MEASURE APPLICATIONS PARTNERSHIP

MAP 2019 Considerations for Implementing Measures in Federal Programs: Hospitals

FINAL REPORT

FEBRUARY 15, 2019

NATIONAL QUALITY FORUM

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GUIDANCE ON CROSS-CUTTING ISSUES

Summary

- MAP noted the importance of providing patient-focused care that aligns with patient and family preferences.
- MAP recognized the need for parsimony and harmonization of measures across programs and care settings.
- MAP supports CMS in its continued efforts towards reducing administrative burden on clinicians and other providers.

The Measure Applications Partnership (MAP) Hospital Workgroup reviewed four measures under consideration (MUC) for two hospital and setting-specific programs:

- Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid EHR Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)

The following seven programs within MAP's purview did not have measures under consideration during this year's pre-rulemaking cycle:

- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Outpatient Quality Reporting (OQR)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR)
- Hospital Value-Based Purchasing (VBP)

MAP's pre-rulemaking recommendations reflect the MAP Measure Selection Criteria (MSC) in addition to how well a measure under consideration could address the goals of the program or enhance the program's measure set. The MSC highlight characteristics of an ideal measure set and are intended to complement program-specific statutory and regulatory requirements. The selection criteria seek measures that are NQF-endorsed whenever possible, address a performance gap, diversify the mix of measure types, relate to person- and family-centered care and services, address disparities and cultural competency, and promote parsimony and alignment among public and private quality programs.

OVERARCHING THEMES

Informed Consumers and their Care

MAP noted an increasing need to align the measures included in the various hospital and setting-specific programs. Providers are performing a growing number of surgeries and/or procedures across the various settings that traditionally occurred in the inpatient setting (e.g. hospital operating room). MAP recognized that patients and their families might face challenges in distinguishing between inpatient and outpatient services while making informed choices about their care.

MAP discussed the importance of aligning the measures for the surgeries and procedures that providers perform in both the inpatient and outpatient settings. Aligning the measures for similar surgeries and procedures in the different settings could help patients and their families make informed choices about their care. MAP reiterated that increasing the alignment of the measures used across programs could reduce burden on providers, as they are required to report to public- and private-sector payers.

Patient- and Family-Focused Care

MAP lauded CMS' Meaningful Measures initiative and its recent focus on minimizing the duplication of measures across programs while focusing on measures in high-priority areas. MAP supports CMS in its continued focus on reducing administrative burden on clinicians and providers. MAP noted the importance of providing patient-focused care that aligns with patient and family preferences. MAP restated the importance of including patient and family preferences when considering the plan of care. MAP recommended that future high-priority measures include patient- and family-focused care that aligns with the patient's overall condition, goals of care, and preferences.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs)

The Hospital Inpatient Quality Reporting Program (IQR) is a pay-for-reporting program that requires hospitals paid under the Inpatient Prospective Payment System (IPPS) to report on process, structure, outcomes, patient perspectives on care, efficiency, and costs of care measures. Hospitals that do not participate or meet program requirements receive a 25 percent reduction of the annual payment update. The program has two goals: (1) to provide an incentive for hospitals to report quality information about their services, and (2) to provide consumers information about hospital quality so they can make informed choices about their care.

MAP conditionally supported three eCQMs for rulemaking: MUC18-107 *Hospital Harm - Pressure Injury,* MUC18-109 *Hospital Harm – Hypoglycemia*, and MUC18-52 *Cesarean Birth (CB)*.

MAP conditionally supported MUC18-52 *Cesarean Birth (CB)* for rulemaking pending NQF evaluation and endorsement. MAP noted the importance of eliminating early deliveries and improving

maternal health outcomes. MAP had a lengthy discussion on high-risk conditions such as pre-eclampsia/eclampsia that would indicate a cesarean birth, patient harm due to medically unnecessary cesarean births, and the implications of the lack of risk adjustment. MAP also discussed EHRs and the current limitations associated with implementing eCQMs and suggests that feasibility testing demonstrates the data are readily available and can be captured without undue burden. MAP also noted there might be a need for balancing measures for cesarean birth rates (for appropriate populations). MAP suggests that multiple stakeholders including methodological, clinical, and policy experts examine risk adjustment, exclusions, and potential unintended consequences of measuring and reporting cesarean birth rates. Finally, MAP suggested that CMS remove this measure from the HAI domain into a more appropriate domain.

