2015 Measures under Consideration List

Program Specific Measure Priorities and Needs

Centers for Medicare and Medicaid Services

Center for Clinical Standards and Quality

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Contents

Measure Selection Requirements for CMS Quality Initiatives

CMS quality initiative programs have identified requirements for selecting measures for future reporting years. In order for measures to be selected, all of the following requirements identified in Section 1 and 2 below, must be met, in addition to program-specific requirements identified in each program description.

1. **Measure Information Requirements**
    a. Title
    b. Numerator
    c. Denominator
    d. Exclusions
    e. Measure Steward
    f. Link to full specifications
    g. Established mechanism for data collection (e.g., CDC NHSN, AHRQ HCAHPS)

    In addition to the aforementioned requirements, electronically specified clinical quality measures (eCQMs) require the following information:

    h. Electronic specifications for eCQMs
    i. Link to full electronic specifications for eCQMs

2. **Measure Requirements**
    a. Measure is responsive to specific program goals and statutory requirements.
    b. 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 affordable care (i.e., NQF's Importance criteria).
    c. Measure addresses one or more of the six National Quality Strategy (NQS) priorities.
    d. Measure selection promotes alignment with CMS program attributes and across HHS programs.
    e. Measure reporting is feasible and measures have been fully developed and tested. In essence, measures must be tested for reliability and validity.
    f. Measure results and performance should identify opportunities for improvement. CMS will not select measures in which evidence already identifies high levels of performance with little opportunity for improvement, e.g. measures that are "topped out."
    g. Potential use of the measure in a program does not result in negative unintended consequences (e.g., reduced lengths of stay, overuse or inappropriate use of care or treatment, limiting access to care).
    h. Measures should not duplicate other measures currently implemented in programs.
    i. Feasibility testing must be conducted for eCQMs.

End-Stage Renal Disease Quality Incentive Program

Program History and Structure:

For more than 30 years, monitoring the quality of care provided to end-stage renal disease (ESRD) patients by dialysis facilities has been an important component of the Medicare ESRD payment system. The ESRD quality incentive program (QIP) is the most recent step in fostering improved patient outcomes by establishing incentives for dialysis facilities to meet or exceed performance standards established by CMS. The ESRD QIP is authorized by section 1881(h) of the Social Security Act, which was added by section 153(c) of Medicare Improvements for Patients and Providers (MIPPA) Act (the Act). CMS established the ESRD QIP for Payment Year (PY) 2012, the initial year of the program in which payment reductions were applied, in two rules published in the Federal Register on August 12, 2010, and January 5, 2011 (75 FR 49030 and 76 FR 628, respectively). Subsequently, CMS published rules in the Federal Register detailing the QIP requirements for PY 2013 through FY 2016. Most recently, CMS published a rule on November 6, 2014 in the Federal Register (79 FR 66119), providing the QIP requirements for PY2017 and PY 2018, with the intention of providing an additional year between finalization of the rule and implementation in future rules.

Section 1881(h) of the Act requires the Secretary to establish an ESRD QIP by (i) selecting measures; (ii) establishing the performance standards that apply to the individual measures; (iii) specifying a performance period with respect to a year; (iv) developing a methodology for assessing the total performance of each facility based on the performance standards with respect to the measures for a performance period; and (v) applying an appropriate payment reduction to facilities that do not meet or exceed the established Total Performance Score (TPS).

Current Program Measure Information:

The following is a table detailing the number of ESRD QIP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed for the ESRD QIP.

	Number of Measures in ESRD Quality Incentive Program	
NQS Primary Measure Domain	**Implemented/Finalized** *	**Proposed****
Effective Prevention and Treatment	12	TBD
Making Care Safer	2	TBD
Communication/Care Coordination	1	TBD
Best Practice of Healthy Living	0	TBD
Making Care Affordable	0	TBD
Patient and Family Engagement	1	TBD

**Implemented: Quality measures implemented for data collection.*

***Proposed: Quality measures proposed for data collection.*

The NPRM has not yet been released that would include proposed measures from the 2014 MUC list.

High Priority Domains for Future Measure Consideration:

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

1. Care Coordination: ESRD patients constitute a vulnerable population that depends on a large quantity and variety medication and frequent utilization of multiple providers, suggesting medication reconciliation is a critical issue. Dialysis facilities also play a substantial role in preparing dialysis patients for kidney transplants, and coordination of dialysis-related services among transient patients has consequences for a non-trivial proportion of the ESRD dialysis population.
2. Safety: ESRD patients are frequently immune-compromised, and experience high rates of blood stream infections, vascular access-related infections, and mortality. Additionally, some medications provided to treat ESRD patients may cause harmful side effects such as heart disease and a dynamic bone disease. Recently, oral-only medications were excluded from the bundle payment, increasing need for quality measures that protect against overutilization of oral-only medications.
3. Patient- and Caregiver-Centered Experience of Care: Sustaining and recovering patient quality of life was among the original goals of the Medicare ESRD program. This includes such issues as physical function, independence, and cognition. Quality of Life measures should also consider the life goals of the particular patient where feasible, to the point of including Patient-Reported Outcomes.

Measure Requirements:

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

Inpatient Rehabilitation Facility Quality Reporting Program

Program History and Structure:
The Quality Reporting Program (QRP) for Inpatient Rehabilitation Facilities (IRFs) was established in accordance with section 1886(j) of the Social Security Act as amended by section 3004(b) of the Affordable Care Act. The IRF QRP applies to all IRF facilities that receive the IRF PPS (e.g., IRF hospitals, IRF units that are co-located with affiliated acute care facilities, and IRF units affiliated with critical access hospitals [CAHs]). Data sources for IRF QRP measures include Medicare FFS claims, the Center for Disease Control's National Health Safety Network (CDC NHSN) data submissions, and Inpatient Rehabilitation Facility - Patient Assessment instrument (IRF-PAI) records. The IRF QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2014, IRFs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable IRF Prospective Payment System (PPS) payment update. Plans for future public reporting of IRF QRP measures are under development.

