules

New Legislation

- Including measure removal input as part of MAP process

> INPUT FOR REMOVAL OF MEASURES—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by inserting after paragraph (3) the following new paragraph: "(4) REMOVAL OF MEASURES—The entity may provide input to the Secretary on quality and efficiency measures described in paragraph (7)(B) that could be considered for removal."

- This presents an opportunity for CMS to receive additional input on potential measure removals in their quality programs through a partnership with NQF

New for MAP in 2021

- Measure Set Review Pilot
  - Purpose: Increase stakeholder feedback in the measure evaluation process across CMS programs.
  - Rollout of a more robust program intended for MAP cycle year 2022-23

- Health Equity Advisory Group
  - Purpose: Ensure health equity is a key consideration in the MAP's review of the measures under consideration.

New Vision for Developed and Tested Measures

Measures on MUC List

MAP Review

Measures in CMS Program

Stakeholders Identify Measures for Removal

MAP Review

Health Equity

Externally

- **CMS' Request for Information**
  - CMS is seeking ways to attain health equity for all patients through policy solutions by way of a Request for Information (RFI) via Hospital Quality reporting programs and other Quality Reporting Programs

- **Quality Action Plan**
  - Focusing on Leverage Quality Measures to Promote Equity and Close Gaps in Care

- **IMPACT ACT**
  - For CMS, focusing on leveraging appropriate tools of payment, quality measurement, value based incentive programs, quality improvement and survey/certification to improve health equity

- **Quality Improvement Organizations**
  - Leveraging our learning networks, such as Quality Improvement Organizations (QIOs), to share best practices across providers.

Internally

- **The CMS Equity Plan for Improving Quality in Medicare**
  - As a program office, CCSQ continues to partner with the Office of Minority Health on efforts to update the 2015 plan.

- **Health Equity Ideation Challenge**
  - Recently hosted a staff innovation challenge to encourage staff to submit new ideas to reach beneficiaries who are facing social, cultural and/or economic barriers to health care by advancing health equity and addressing the social determinants of health.

NQF and MAP help achieve goals

❤️	Use Meaningful Measures Framework to Streamline and Align Quality Measurement
📊	Leverage Measures to Drive Outcome Improvement through Public Reporting and Payment Programs
☑️	
⚖️	

Program Requirements

- Each program is developed in legislation, passed by Congress (most have had significant bipartisan support)

- Because each program is linked to different legislation, there are unique and different statutory requirements for all

- Changes and updates are made annually through rulemaking – CMS releases proposed changes in the Federal Register, followed by a 60 day public comment, and then release of final rules. Generally this is from March thru September

- During rulewriting CMS cannot discuss what is planned in the rules so as to not cause undue advantage to any organization

Merit-based Incentive Payment System (MIPS)

- Program Type: Quality Payment Program

- Incentive Structure: Pay-for-performance

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

Medicare Shared Savings Program (MSSP)

- Program Type: Mandated by Section 3022 of ACA

- Incentive Structure: Pay-for-performance

- Program Goals:
  - Promote accountability for a patient population.
  - Coordinate items and services for Medicare FFS beneficiaries.
  - Encourage investment in high quality and efficient services.

Medicare Part C and D Star Ratings

- Program Type: Quality Payment Program & Public Reporting

- Incentive Structure:
  - Medicare Advantage: Public report and quality bonus payments
  - Stand-alone Prescription Drug: Public reporting

- Program Goals:
  - Provide information about plan quality and performance indicators to beneficiaries to help them make informed plan choices.
  - Incentivize high performing plans (Part C).

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- Program Type: Pay for reporting and public reporting

- Incentive Structure: SNFs that do not submit the required quality data will have their annual payment update reduced by 2%.

- Program Goal: Increase transparency so that patients are able to make informed choices.

Skilled Nursing Facility Value-Based Purchasing (SNF VBP)

- Program Type: Pay for Performance

- Incentive Structure:
  - VBP payments are made to SNFs in a fiscal year based by their performance on a hospital readmission measure.
  - CMS scores SNFs on both improvement and achievement. SNFs earn incentive payment multipliers (negative or positive) based on their performance. The higher of the achievement and improvement scores becomes the SNF's performance score.