MAP conditionally supported MUC18-107 *Hospital Harm - Pressure Injury* for IQR pending NQF review and endorsement once the measure is fully tested. MAP expressed its broad support for the measure and agreed that this measure can reduce patient harm due to pressure injury. MAP raised concerns about the measure that should be considered as testing is completed and the measure is vetted through the NQF endorsement process including input from the NQF Disparities Committee. MAP noted that deep tissue injury (DTI) could take longer than 24 hours to develop; therefore, a wider time window may be indicated to identify DTI. MAP also recommended that present on admission (POA) and Stage II pressure ulcers are specifically looked at due to past reliability challenges in capturing these data in the electronic medical record. MAP noted that appropriate risk adjustment might be necessary to ensure that the measure does not disproportionately penalize facilities who may treat more complex patients (e.g., academic medical centers or safety net providers). MAP suggested excluding patients undergoing certain types of treatment that may not be appropriate to receive evidence-based pressure injury reducing interventions (e.g., extracorporeal membrane oxygenation [ECMO]). MAP also cautioned about potential bias against facilities that do not have the expertise needed to stage pressure injuries accurately (e.g., certified wound care nurses). MAP recommended that other patient clinical data like albumin, which are available in the electronic medical record, be considered for risk adjustment in the future. Lastly, MAP recommended that the developer consider how multiple pressure injuries are identified and assessed in the same encounter.

MAP conditionally supported MUC18-109 *Hospital Harm - Hypoglycemia* for IQR pending NQF review and re-endorsement once the revised measure is fully tested. MAP agreed that severe hypoglycemia events are largely avoidable by careful use of antihyperglycemic medication and blood glucose monitoring. MAP raised concerns that the measure developer should consider as testing is completed and the measure is vetted through the endorsement process. MAP's concerns included the low glucose value (less than 40 mg/dL), the defined lab tests (e.g., point-of-care vs. lab values), and the feasibility of the subsequent lab test for glucose within five minutes of the low glucose result. The measure developer clarified that the glucose lab test includes both point-of-care and lab values and that the measure does not require a glucose lab test recheck within five minutes of the low glucose result. The subsequent blood glucose time stamp is captured automatically in the electronic medical record without undue burden. MAP suggested monitoring the potential impact of the FDA's most recent recommendations for new blood glucose meters entering the market and the implementation of this measure. MAP recommended continuously assessing the low blood glucose threshold and time interval for unintended consequences and recommended a hyperglycemia balancing measure. MAP also recommended evaluating multiple hypoglycemia events per hospitalization, compared to one hypoglycemia event per hospitalization, and considered risk adjustment and/or stratification

if appropriate. MAP generally recommended using drug class or subclass instead of Rx Norm codes for eCQMs that include medications in the measure specifications. Including drug class rather than a list of Rx Norm codes that require updating every year reduces the burden of maintaining the measure for implementation.

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 reporting program. The program's goal is to provide information about the quality of care in the 11 cancer hospitals that are exempt from the Medicare Inpatient Prospective Payment System (IPPS).

In its 2018-2019 pre-rulemaking deliberations, MAP reviewed one measure under consideration for the PCHQR program and did not support it for rulemaking with potential for mitigation.

MAP did not support the implementation of MUC18-150 *Surgical Treatment Complications for Localized Prostate Cancer* in PCHQR due to several concerns with the measure as specified. MAP noted the importance of patient-relevant outcomes for patients who have undergone surgical treatment for prostate cancer but questioned whether the measure fills a gap in the proposed program and if the measure is better suited to the clinician level of analysis in the outpatient setting. MAP discussed the differences between surgical procedures (e.g., open, closed, minimally invasive, robotic, etc.) and recommended that nonopen procedures be grouped separately. MAP also asked why the measure is limited to patients age 66 or older. They discussed the need for risk adjustment and noted that a patient-reported outcome (PRO) may be a better measure to capture patient symptoms. The measure developer acknowledged that facilities might find the measure results more meaningful and actionable if they are stratified by surgical procedure; however, the measure is intended to calculate one overall facility rate for accountability purposes. This is a facility level measure because it intends to capture the importance of the team-based approach to patient care. Additionally, the measure developer noted that the number of surgeons that would qualify for this measure at the clinician level of analysis likely would not be large enough. The measure developer clarified that the measure is specified for patients age 66 or older because the measure was tested with CMS claims data only. The measure developer also explained that risk adjustment is limited for cancer patients when using claims data (e.g., cancer stage not captured in claims data). The developer explained that risk adjusting the measure did not demonstrate any differences at the hospital level; therefore, they chose not to risk adjust the measure. The measure developer agreed with the importance of PROs and acknowledged the various barriers associated with converting this measure into a PRO (e.g., data collection burden, one-year time interval). MAP agreed with the NQF Scientific Methods Panel's recommendations and suggested that MUC18-150 be re-submitted to NQF for evaluation and endorsement before supporting it for future rulemaking. MAP acknowledged the importance of measuring outcomes for cancer patients and encouraged CMS to bring the measure back through the pre-rulemaking process once the measure developer revises it as recommended. MAP also noted the need for additional measures to capture the quality of cancer care.

