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Welcome to Today's Meeting!

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

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NATIONAL QUALITY FORUM
Driving measurable health improvements together

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Measure Applications Partnership (MAP)

Hospital Workgroup Virtual Review Meeting

December 15, 2021

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

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Agenda

- Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives
- CMS Opening Remarks
- Overview of Pre-Rulemaking Approach
- Review of Programs and Measures Under Consideration (MUCs)
- Lunch
- Review of Programs and MUCs (Continued)
- Opportunity for Public Comment
- Summary of Day and Next Steps
- Adjourn

Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives

Hospital Workgroup Membership

Workgroup Co-Chairs: Akin Demehin, MPH; R. Sean Morrison, MD

Organizational Members (Voting)

- America's Essential Hospitals
- American Case Management Association
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Association of American Medical Colleges
- City of Hope
- Dialysis Patient Citizens
- Greater New York Hospital Association
- Henry Ford Health System
- Kidney Care Partners
- Medtronic
- Memphis Business Group on Health
- National Association for Behavioral Healthcare
- Premier Healthcare Alliance
- Press Ganey
- Project Patient Care
- Service Employees International Union
- Society for Maternal-Fetal Medicine
- Stratis Health
- UPMC Health Plan

Hospital Workgroup Membership (continued)

Individual Subject Matter Experts (Voting)

- Lindsey Wisham, MPA
- Richard Gelb, MA
- Suellen Shea, MSN, RN-BC, CPHQ, CPPS, LSSGB

Federal Government Liaisons (Non-voting)

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)

Workgroup Staff

- **Matthew Pickering, PharmD,** Senior Director
- **Ivory Harding, MS,** Manager
- **Ashlan Ruth, BS IE,** Project Manager
- **Becky Payne, MPH,** Senior Analyst
- **Joelencia LeFlore,** Coordinator
- **Taroon Amin, PhD,** Consultant

CMS Staff

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

Objectives for Today's Meeting

- Review and provide input on MUC for the MAP Hospital programs
- Identify measure gaps for the MAP Hospital programs

CMS Welcoming Remarks

Measure Applications Partnership

Hospital Workgroup

December 2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Purpose of the MAP

- The Measure Applications Partnership is a convened group of experts who provide recommendations to CMS about whether or not measures under consideration should be included in CMS value based programs.
- Multi-stakeholder group feedback on the MUC List is a statutory requirement.
- MAP makes recommendations but does not have final authority for decisions around CMS programs.
- However, all MAP recommendations are strongly considered and assist CMS in decisions about programs.
- Measure set review was new for MAP this year.

Hospital MAP

- The Hospital MAP recommends measures that may potentially be included in future rule-writing for Value Based Programs.
- Programs include: IQR, HAC, HRRP, HVBP, Cancer Exempt, ESRD, Inpatient Psychiatry, Hospital Outpatient, Ambulatory Surgery.
- These are a mix of pay for reporting as well as pay for performance; some are also used in the calculation of Hospital Stars.
- Almost all measures are publicly reported.

CMS Strategic Priorities

Vision: CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes	
Pillar 1	Advance health equity by addressing the health disparities that underlie our health system
Pillar 2	Build on the Affordable Care Act, expand access to quality and affordable health coverage
Pillar 3	Engage our partners and communities we serve throughout the policymaking and implementation process
Pillar 4	Drive innovation to tackle our health system challenges and promote high-value, person-centered care
Pillar 5	Protect our programs' sustainability for future generations by serving as a responsible steward of public funds
Pillar 6	Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS's operations

CMS Key Focus Areas for Quality

- COVID-19 and the PHE
- Equity – Access, Outcomes, Referrals, Experience
- Maternal Health and Safety
- Mental Health
- Resiliency and Emergency Preparedness
- Safety – not just patient safety, but workforce safety
- Digital transformation
- Climate Change
- Value