Further, the Improving Medicare Post-Acute Care Transformation (IMPACT Act of 2014, amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCH), Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF) and Home Health Agencies (HHA) to report data on resource use and other measures and standardized patient assessment data on quality measures and specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers; amending the Social Security Act for each of the provider types to add such requirements under the IMPACT Act. The IMPACT Act delineates the reporting of standardized assessment data on quality measures in at least the following domains: Functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings. It also delineates the implementation of resource use and other measures in at least these following domains: Total estimated Medicare spending per beneficiary Discharge to the community, all condition risk adjusted potentially presentable hospital readmission rates. Further, the IMPACT Act requires the modification of such assessment instruments to achieve the standardization of such data.

Current Program Measure Information:
The following is a table detailing the number of IRF QRP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed in the program:

NQS Primary Measure Domain	Number of Measures in Inpatient Rehabilitation Facility QRP	
	Implemented/Finalized *	Proposed**
Effective Prevention and Treatment	2	0
Making Care Safer	4	2
Communication/Care Coordination	1	6
Best Practice of Healthy Living	0	0
Making Care Affordable	0	0
Patient and Family Engagement	0	0

*Implemented/Finalized: Quality measures implemented/finalized for data collection.
**Proposed: Quality measures proposed for data collection.

High Priority Domains for Future Measure Consideration:
CMS identified the following four domains as high-priority for future measure consideration:

1. *Making Care Safer* (subdomains: hospital-acquired infections and hospital-acquired conditions): Patient safety is an important priority domain for the IRF QRP as IRF patients are at risk for injury due to falls, new or worsened pressure ulcers and infections such as CAUTI, C. Diff. and MRSA.
2. *Patient and Family Engagement:* A primary focus of IRF care is restoring functional status. Metrics showing change in self-care and mobility function and discharge self-care and mobility are under development. Metric for achievement of functional status goals such as discharge to community. In addition, the experiences of patients and caregivers are important to measure and are important priority for the IRF QRP.
3. *Making Care Affordable:* An important consideration for the IRF QRP is to better assess medical costs based on PAC episodes of care. Therefore, CMS is considering developing efficiency-based measures such as a Medicare Spending per Beneficiary measure concept.
4. *Communication/Care Coordination:* Assessing patient care transitions and rehospitalizations are important. Therefore, CMS is considering developing measures that assesses discharge to the community and potentially preventable readmissions.
5. *Communication/Care Coordination:* Infrastructure and processes for care coordination are important for the IRF QRP. Therefore, a medication reconciliation quality measure for IRF patients is being considered for future quality measure development. Medication reconciliation conceptually highlights care transitions and resident follow-up.

Long-Term Care Hospital Quality Reporting Program

Program History and Structure:
The Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) was established in accordance with section 1886(m) of the Social Security Act, as amended by Section 3004(a) of the Affordable Care Act. The LTCH QRP applies to all LTCHs facilities designated as an LTCH under the Medicare program. Data sources for LTCH QRP measures include Medicare FFS claims, the Center for Disease Control and Prevention's National Health Safety Network (CDC's NHSN) data submissions, and the LTCH Continuity Assessment Record and Evaluation Data Sets (LCDS). The LTCH QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2014, LTCHs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable Prospective Payment System (PPS) increase factor.

Further, the Improving Medicare Post-Acute Care Transformation (IMPACT Act of 2014, amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCH), Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF) and Home Health Agencies (HHA) to report data on resource use and other measures and standardized patient assessment data on quality measures and specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers; amending the Social Security Act for each of the provider types to add such requirements under the IMPACT Act. The IMPACT Act delineates the reporting of standardized assessment data on quality measures in at least the following domains: Functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings. It also delineates the implementation of resource use and other measures in at least these following domains: Total estimated Medicare spending per beneficiary Discharge to the community, all condition risk adjusted potentially presentable hospital readmission rates. Further, the IMPACT Act requires the modification of such assessment instruments to achieve the standardization of such data.

Current Program Measure Information (Includes Measures included in the FY 2015 NPRM):
The following is a table detailing the number of LTCH QRP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed in the program:

NQS Primary Measure Domain	Number of Measures in Long-Term Care Hospital QRP	
	Implemented/Finalized*	Proposed**
Effective Prevention and Treatment	0	0
Making Care Safer	7	2
Communication/Care Coordination	1	2
Best Practice of Healthy Living	1	0
Making Care Affordable	0	0
Patient and Family Engagement	0	0

*Implemented/Finalized: Quality measures implemented/finalized for data collection.
**Proposed: Quality measures proposed for data collection.

High Priority Domains for Future Measure Consideration:

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

1. *Effective Prevention and Treatment:* Having measures related to ventilator use, ventilator-associated event and ventilator weaning rate are a high priority for CMS as prolonged mechanical ventilator use is quite common in LTCHs and respiratory diagnosis with ventilator support for 96 or more hours is the most frequently occurring diagnosis.
2. *Effective Prevention and Treatment* (Aim: Healthy People/Healthy Communities): In discussions with LTCH providers, it was noted that mental health status is an important measure of care for LTCH patients. CMS is considering a Depression Assessment & Management quality measure.
3. *Patient and Family Engagement:* While rehabilitation and restoring functional status are not the primary goals of patient care in the LTCH setting, functional outcomes remain an important indicator of LTCH quality as well as key to LTCH care trajectories. Providers must be able to provide functional support to patients with impairments. Thus, metrics showing change in self-care and mobility function are under development.
4. *Patient and Family Engagement:* CMS would like to explore measures that will evaluate the patient's experiences of care as this is a high priority of providers. Therefore, the HCAHPS and Care Transition quality measure (CTM)-3 is being considered.
5. *Making Care Affordable:* An important consideration for the LTCH QRP is to better assess medical costs based on PAC episodes of care. Therefore, CMS is considering developing efficiency-based measures such as a Medicare Spending per Beneficiary measure concept.
6. *Communication/Care Coordination:* Assessing patient care transitions and rehospitalizations are important. Therefore, CMS is considering developing measures that assesses discharge to the community and potentially preventable readmissions.
7. *Communication/Care Coordination:* Infrastructure and processes for care coordination are important for the LTCH QRP. Therefore, a medication reconciliation quality measure for LTCH patients is being considered for future quality measure development. Medication reconciliation conceptually highlights care transitions and resident follow-up.