INPUT ON ADDRESSING PAIN MANAGEMENT THROUGH QUALITY MEASUREMENT

For fiscal year 2018, CMS removed the pain questions from the HCAHPS due to concern about potential unintended consequences of opioid use. During the MAP meeting, CMS asked MAP for input on alternative questions to address areas of pain control. Members of the Workgroup recommended several adjustments and areas of consideration.

- **Focus on measuring expectations and appropriate care.** MAP members recommended focusing on questions that measure patient expectations of pain management and identification of appropriate care, rather than well-managed care. This reframing of questions will also encourage hospitals to set the patients' expectations for pain management. MAP supported the development of measures encouraging the assessment of alternative pain management methods in the hospital. MAP also emphasized the need to have patient-reported outcome measures related to pain.
- **Additional populations to consider.** MAP suggested CMS incorporate the perspectives of patients and family caregivers, patients with chronic pain, and behavioral health specialists during the measure development process. MAP members noted a need for measures that address individuals with current substance use disorders and measures that assess appropriate prescribing in dental care.
- **Realign incentives and intended effects.** MAP raised concerns regarding the misalignment of program incentives to and the intended effect of the measure. MAP noted that the linkage of incentives to patient experience does not achieve the goal of encouraging providers to adhere to prescribing guidelines. MAP suggested CMS consider these unintended consequences when implementing these measures. When implementing the measures in programs, MAP suggested CMS allow providers the flexibility to tailor the use of the measure to address the needs of their patient populations.
- **System level approach.** MAP emphasized that the management of pain is not setting-specific. MAP recognized than an outcome measure may not be appropriate. Pain management cannot be addressed through a single measure but instead requires a multifaceted approach. MAP noted the analysis of measure sets and systems may provide an appropriate approach. MAP recommended CMS consider measures that support improved interoperability and feasibility across settings. MAP also acknowledged the numerous successful activities to address opioid use at the state level.

APPENDIX A:
Program Summaries

The material in this appendix was extracted from the CMS Program Specific Measure Priorities and Needs document, which was released in May 2018, as well as the CMS website.

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

Program Type

- Pay for performance and public reporting

Incentive Structure

- 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 percent per year.

Program Goals

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

Measure Requirements

- Measures for anemia management reflecting FDA labeling, as well as measures for dialysis adequacy.
- Measure(s) of patient satisfaction, to the extent feasible.
- Measures of iron management, bone mineral metabolism, and vascular access, to the extent feasible.
- Measures should be NQF-endorsed, save where due consideration is given to endorsed measures of the same specified area or medical topic.
- Must include measures considering unique treatment needs of children and young adults.
- May incorporate Medicare claims and/or CROWNWeb data; alternative data sources will be considered depending on available infrastructure.

Prospective Payment System (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 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.

Measure Requirements

- Measures must adhere to CMS 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, as long as endorsed measures have been given due consideration.

- Measure specifications must be publicly available.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.
- Promote alignment with specific program attributes and across CMS and HHS programs. Measure alignment should support the measurement across the patient's episode of care, demonstrated by assessment of the person's trajectory across providers and settings.
- Potential use of the measure in a program does not result in negative unintended consequences (e.g., inappropriate reduced lengths of stay, overuse or inappropriate use of care or treatment, limiting access to care).
- Measures must be fully developed and tested, preferably in the PCH environment.
- Measures must be feasible to implement across PCHs (e.g., calculation, and reporting).
- Measure addresses an important condition/ topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure when implemented can lead to the desired outcomes and/or more appropriate costs.
- CMS has the resources to operationalize and maintain the measure.

Ambulatory Surgical Center Quality Reporting (ASCQR)

Program Type

- Pay-for-reporting and public reporting

Incentive Structure

- Ambulatory surgical centers (ACSs) that treat Medicare beneficiaries and fail to report data will receive a 2.0 percent reduction in their annual payment update. The program includes ASCs operating exclusively to provide surgical services to patients not requiring hospitalization.

Program Goals

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

Measure requirements

- Measure must adhere to CMS statutory requirements, including specification under the Hospital IQR program and posting dates on the Hospital Compare website.
  - 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, currently the National Quality Forum (NQF).
  - 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, as long as endorsed measures have been given due consideration.

- Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high-priority domains for future measure consideration.
- Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
- Measure must be field tested for the ASC clinical setting.
- Measure that is clinically useful.
- Reporting of measure limits data collection and submission burden since many ASCs are small facilities with limited staffing.
- Measure must supply sufficient case numbers for differentiation of ASC performance.
- Measure must promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Inpatient Psychiatric Facilities 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 percent reduction in annual payment update.

Program Goals

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

Measure Requirements

- Measure must adhere to CMS 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, as long as endorsed measures have been given due consideration.
- Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
- The measure assesses meaningful performance differences between facilities.
- The measure addresses an aspect of care affecting a significant proportion of IPF patients.
- Measure must be fully developed, tested, and validated in the acute inpatient setting.
- Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high-priority domains for future measure consideration.
- Measure must promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

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 percent reduction in annual payment update.