- Program Goal:
  - Transforming how care is paid for, moving increasingly toward rewarding better value, outcomes, and innovations instead of merely volume.
  - Linking payments to performance on a single readmission measure.

- Consolidated Appropriations Act 2021 authorized an expansion to include up to 10 measures that will begin in 2023 - propose measures in rulewriting in 2022.

Home Health Quality Reporting Program (HH QRP)

- Program Type: Pay for reporting and public reporting

- Incentive Structure: Home health agencies (HHAs) that do not submit data will have their annual HH market basket percentage increase reduced by 2%.

- Program Information: 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.

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

- Program Type: Pay for reporting and public reporting

- Incentive Structure: IRFs that fail to submit data will have their applicable IRF Prospective Payment System (PPS) payment update reduced by 2%.

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

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

- Program Type: Pay for reporting and public reporting

- Incentive Structure: LTCHs that fail to submit data will have their applicable annual payment update (APU) reduced by 2%.

- Program Goal: 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).

Hospice Quality Reporting Program (HQRP)

- Program Type: Pay for reporting and public reporting

- Incentive Structure: Hospices that fail to submit quality data will have their annual payment update reduced by 2%.

- Program Goal: Addressing pain and symptom management for hospice patients and meeting their patient-centered goals, while remaining primarily in the home environment.

Hospital Programs

End-Stage Renal Disease (ESRD) QIP

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

Ambulatory Surgical Center Quality Reporting (ASCQR)

Inpatient Psychiatric Facility Quality Reporting (IPFQR)

Hospital Outpatient Quality Reporting (HOQR)

Hospital Inpatient Quality Reporting (IQR)

Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals and Critical Access Hospitals

Hospital Value-Based Purchasing (VBP)

Hospital Readmissions Reduction Program (HRRP)

Hospital-Acquired Condition Reduction Program (HACRP)

End-Stage Renal Disease (ESRD) QIP

- Program Type: Pay for Performance and Public Reporting

- Incentive Structure: As of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions will be on a sliding scale, which could amount to a maximum of 2.0% per year.

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

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

- Program Type: Quality Reporting Program

- Incentive Structure: PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare.

- Program Goal: 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.

Ambulatory Surgical Center Quality Reporting (ASCQR)

- Program Type: Pay for Reporting and Public Reporting

- Incentive Structure: Ambulatory surgical centers (ASCs) that do not participate or fail to meet program requirements receive 2.0% reduction in annual payment update.

- Program Goal: Promote higher quality, more efficient healthcare for Medicare beneficiaries through measurement, and allow consumers to find and compare the quality of care given at ASCs to inform decisions on where to get care.

Inpatient Psychiatric Facility Quality Reporting (IPFQR)

- Program Type: Pay for Reporting and Public Reporting

- Incentive Structure: Inpatient psychiatric facilities (IPFs) that do not submit data on all required measures receive a 2.0% reduction in annual payment update.

- Program Goal: Provide consumers with quality-of-care information to make more informed decisions about healthcare options, and encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware of and reporting on best practices.

Hospital Outpatient Quality Reporting (HOQR)

- Program Type: Pay for Reporting and Public Reporting

- Incentive Structure: Hospitals that do not report data on required measures receive a 2.0% reduction in annual payment update.

- Program Goal: Provide consumers with quality-of-care information to make more informed decisions about healthcare options, and establish a system for collecting and providing quality data to hospitals providing outpatient services such as emergency department visits, outpatient surgery, and radiology services.

Hospital Inpatient Quality Reporting (IQR)

- Program Type: Pay for Reporting and Public Reporting

- Incentive Structure: Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update

- Program Goal: Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals and Critical Access Hospitals

- Program Type: Pay for Reporting and Public Reporting

- Incentive Structure: Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.

- Program Goal: Promote interoperability between EHRs and CMS data collection.