Home Health Quality Reporting Program

Program 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. Section 1895(b) (3)(B)(v)(I) of the Act also requires that HHAs that do not submit quality data to the Secretary be subject to a 2 percent reduction in the annual payment update, effective in calendar year 2007 and every subsequent year. Data sources for the HH QRP include the Outcome and Assessment Information Set (OASIS) and Medicare FFS claims. Data is publically reported on the Home Health Compare website. The HH QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups.

Further, the Improving Medicare Post-Acute Care Transformation (IMPACT Act of 2014, amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCH), Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF) and Home Health Agencies (HHA) to report data on resource use and other measures and standardized patient assessment data on quality measures and specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers; amending the Social Security Act for each of the provider types to add such requirements under the IMPACT Act. The IMPACT Act delineates the reporting of standardized assessment data on quality measures in at least the following domains: Functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings. It also delineates the implementation of resource use and other measures in at least these following domains: Total estimated Medicare spending per beneficiary Discharge to the community, all condition risk adjusted potentially presentable hospital readmission rates. Further, the IMPACT Act requires the modification of such assessment instruments to achieve the standardization of such data.

Current Program Measure Information:
The following is a table detailing the number of HH QRP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed for the HH QRP.

NQS Primary Measure Domain	**Number of Measures in Home Health QRP**	
	Implemented/Finalized*	**Proposed****
Effective Prevention and Treatment	53	TBD***
Making Care Safer	9	TBD***
Communication/Care Coordination	9	TBD***
Best Practice of Healthy Living	6	TBD***
Making Care Affordable	0	TBD***
Patient and Family Engagement	9	TBD***

*Implemented/Finalized: Quality measures implemented/finalized for data collection.
**Proposed: Quality measures proposed for data collection. NOTE: The NPRM has not yet been released that would include proposed measures from the 2014 MUC list.
***TBD as of April 17, 2015

High Priority Domains for Future Measure Consideration:

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

1. *Patient and Family Engagement:* Quality care in home health settings should addressed not only assessing for what the patient/family desires, but also to assess how well care is provided and what services are offered to meet an individual's care preferences.
2. *Patient and Family Engagement:* Functional status and functional decline are important to assess for individuals who reside in a home-based setting. Individuals who receive care in home-based settings may have functional limitations and may be at risk for further decline in function due to limited mobility and ambulation. Therefore, measures to assess functional status are in development.
3. *Making Care Safer:* Safety for individuals in a home-based setting is an important priority for the HH QRP as persons in home health settings are at risk for major injury due to falls, new or worsened pressure ulcers, pain, and functional decline. Therefore, these concepts will be considered for future measure development.
4. *Making Care Affordable:* An important consideration for the HH QRP is to better assess medical costs based on PAC episodes of care. Therefore, CMS is considering developing efficiency-based measures such as a Medicare Spending per Beneficiary measure concept.
5. *Communication/Care Coordination:* Assessing an individual's care transitions and rehospitalizations is important. Therefore, CMS is considering developing measures that assesses discharge to the community and potentially preventable readmissions.
6. *Communication/Care Coordination:* Infrastructure and processes for care coordination are important for the HH QRP. Therefore, a medication reconciliation quality measure for individuals in a home health setting is being considered for future quality measure development. Medication reconciliation conceptually highlights care transitions and resident follow-up.

Hospice Quality Reporting Program

Program History and Structure:
The Hospice Quality Reporting Program (HQRP) was established in accordance with section 1814(i) of the Social Security Act, as amended by section 3004(c) of the Affordable Care Act. The HQRP applies to all hospices, regardless of setting. Proposed data sources for future HQRP measures include the Hospice Item Set and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaire. HQRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2014, Hospices that fail to submit quality data will be subject to a 2.0 percentage point reduction to their annual payment update.

Current Program Measure Information:
The following is a table detailing the number of HQRP measures (prioritized under the National Quality Strategy (NQS) quality measure domains) that are currently implemented or proposed in the program:

NQS Primary Measure Domain	Number of Measures in Hospice QRP	
	Implemented/Finalized *	Proposed**
Effective Prevention and Treatment	6	TBD***
Making Care Safer	0	TBD***
Communication/Care Coordination	0	TBD***
Best Practice of Healthy Living	0	TBD***
Making Care Affordable	0	TBD***
Patient and Family Engagement	1	TBD***

*Implemented/Finalized: Quality measures implemented/finalized for data collection.
**Proposed: Quality measures proposed for data collection. NOTE: The NPRM has not yet been released that would include proposed measures from the 2014 MUC list.
***TBD as of April 17, 2015

High Priority Domains for Future Measure Consideration:
CMS identified the following domains as high-priority for Hospice QRP future measure consideration:

1. Overall goal HQRP: Symptom Management Outcome Measures. There is a lack of tested and endorsed outcome measures for hospice across domains of hospice care, including symptom management (e.g.; physical and other symptoms). Developing and implementing outcome measures for hospice is important for providers, patients and families, and other stakeholders because symptom management is a central aspect of hospice care.
2. Communication/Care Coordination and/or Patient and Family Engagement: Patient preference for care is difficult to measure at end of life when patients may or may not be able to state their preferences, and may have changes in their preferences. However, a central tenet of hospice care is responsiveness to patient and family care preferences; as much as possible, patient preferences should be incorporated into new measure development.
3. Patient and Family Engagement: Measurement of goal attainment is naturally linked to determining patient/family preferences. Quality care in hospice should address not only establishing what the patient/family desires but also providing care and services in line with those preferences.
4. Making Care Safer: Timeliness/responsiveness of care. While timeliness of referral to hospice is not within a hospices' control, hospice initiation of treatment once a patient has elected the hospice benefit is under the control of the hospice. Responsiveness of the hospice during times

of patient or family need is an important indicator about hospice services for consumers in particular.

5. Communication/Care Coordination: Measurement of care coordination is integral to the provision of quality care and should be aligned across care settings.