Program Goals

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

Measure Requirements

- Measure must adhere to CMS 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, as long as endorsed measures have been given due consideration.
- Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration.
- Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
- Measure must be fully developed, tested, and validated in the hospital outpatient setting.
- Measure must promote alignment across HHS and CMS programs.
- Feasibility of Implementation: An evaluation of feasibility is based on factors including, but not limited to:
  - The level of burden associated with validating measure data, both for CMS and for the end user.
  - Whether the identified CMS system for data collection is prepared to accommodate the proposed measure(s) and timeline for collection.
  - The availability and practicability of measure specifications (e.g., measure specifications in the public domain).
  - The level of burden the data collection system or methodology poses for an end user.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs)

Program Type

- Pay-for-reporting and public reporting

Incentive Structure

- Hospitals that do not participate or meet program requirements receive a 25 percent reduction of the annual payment update

Program Goals

- Progress towards paying providers based on the quality, rather than the quantity of care they give patients.
- Interoperability between EHRs and CMS data collection.
- To provide consumers information about hospital quality so they can make informed choices about their care.

Measure Requirements

- Measure must adhere to CMS 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, currently the National Quality Forum (NQF).
  - 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, as long as endorsed measures have been given due consideration.
- If feasible, measure must be claims-based or an electronically specified clinical quality measure (eCQM).
  - A Measure Authoring Tool (MAT) number must be provided for all eCQMs, created in the HQMF format.
  - eCQMs must undergo reliability and validity testing including review of the logic and value sets by the CMS partners, including, but not limited to, MITRE and the National Library of Medicine.
  - eCQMs must have successfully passed feasibility testing.
- Measure may not require reporting to a proprietary registry.
- Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
- Measure must be fully developed, tested, and validated in the acute inpatient setting.
- Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high-priority domains and/or measurement gaps for future measure consideration.
- Measure must promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Value-Based Purchasing (HVBP)

Program Type

- Pay for performance

Incentive Structure

- The amount withheld from reimbursements increases over time.
  - FY 2017 and future fiscal years: 2.0 percent

Program Goals

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

Measure Requirements

- Measure must adhere to CMS statutory requirements, including specification under the Hospital IQR program and posting dates on the *Hospital Compare* website.
  - 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, currently the National Quality Forum (NQF).
  - 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, as long as endorsed measures have been given due consideration.
- Measure may not require reporting to a proprietary registry.
- Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
- Measure must be fully developed, tested, and validated in the acute inpatient setting.
- Measure must address a Meaningful Measure area, with preference for measures addressing the high-priority domains and/or measurement gaps for future measure consideration.
- Measure must promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Readmissions Reduction Program (HRRP)

Program Type

- Pay for performance and public reporting (HRRP measure results are publicly reported annually on the *Hospital Compare* website)

Incentive Structure

- Diagnosis-related group (DRG) payment rates will be reduced based on a hospital's ratio of predicted to expected readmissions. The maximum payment reduction is 3 percent.

Program Goals

- Reduce excess readmissions in acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), which includes more than three-quarters of all hospitals.
- Provide consumers with information to help them make informed decisions about their healthcare.

Measure Requirements

- CMS is statutorily required to select measures for applicable conditions, which are defined

as conditions or procedures selected by the Secretary in which readmissions are high volume or high expenditure.

- Measures selected must be endorsed by the consensus-based entity with a contract under Section 1890 of the Act. However, the Secretary can select measures which are feasible and practical in a specified area or medical topic determined to be appropriate by the Secretary, that have not been endorsed by the entity with a contract under Section 1890 of the Act, as long as endorsed measures have been given due consideration.
- Measure methodology must be consistent with other readmissions measures currently implemented or proposed in the HRRP.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Acquired Condition Reduction Program (HACRP)

Program Type

- Pay-for-reporting and public reporting

Incentive Structure

- The 25 percent of hospitals that have the highest rates of HACs (as determined by the measures in the program) will have their Medicare payments reduced by 1.0 percent.

Program Goals

- Provide an incentive to reduce the incidence of HACs to improve both patient outcomes and the cost of care.
- 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.

Measure Requirements

- Measures must be identified as a HAC under Section 1886(d)(4)(D) or be a condition identified by the Secretary.
- Measures must address high-cost or high-volume conditions.
- Measures must be easily preventable by using evidence-based guidelines.
- Measures must not require additional system infrastructure for date submission and collection.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

APPENDIX B:
MAP Hospital Workgroup Roster and NQF Staff

WORKGROUP CHAIRS (VOTING)

Cristie Upshaw Travis, MSHHA (Co-Chair)

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