Hospital Value-Based Purchasing (VBP)

- Program Type: Pay for Performance

- Incentive Structure: The amount equal to 2.0% of base operating DRG is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments

- Program Goal: Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards

Hospital Readmissions Reduction Program (HRRP)

- Program Type: Pay for Performance and Public Reporting

- Incentive Structure: Medicare fee-for-service (FFS) base operating diagnosis-related group (DRG) payment rates are reduced for hospitals with excess readmissions. The maximum payment reduction is 3.0%.

- Program Goal: Reduce excess readmissions in acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), which includes more than three-quarters of all hospitals, and encourage hospitals to improve communication and care coordination efforts to better engage patients and caregivers, with respect to post-discharge planning.

Hospital-Acquired Condition Reduction Program (HACRP)

- Program Type: Pay for Performance and Public Reporting

- Incentive Structure: The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.

- Program Goal: Encourage hospitals to reduce HACs through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

Importance of the CMS/NQF Partnership

- Gathering multi-stakeholder feedback

- Increasing transparency in the evaluation of measures (in CMS programs) and across the quality measures ecosystem

- Scientific rigor and measure specifications support impact, feasibility, reliability, validity, and alignment

- Reaching consensus among diverse groups of stakeholders, including consumers and patient advocates

Importance to CMS

- This presents an opportunity for CMS to receive additional input on potential measure removals in their quality programs through a partnership with NQF.
  - Increased stakeholder feedback
  - Increased transparency
- CMS looks forward to the robust discussion by the MAP to provide meaningful feedback on measures used in federal programs.

Scope of Work and Timeline for Measure Set Review (MSR) Pilot

Goals and Scope of Work

- 2021 is the **pilot year** for the MSR initiative

- MAP Coordinating Committee members will use this year to **discuss, evaluate, and provide feedback** on measures selected for review using pilot year criteria and processes

- Committee members will have the opportunity to review and **debrief on the pilot year process** at the Coordinating Committee Strategic Meeting on September 15, 2021.

Measure Selection Process

Coordinating Committee members each select 10 measures	NQF staff aggregate responses	Final list (up to 24) is published in advance of MSR meetings

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Measure Selection Process - Representation

- If the aggregated list does not contain at least one measure chosen by each of the stakeholder groups, up to three top measures from that stakeholder group may be added to the list for discussion
  - For the purposes of this process, stakeholder groups are **facilities, providers, health plans, purchasers,** and **patients**

- If the aggregated list does not contain at least one measure from each setting (hospital, clinician, PAC/LTC), the top measure from each program may be added to the list for discussion
  - If no Committee members chose a measure from a setting for discussion, that setting will not be discussed at the MSR Meetings this year

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 pilot measure review criteria, and feedback will be captured by NQF staff

Measure Review Criteria (Pilot Year)

1. Measure does not contribute to the overall goals and objectives of the program

2. Performance or improvement on the measure does not result in better patient outcomes

3. Measure is not NQF endorsed

4. Evidence base for measure has changed and measure no longer reflects current evidence

5. Measure performance is uniformly high and lacks variation in performance overall and by subpopulation

6. Measure is not feasible to implement

7. Measure is duplicative of other measures in the program

8. Measure has negative unintended consequences

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Timeline (Pilot Year)

August 9, 2021:
Education Meeting

**September 8-9,
2021:** Measure Set
Review Meetings

October 1, 2021:
Final
Recommendations
Spreadsheet
Published

August 16, 2021:
Measure Selection
Due

**September 15,
2021:** Coordinating
Committee
Strategic Meeting

Break

MAP Coordinating Committee Discussion

Opportunity for Public Comment

Next Steps

MSR Process Next Steps

- **Be on the lookout for the invitation to submit 10 measures to NQF staff by August 16, 2021**

- If you have not already completed your disclosure of interest (DOI) form, please do so by **Wednesday, August 18, 2021**

- Save the date for the MAP Coordinating Committee Measure Set Review Meetings on **September 8-9, 2021**

  - If you have not received a calendar invitation to these events, please contact the team

- Contact MAPCoordinatingCommittee@qualityforum.org with any additional thoughts, concerns, or questions

THANK YOU.

NATIONAL QUALITY FORUM

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