Merit-Based Incentive Payment System (MIPS)

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

Current Program Measure Information:
To implement the quality category of the MIPS, CMS anticipates using the measures in the existing quality programs (PQRS, VM and EHR).
The following is a table detailing the number of quality and cost measures prioritized under each domain that are currently implemented in the existing physician quality programs and that could be eligible for implementation in the MIPS program:

NQS Primary Measure Domain	Number of Measures	
	Implemented/Finalized* **(2015 Measure Set)**	**Proposed** ** **(2014 MUC list)**
Effective Clinical Care	138	TBD***
Patient Safety	34	TBD***
Communication/Care Coordination	40	TBD***
Community/Population Health	15	TBD***
Efficiency and Cost Reduction	21	TBD***
Person and Caregiver-Centered Experience and Outcomes	14	TBD***
TOTAL	257	TBD***

*Implemented/Finalized: Quality measures implemented/finalized for data collection.
**Proposed: The NPRM has not yet been released that would include proposed measures from the 2014 MUC list.
***TBD as of April, 2015

High Priority Domains for Future Measure Consideration:
In the CY 2016 PFS Rule, CMS will not propose the implementation of measures that do not meet the MIPS criteria of performance and measure set gaps. MIPS has a priority focus on outcome measures and

measures that are relevant for specialty providers. CMS identifies the following domains as high-priority for future measure consideration:

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

Measure Requirements:

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

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

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

- Measures implemented in MIPS may be available for public reporting on Physician Compare.
    - Preference will be given to electronically specified measures (eCQMs)
- eCQMs must meet EHR system infrastructure requirements, as defined by the future MIPS regulation.
    - The data collection mechanisms must be able to transmit and receive requirements as identified in future MIPS regulation. For example, eCQMs must meet QRDA standards.
- Measures must be fully developed and tested.
    - Reliability and validity testing must be conducted for measures.
    - Feasibility testing must be conducted for eCQMs.
- Measures should not duplicate other measures currently in the MIPS. Duplicative measures are assessed to see which would be the better measure for the MIPS measure set.
- Measure performance and evidence should identify opportunities for improvement. CMS does not intend to implement measures in which evidence identifies high levels of performance with little variation or opportunity for improvement, e.g. measures that are “topped out.”

Physician Compare

Program History and Structure:

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

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

2013 PQRS GPRO and ACO measures

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

2013 CAHPS for ACOs measures

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

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

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

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

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

	Number of Measures Finalized for Potential Reporting on Physician Compare									
	2012 PFS Final Rule		2013 PFS Final Rule		2014 PFS Final Rule			2015 PFS Final Rule		
NQS Priority Domains	Groups	ACOs	Groups	ACOs	EPs	Groups	ACOs	EPs	Groups	ACOs
Effective Clinical Care	27	20	20	20	13	14	14	110	138	8
Patient Safety	1	1	1	1	2	2	2	26	34	2
Communication/Care Coordination	1	1	1	1	0	0		29	37	0
Community/Population Health	0	0	0	0	5	5	5	14	15	5
Efficiency and Cost Reduction	0	0	0	0	0	0	0	15	16	0
Person and Caregiver-Centered Experience and Outcomes	0	0	25	35	0	12	12	12	14	12

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

- Outcome measures
- Composite measures
- Risk adjusted measures

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

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

Consumers can provide valuable feedback when engaged early in the measure development process. They can determine if measures are understandable and useful in decision making. We understand that all measures are not intended for public reporting. However, the continued growth of public reporting makes the consumer perspective increasingly important. Moving towards more consumer-friendly measures, specifically outcome measures, composite measures, and risk-adjusted measures, will be instrumental toward achieving Physician Compare's goal, as defined by the Affordable Care Act, of providing consumers useful quality data to inform health care decisions.

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

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

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

Medicare Shared Savings Program

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

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

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

Domain	Number of Measures Implemented
Patient/Caregiver Experience	8
Care Coordination/Patient Safety	10
Preventive Health	8
Clinical Care for At Risk Population	7

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

Measure Requirements:
Specific measure requirements include:

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

Hospital Acquired Condition Reduction Program

Program History and Structure:
Section 3008 of the Patient Protection and Affordable Care Act of 2010 (ACA) established the Hospital-Acquired Condition (HAC) Reduction Program (HAC Reduction Program). Created under Section 1886(p) of the Social Security Act (the Act), the HAC Reduction Program provides an incentive for hospitals to reduce the number of HACs. Effective Fiscal Year (FY) 2014 and beyond, the HAC Reduction Program requires the Secretary to make payment adjustments to applicable hospitals that rank in the top quartile of all subsection (d) hospitals relative to a national average of HACs acquired during an applicable hospital stay. HACs include a condition identified in subsection 1886(d)(4)(D)(iv) of the Act and any other condition determined appropriate by the Secretary. Section 1886(p)(6)(C) of the Act requires the HAC information be posted on the Hospital Compare website.

CMS finalized in the FY 2014 IPPS/LTCH PPS final rule that hospitals will be scored using a Total HAC Score based on measures categorized into two (2) domains of care, each with a different set of measures. Domain 1 consists of Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI), and Domain 2 consists of Hospital Associated Infections (HAI) as collected by the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). Both domains of the HAC Reduction Program are categorized under the National Quality Strategy (NQS) priority of "Making Care Safer". Measures in each domain are assigned points so that each domain has a score. In the FY 2016 IPPS/LTCH PPS proposed rule, we are proposing that the weighting of the domain scores be changed as follows for the FY 2017 program: (1) Domain 1 weight would be decreased from 25% to 15%; and (2) Domain 2 weight would be increased from 75% to 85%. The Total HAC Score is the sum of the two weighted domain scores.

Current Program Measure Information:
The following table details the number of quality measures finalized since the FY 2015 IPPS/LTCH PPS final rule. All measures in the HAC Reduction Program address the NQS priority of "Making Care Safer".