COVID-19 impact to Value Based Programs

- THANK YOU for heroic efforts to care for all (patients, staff, others)
- Trend of worsening quality and safety performance being evaluated
- Future focus of resiliency, emergency preparedness; workforce
- Value Based Programs proposed (and finalized IPPS) measure suppression and other actions to limit financial impact while still preserving, where appropriate, public reporting
  - IPPS programs
  - MIPS program
- COVID-19 HCP vaccination measures; COVID-19 HCP vaccination mandate finalized

Provider discussions highlighted key enablers and challenges influencing implementation of response

Key enablers for implementation

1. Leadership, culture, & governance
2. Infection prevention & control expertise
3. Local planning & coordination

Key challenges faced during implementation

4. Planning for underserved & vulnerable pop.
5. Data reporting
6. Technical assistance
7. Managing federal & STLT (state, tribal, local, and territorial) guidance

What is new in IPPS rules?

- Measure suppression and payment impacts
  - HVBP all hospitals neutral; measure suppression HCAHPS, HAI, MSPB, PNU Mortality
  - HAC program used 2019 data; did not use 2020 data due to COVID-19 impact
  - HRRP (readmissions) suppression of PNU; removed COVID-19 from denominator
- 5 new measures: maternal morbidity structural; hybrid hospital wide mortality, COVID-19 HCP vaccination; electronic hyper and hypoglycemia

Hospital Promoting Interoperability

- Public Health Reporting – mandatory reporting of 4 public health electronic data – syndromic surveillance, immunization registry, electronic case reporting and electronic lab results
- Bidirectional HIE
- eCQM measures to be publicly reported; expands quarters needed to report
- Attestation to review of SAFER guidelines (EMR safety)

Potential Future Directions

- Maternal Health and Safety
- Safety – patient and workforce
- Mental Health
- Reducing disparities
  - Measure stratification; measures related to equity

Summary

- Thank you for your contributions and your important voice for hospitals and hospital related care.
- Thank you for your contributions and heroic efforts for the COVID-19 PHE.
- Look forward to your comments and recommendations today on the measures moving forward.
- Happy Holidays!

Overview of Pre-Rulemaking Approach

Preliminary Analyses

Preliminary Analysis of Measures Under Consideration

- The preliminary analysis is intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions.
- Staff use an algorithm developed from the MAP Measure Selection Criteria to evaluate each measure considering MAP's previous guidance.

MAP Preliminary Analysis Algorithm

Assessment	Definition	Outcome
1) The measure addresses a critical quality objective not adequately addressed by the measures in the program set.	• The measure addresses key healthcare improvement priorities; or • The measure is responsive to specific program goals and statutory or regulatory requirements; or • The measure can distinguish differences in quality, is meaningful to patients/consumers and providers, and/or addresses a high-impact area or health condition.	Yes: Review can continue. No: Measure will receive a Do Not Support. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.
2) The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.	• For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented can lead to the desired outcome(s). • For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is influenced by healthcare processes or structures.	Yes: Review can continue. No: Measure will receive a Do Not Support. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.
3) The measure addresses a quality challenge.	• The measure addresses a serious reportable event (i.e., a safety event that should never happen); or • The measure addresses unwarranted or significant variation or a gap in care that is evidence of a quality challenge.	Yes: Review can continue. No: Measure will receive a Do Not Support. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

MAP Preliminary Analysis Algorithm (Continued)

Assessment	Definition	Outcome
4) The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.	• The measure is either not duplicative of an existing measure or measure under consideration in the program or is a superior measure to an existing measure in the program; or • The measure captures a broad population; or • The measure contributes to alignment between measures in a particular program set (e.g. the measure could be used across programs) or • The value to patients/consumers outweighs any burden of implementation.	Yes: Review can continue No: Highest rating can be do not support with potential for mitigation MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.
5) The measure can be feasibly reported.	• The measure can be operationalized (e.g. the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care.)	Yes: Review can continue No: Highest rating can be do not support with potential for mitigation MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

MAP Preliminary Analysis Algorithm (Continued 2)