NQS Primary Measure Domain	Number of Measures in Hospital-Acquired Condition Reduction Program	
	Implemented/Finalized *	**Proposed****
Effective Prevention and Treatment	0	0
Making Care Safer	6	0
Communication/Care Coordination	0	0
Best Practice of Healthy Living	0	0
Making Care Affordable	0	0
Patient and Family Engagement	0	0
Not Assignable	0	0

**Implemented/Finalized: Quality measures implemented/finalized for performance calculation and payment adjustment..*
***Proposed: Quality measures proposed for performance calculation and payment adjustment.*

High Priorities for Future Measure Consideration:
For FY 2017 federal rulemaking, CMS may propose the adoption, removal, and/or suspension of measures for fiscal years 2018 and beyond of the HAC Reduction Program. CMS identified the following topics as areas within the NQS priority of "Making Care Safer" for future measure consideration:

1. Making Care Safer:
    a. Adverse Drug Events
    b. Ventilator Associated Events
    c. Additional Surgical Site Infection Locations
    d. Outcome Risk-Adjusted Measures

Measure Requirements:
CMS applies criteria for measures that may be considered for potential adoption in the HAC Reduction Program. At a minimum, the following requirements must be met for consideration in the HAC Reduction Program:

- 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.
- Measures must be risk adjusted.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Readmissions Reduction Program

Program History and Structure:
Section 3025 of the Patient Protection and Affordable Care Act of 2010 (ACA) established the Hospital Readmissions Reduction Program (HRRP). Codified under Section 1886(q) of the Social Security Act (the Act), the HRRP provides an incentive for hospitals to reduce the number of excess readmissions that occur in their settings. Effective Fiscal Year (FY) 2012 and beyond, the HRRP requires the Secretary to establish readmission measures for applicable conditions and to calculate an excess readmission ratio for each applicable condition, which will be used to determine a payment adjustment to those hospitals with excess readmissions. A readmission is defined as an admission to an acute care hospital within 30 days of a discharge from the same or another acute care hospital. A hospital's excess readmission ratio measures a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. Applicable conditions in the HRRP program currently include measures for acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, and elective total knee and total hip arthroplasty. Readmission following coronary artery bypass graft surgery has been finalized as an applicable condition beginning with the FY 2017 payment determination. Planned readmissions are excluded from the excess readmission calculation.

Current Program Measure Information:
The following table details the number of quality measures finalized in prior rulemaking. All measures in the HRRP program address the National Quality Strategy (NQS) priority of "Communication/Care Coordination".

NQS Primary Measure Domain	Number of Measures in Hospital Readmissions Reduction Program	
	Implemented/Finalized *	**Proposed****
Effective Prevention and Treatment	0	0
Making Care Safer	0	0
Communication/Care Coordination	6	0
Best Practice of Healthy Living	0	0
Making Care Affordable	0	0
Patient and Family Engagement	0	0

**Implemented/Finalized: Quality measures implemented/finalized for performance calculation and payment adjustment.*
***Proposed: Quality measures proposed for performance calculation and payment adjustment.*

High Priority Domains for Future Measure Consideration:
For FY 2017 federal rulemaking, CMS may propose the adoption, removal, refinement, and or suspension of measures for fiscal year 2018 and subsequent years of the HRRP. CMS continues to emphasize the importance of the NQS priority of "Communication/Care Coordination" for this program.

- Care Coordination
    - Measures that address high impact conditions identified by the Medicare Payment Advisory Commission or the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) reports.

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the HRRP program. At a minimum, the following criteria and requirements must be met for consideration in the HRRP program:

- 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 program.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Inpatient Quality Reporting, EHR Incentive Program, and Value-Based Purchasing Program

Program History and Structure:
The Hospital Inpatient Quality Reporting (IQR) Program was established by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and later amended by the Deficit Reduction Act (DRA) of 2005. The program 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 receive a quarter of the applicable percentage point of the annual market basket (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) payment update. Hospitals who choose non-participation in the program receive a reduction by that same amount. Performance of quality measures are publicly reported on the CMS Hospital Compare website.

The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5) amended Titles XVIII and XIX of the Social Security Act (the Act) to authorize incentive payments to eligible hospitals (EHs) and Critical Access Hospitals (CAHs) and other groups eligible to participate in the EHR Incentive Program, to promote the adoption and meaningful use of certified electronic health record (EHR) technology (CEHRT). EHs and CAHs are required to report on electronically specified clinical quality measures (eCQMs) using CEHRT in order to qualify for incentive payments under the Medicare and Medicaid EHR Incentive. All EHR Incentive Program requirements related to eCQM reporting will be addressed in IQR Program rulemaking including, but not limited to, new program requirements, reporting requirements, reporting and submission periods, reporting methods, and information regarding the eCQMs.

The Hospital Value-Based Purchasing (VBP) Program was established by Section 3001(a) of the Affordable Care Act, under which value-based incentive payments are made in a fiscal year to hospitals meeting performance standards established for a performance period for such fiscal year. The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. However, measures of five conditions (acute myocardial infarction, pneumonia, heart failure, surgeries, and healthcare-associated infections), the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and efficiency measures must be included. Measures are eligible for adoption in the Hospital VBP Program based on the statutory requirements, including specification under the Hospital IQR Program and posting dates on the *Hospital Compare* Web site.

Current Program Measure Information:
The following tables detail the number of quality measures currently implemented in each program:

NQS Priority	Number of Measures in Hospital IQR Program Number of eCQMs reportable under both IQR and EHR Incentive Programs are listed in parenthesis ( )	
	Finalized *	**Proposed****
Effective Prevention and Treatment	22 (14)	-4 (0)
Making Care Safer	18 (6)	-1 (0)
Communication/Care Coordination	11 (2^)	2 (0)
Best Practice of Healthy Living	1 (0)	0 (0)
Making Care Affordable	4 (2)	5 (0)
Patient and Family Engagement	4 (5)	-1 (0)
Not Assignable	2	0

Domain	Number of Measures in Hospital VBP Program	
	Finalized*	**Proposed****
Clinical Care	3 Process	-2 Process
	3 Outcome	1 Outcome
Safety	6	0†
Efficiency and Cost Reduction	1	0
Patient and Caregiver-Centered Experience of Care/Care Coordination	1	1

** Finalized: Quality measures implemented/finalized for data collection (excludes suspended measures)*
***Proposed: Quality measures proposed and proposed for removal in FY 2016 IPPS Proposed Rule*
^ All EHR Incentive Program eCQMs, represented in parenthesis, are reportable in both the EHR Incentive and IQR program except ED-3--Median time from ED arrival to ED discharge for discharged patients which may be submitted to EHR Incentive program
† *Proposed movement of a clinical care-process measure to the safety domain*

High Priority Domains for Future Measure Consideration:
CMS identified the following categories as high-priority for future measure consideration:

1. **Patient and Family Engagement:**
    a. Measures that foster the engagement of patients and families as partners in their care.
2. **Best Practices of Healthy Living:**
    a. Measures that promote best practices to enable healthy living.
3. **Making Care Affordable:**
    a. Measures that effectuate changes in efficiency and reward value over volume.

Measurement Gaps for Future Measure Consideration:
CMS identified the following topics/areas as high-priority for future measure consideration:

Adverse Drug Events	**Cancer**	**Palliative and End of Life Care**
Behavioral Health	**Care Transitions**	**Medication Reconciliation**

Measure Requirements:
CMS applies criteria for measures that may be considered for potential adoption in the IQR program. At a minimum, the following criteria will be considered in selecting measures for IQR program implementation:

1. 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
2. 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
3. Measure may not require reporting to a proprietary registry.
4. 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.
5. Measure must be fully developed, tested, and validated in the acute inpatient setting.
6. 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.
7. Measure must promote alignment across HHS and CMS programs.
8. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Inpatient Psychiatric Facility Quality Reporting Program

Program History and Structure:
The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program was established by Section 1886(s)(4) of the Social Security Act, as added by sections 3401(f)(4) and 10322(a) of the Patient Protection and Affordable Care Act (the Affordable Care Act). Under current regulations, the program requires participating inpatient psychiatric facilities (IPFs) to report on 10 quality measures or face a 2.0 percentage point reduction to their annual update. Reporting on these measures apply to payment determinations for Fiscal Year (FY) 2016 and beyond. The reporting period for the FY 2016 payment determination was CY 2014, with the exception of the Follow-Up After Hospitalization for Mental Illness measure which was July 1, 2013 – June 30, 2014. Four measures were added for the FY 2017 payment determination, two with reporting periods of October 1, 2015 - March 31, 2016 and two with reporting periods of CY 2015.

Current Program Measure Information:
The program seeks to adopt measures that reflect the priorities of the National Quality Strategy (NQS) and CMS Quality Strategy goals. The following is a table detailing the number of quality measures under each NQS Priority/CMS Quality Strategy Goal that are currently implemented in the program and proposed for adoption or removal:

NQS Priorities/CMS Quality Strategy Goals	Number of Measures in IPFQR Program	
	Implemented/Finalized*	**Proposed****
Effective Prevention and Treatment	4	-1, +2
Making Care Safer	2	+1
Communication/Care Coordination	3	-2, +2
Best Practice of Healthy Living	2	0
Making Care Affordable	0	0
Patient and Family Engagement	1	0
Not Assignable	1	0

**Implemented/Finalized: Quality measures implemented/finalized for data collection.*
***Proposed: Quality measures proposed for removal and new data collection in the FY 2016 IPF PPS proposed rule.*

High Priority Domains for Future Measure Consideration:
CMS identified the following categories as high-priority for future measure consideration:

1. **Patient and Family Engagement**
    a. Patient experience of care
2. **Effective Prevention and Treatment**
    a. Inpatient psychiatric treatment and quality of care of geriatric patients and other adults, adolescents, and children
    b. Quality of prescribing for antipsychotics and antidepressants
3. **Communication/Care Coordination**
    a. Readmissions and re-hospitalizations
4. **Best Practices of Healthy Living**
    a. Screening and treatment for non-psychiatric comorbid conditions for which patients with mental or substance use disorders are at higher risk
    b. Access to care
5. **Making Care Affordable**
    a. Measures which effectuate changes in efficiency and that reward value over volume.

Measure Requirements:
CMS applies criteria for measures that may be considered for potential adoption in the IPFQR program. At a minimum, the following criteria will be considered in selecting measures for IPFQR program implementation:

1. 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
2. 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.
3. The measure assesses meaningful performance differences between facilities.
4. The measure addresses an aspect of care affecting a significant proportion of IPF patients.
5. Measure must be fully developed, tested, and validated in the acute inpatient setting.
6. Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration.
7. Measure must promote alignment across HHS and CMS programs.
8. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

Program History and Structure:
Section 3005 of the Affordable Care Act added new subsections (a)(1)(W) and (k) to section 1866 of the Social Security Act (the Act). Section 1866(k) of the Act establishes a quality reporting program for hospitals described in section 1886(d)(1)(B)(v) of the Act (referred to as a "PPS-Exempt Cancer Hospital" or "PCH"). Section 1866(k)(1) of the Act states that, for FY 2014 and each subsequent fiscal year, a PCH shall submit data to the Secretary in accordance with section 1866(k)(2) of the Act with respect to such a fiscal year. In FY 2014 and each subsequent fiscal year, each hospital described in section 1886(d)(1)(B)(v) of the Act shall submit data to the Secretary on quality measures (QMs) specified under section 1866(k)(3) of the Act in a form and manner, and at a time, specified by the Secretary.

The program requires PCHs to submit data for selected QMs to CMS. PCHQR is a voluntary quality reporting program, in which data will be publicly reported on a CMS website. In the FY 2012 IPPS rule, five NQF endorsed measures were adopted and finalized for the FY 2014 reporting period, which was the first year of the PCHQR program. In the FY 2013 IPPS rule, one additional measure was adopted. Twelve new measures were adopted in the FY 2014 IPPS rule and one measure was adopted in the FY 2015 IPPS rule. Data collection for the FY 2016 and FY 2017 reporting periods is underway. We published the FY 2014 measure rates on HospitalCompare.gov on October 1, 2014 after a 30-day preview period.

Current Program Measure Information:
The following is a table detailing the number of quality measures prioritized under each NQS Priority/CMS Quality Strategy Goal that are currently implemented in the program:

NQS Priorities/CMS Quality Strategy Goals	Number of Measures in PPS-Exempt Cancer Hospital QRP	
	Implemented/Finalized *	**Proposed****
Effective Prevention and Treatment	12	-6^
Making Care Safer	3	+2
Communication/Care Coordination	2	0
Best Practice to Enable Healthy Living	0	+1
Making Care Affordable	1	0
Person and Family Engagement	1	0
Not Assignable	0	0

**Implemented/Finalized: Quality measures implemented/finalized for data collection.*
***Proposed: Quality measures proposed for removal and new data collection in FY 2016 IPPS proposed rule.*
^ Proposed removing six measures.

High Priority Domains for Future Measure Consideration:
CMS identified the following categories as high-priority for future measure consideration:

1. **Communication and Care Coordination**
   - Measures regarding care coordination with other facilities and outpatient settings, such as hospice care.
   - Measures of the patient's functional status, quality of life, and end of life.
2. **Making Care Affordable**
   - Measures related to efficiency, appropriateness, and utilization (over/under-utilization) of cancer treatment modalities such as chemotherapy, radiation therapy, and imaging treatments.

3. Person and Family Engagement

- Measures related to patient-centered care planning, shared decision-making, and quality of life outcomes.

Measure Requirements:

The following requirements will be considered by CMS when selecting measures for program implementation:

1. Measure is responsive to specific program goals and statutory requirements.
    a. Measures are required to reflect consensus among stakeholders, 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)
    b. 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
2. Measure specifications must be publicly available.
3. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.
4. 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.
5. 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).
6. Measures must be fully developed and tested, preferably in the PCH environment.
7. Measures must be feasible to implement across PCHs, e.g., calculation, and reporting.
8. 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.
9. CMS has the resources to operationalize and maintain the measure.

Ambulatory Surgical Center Quality Reporting Program

Program History and Structure:
The Ambulatory Surgical Center (ASC) Quality Reporting Program 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 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 2.0 percentage point 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.

Current Program Measure Information:
The following is a table detailing the number of quality measures prioritized under each National Quality Strategy (NQS) Priority and CMS Quality Strategy Goal that are currently implemented in the program as finalized in the CY 2015 OPPS and prior rules and in the CY 2016 OPPS proposed rule for adoption or removal:

NQS Priorities / CMS Quality Strategy Goals	Number of Measures in ASCQR Program	
	Implemented/Finalized *	**Proposed****
Effective Prevention and Treatment	2	0
Making Care Safer	6	0
Communication/Care Coordination	1	0
Best Practice of Healthy Living	0	0
Making Care Affordable	2	0
Patient and Family Engagement	0	0
Not Assignable	1	0

**Implemented/Finalized: Quality measures implemented/finalized for data collection.*
***Proposed: Quality measures proposed for data collection in CY 2016 OPPS proposed rule.*

High Priority Domains for Future Measure Consideration:
CMS identified the following categories as high-priority for future measure consideration:

1. **Making Care Safer**
   a. Measures of infection rates
2. **Person and Family Engagement**
   a. Measures that improve experience of care for patients, caregivers, and families.
   b. Measures to promote patient self-management.
3. **Best Practice of Healthy Living**
   a. Measures to increase appropriate use of screening and prevention services.
   b. Measures which will improve the quality of care for patients with multiple chronic conditions.
   c. Measures to improve behavioral health access and quality of care.
4. **Effective Prevention and Treatment**
   a. Surgical outcome measures
5. **Communication/Care Coordination**

a. Measures to embed best practice to manage transitions across practice settings.
b. Measures to enable effective health care system navigation.
c. To reduce unexpected hospital/emergency visits and admissions.

Measure Requirements:
CMS applies criteria for measures that may be considered for potential adoption in the ASCQR program. At a minimum, the following requirements will be considered in selecting measures for ASCQR Program implementation:

1. Measure must adhere to CMS statutory requirements.
    a. 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
    b. 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
2. Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration.
3. 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.
4. Measure must be field tested for the ASC clinical setting.
5. Measure that is clinically useful.
6. Reporting of measure limits data collection and submission burden since many ASCs are small facilities with limited staffing.
7. Measure must supply sufficient case numbers for differentiation of ASC performance.
8. Measure must promote alignment across HHS and CMS programs.
9. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Outpatient Quality Reporting Program

Program History and Structure:
The Hospital Outpatient Quality Reporting (OQR) Program was 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. Hospitals receive a 2.0 percentage point reduction of their annual payment update (APU) under the Outpatient Prospective Payment System (OPPS) for non-participation in the program. Performance on quality measures is publicly reported on the CMS *Hospital Compare* website.

Current Program Measure Information:
The following is a table detailing the number of quality measures prioritized under each National Quality Strategy (NQS) Priority and CMS Quality Strategy Goal that are currently implemented in the program as finalized in the CY 2015 OPPS and prior rules and in the CY 2016 OPPS proposed rule for adoption or removal:

NQS Priorities / CMS Quality Strategy Goals	Number of Measures in Hospital OQR Program,	
	Implemented/Finalized *	**Proposed****
Effective Prevention and Treatment	10	+1
Making Care Safer	2	0
Communication/Care Coordination	3	+1
Best Practice of Healthy Living	0	0
Making Care Affordable	8	-1
Patient and Family Engagement	1	0
Not Assignable	1	0

**Implemented/Finalized: Quality measures implemented/finalized for data collection.*
***Proposed: Quality measures proposed for removal and new data collection in CY 2016 OPPS proposed rule.*

High Priority Domains for Future Measure Consideration:
CMS identified the following categories as high-priority for future measure consideration:

1. **Making Care Safer:**
    a. Measures that address processes and outcomes designed to reduce risk in the delivery of health care, e.g., emergency department overcrowding and wait times.
2. **Best Practices of Healthy Living:**
    a. Measures that focus on primary prevention of disease or general screening for early detection of disease unrelated to a current or prior condition.
3. **Patient and Family Engagement**:
    a. Measures that address engaging both the person and their family in their care.
    b. Measures that address cultural sensitivity, patient decision-making support or care that reflects patient preferences.
4. **Communication/Care Coordination:**
    a. Measures to embed best practices to manage transitions across practice settings.
    b. Measures to enable effective health care system navigation.
    c. Measures to reduce unexpected hospital/emergency visits and admissions.

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the HOQR program. At a minimum, the following criteria will be considered in selecting measures for HOQR program implementation:

1. Measure must adhere to CMS statutory requirements.
    a. 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
    b. 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
2. Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration.
3. 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.
4. Measure must be fully developed, tested, and validated in the hospital outpatient setting.
5. Measure must promote alignment across HHS and CMS programs.
6. Feasibility of Implementation: An evaluation of feasibility is based on factors including, but not limited to
    a. The level of burden associated with validating measure data, both for CMS and for the end user.
    b. Whether the identified CMS system for data collection is prepared to accommodate the proposed measure(s) and timeline for collection.
    c. The availability and practicability of measure specifications, e.g., measure specifications in the public domain.
    d. The level of burden the data collection system or methodology poses for an end user.
7. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Skilled Nursing Facility Quality Reporting System

Program History and Structure:
The Improving Medicare Post-Acute Care Transitions Act of 2014 (The IMPACT Act) added Section 1899B to the Social Security Act establishing the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). Facilities that submit data under the SNF PPS are required to participate in the SNF QRP, excluding units that are affiliated with critical access hospitals (CAHs). Data sources for SNF QRP measures include Medicare FFS claims as well as Minimum Data Set (MDS) assessment data. The SNF QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2018, providers that fail to submit required quality data to CMS will have their annual updates reduced by 2.0 percentage points.

Further, the Improving Medicare Post-Acute Care Transformation (IMPACT Act of 2014, amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCH), Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF) and Home Health Agencies (HHA) to report data on resource use and other measures and standardized patient assessment data on quality measures and specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers; amending the Social Security Act for each of the provider types to add such requirements under the IMPACT Act. The IMPACT Act delineates the reporting of standardized assessment data on quality measures in at least the following domains: Functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings. It also delineates the implementation of resource use and other measures in at least these following domains: Total estimated Medicare spending per beneficiary Discharge to the community, all condition risk adjusted potentially presentable hospital readmission rates. Further, the IMPACT Act requires the modification of such assessment instruments to achieve the standardization of such data.

Current Program Measure Information:
The following is a table detailing the number of SNF QRP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed for the SNF QRP.

NQS Primary Measure Domain	Number of Measures in Skilled Nursing Facility QRP	
	Implemented/Finalized*	Proposed**
Effective Prevention and Treatment	0	0
Making Care Safer	0	2
Communication/Care Coordination	0	1
Best Practice of Healthy Living	0	0
Making Care Affordable	0	0
Patient and Family Engagement	0	0

*Implemented/Finalized: Quality measures implemented/finalized for data collection.
**Proposed: Quality measures proposed for data collection.

High Priority Domains for Future Measure Consideration:

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

1. *Patient and Family Engagement:* Functional status and functional decline are important to assess for residents in SNF settings. Residents who receive care while in a SNF may have functional limitations and may be at risk for further decline in function due to limited mobility and ambulation. Therefore, measures to assess functional status are in development.
2. *Making Care Safer:* Resident safety is an important priority domain for the SNF QRP as persons in SNF settings are at risk for major injury due to falls, new or worsened pressure ulcers, pain, and functional decline. Therefore, these concepts will be considered for future measure development.
3. *Making Care Affordable:* An important consideration for the SNF QRP is to better assess medical costs based on PAC episodes of care. Therefore, CMS is considering developing efficiency-based measures such as a Medicare Spending per Beneficiary measure concept.
4. *Communication/Care Coordination:* Assessing resident care transitions and rehospitalizations are important. Therefore, CMS is considering developing measures that assesses discharge to the community and potentially preventable readmissions.
5. *Communication/Care Coordination:* Infrastructure and processes for care coordination are important for the SNF QRP. Therefore, a medication reconciliation quality measure for SNF residents is being considered for future quality measure development. Medication reconciliation conceptually highlights care transitions and resident follow-up.

Skilled Nursing Facility Value-Based Purchasing Program

Program History and Structure:
The Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program was established by Section 215 (b)of the Protecting Access to Medicare Act of 2014. The facility adjusted Federal per diem rate will be reduced by 2% and an incentive payment will then be applied to facilities based upon readmission measure performance.

The legislation mandates that CMS will specify a SNF all-cause all-condition hospital readmission measure by no later than October 1, 2015. It further requires that a resource use measure that reflects resource use by measuring all-condition risk-adjusted potentially preventable hospital readmission rates for SNFs will be specified no later than October 1, 2016 and replace the all-cause all-condition measure as soon as is practicable.

Current Program Measure Information:
The following is a table detailing the number of quality measures prioritized under each NQS Priority that are currently implemented in the program:

NQS Primary Measure Domain	Number of Measures in Skilled Nursing Facility Value-Based Purchasing Program	
	Implemented/Finalized *	**Proposed****
Effective Prevention and Treatment	0	0
Making Care Safer	0	0
Communication/Care Coordination	0	1
Best Practice of Healthy Living	0	0
Making Care Affordable	0	0
Patient and Family Engagement	0	0

**Implemented/Finalized: Quality measures implemented/finalized for data collection.*
***Proposed: Quality measures proposed for data collection.*

High Priority Domains for Future Measure Consideration:
CMS identified the following categories as high-priority for future measure consideration:

1. The sole measure requirement at this time is the specification of a potentially preventable readmission measure. CMS lacks the authority to implement additional measures beyond the two described in the statute.

Measure Requirements:
CMS applies criteria for measures that may be considered for potential adoption in the SNF-VBP program. At a minimum, the following requirements must be met for selection in the SNF-VBP program:

- Must meet statutory requirements for all-condition potentially preventable hospital readmissions measure for SNFs.
- Must provide documentation sufficient to complete MUC list required data fields.
- Measures should be NQF endorsed, save where due consideration is given to endorsed measures of the same specified area or medical topic.
- May incorporate Medicare claims and/or alternative data sources will be considered dependent upon available infrastructure.

For more information, contact Michelle Geppi at Michelle.Geppi@cms.hhs.gov.