Assessment	Definition	Outcome
6) The measure is applicable to and appropriately specified for the program's intended care setting(s), level(s) of analysis, and population(s).	• The measure is NQF-endorsed; or • The measure is fully developed and full specifications are provided; and • Measure specifications are provided for the level of analysis, program, and/or setting(s) for which it is being considered.	Yes: Measure could be supported or conditionally supported. No: Highest rating can be Conditional support. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.
7) If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.	• Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or • Feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and • Feedback is supported by empirical evidence.	If no implementation issues have been identified: Measure can be supported or conditionally supported. If implementation issues are identified: The highest rating can be Conditional Support. MAP can also choose to not support the measure, with or without the potential for mitigation. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

MAP Voting Decision Categories

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MAP Decision Categories 2021-2022

Decision Category	Definition	Evaluation Criteria
Support for Rulemaking	MAP supports implementation with the measure as specified and has not identified any conditions that should be met prior to implementation.	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP Preliminary Analysis Algorithm. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	MAP supports implementation of the measure as specified but has identified certain conditions or modifications that would ideally be addressed prior to implementation.	The measure meets assessments 1-3, but may need modifications. A designation of this decision category assumes at least one assessment 4-7 is not met. MAP will provide a rationale that outlines each suggested condition (e.g., measure requires NQF review or endorsement OR there are opportunities for improvement under evaluation). Ideally, the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to MAP prior to rulemaking.
Do Not Support for Rulemaking with Potential for Mitigation	MAP does not support implementation of the measure as specified. However, MAP agrees with the importance of the measure concept and has suggested modifications required for potential support in the future. Such a modification would be considered to be a material change to the measure. A material change is defined as any modification to the measure specifications that significantly affects the measure result.	The measure meets assessments 1-3 but cannot be supported as currently specified. A designation of this decision category assumes at least one assessment 4-7 is not met.
Do Not Support for Rulemaking	MAP does not support the measure.	The measure under consideration does not meet one or more of assessments 1-3.

MAP Voting Process

Key Voting Principles

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

Voting Procedure

- **Step 1.** Staff will review the Preliminary Analysis for each measure under consideration (MUC) using the MAP selection criteria and programmatic objectives.

- **Step 2.** The co-chairs will ask for clarifying questions from the Workgroup. The co-chairs will compile all Workgroup questions.
  - Measure developers will respond to the clarifying questions on the specifications of the measure.
  - NQF staff will respond to clarifying questions on the preliminary analysis.

Voting Procedure (continued)

- **Step 3.** Voting on acceptance of the preliminary analysis decision
  - After clarifying questions have been resolved, the co-chairs will open for a vote on accepting the preliminary analysis assessment. This vote will be framed as a "yes" or "no" vote to accept the result.
  - If greater than or equal to 60% of the Workgroup members vote to accept the preliminary analysis assessment, then the preliminary analysis assessment will become the Workgroup recommendation. If less than 60% of the Workgroup votes to accept the preliminary analysis assessment, discussion will open on the measure.

Voting Procedure (continued 2)

- **Step 4.** Discussion and Voting on the MUC
  - Lead Discussants will review and present their findings.
  - The co-chairs will then open for discussion among the Workgroup. Workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
  - After the discussion, the co-chairs will open the MUC for a vote.
    - NQF staff will summarize the major themes of the Workgroup's discussion.
    - The co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions.
    - If the co-chairs do not feel there is a consensus position to use to begin voting, the Workgroup will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with potential for mitigation, then do not support.

Voting Procedure (continued 3)

- **Step 5:** Tallying the Votes
  - If a decision category put forward by the co-chairs receives greater than or equal to 60% of the votes, the motion will pass and the measure will receive that decision.
  - If no decision category achieves greater than 60% to overturn the preliminary analysis, the preliminary analysis decision will stand. This will be marked by staff and noted for the Coordinating Committee's consideration.

Review of Measures Under Consideration (MUCs) by MAP Advisory Groups

MAP Rural Health Advisory Group Charge

- To help address priority rural health issues, including the challenge of low case-volume
- To provide:
  - Timely input on measurement issues to other MAP Workgroups and committees
  - Rural perspectives on the selection of quality measures in MAP

Rural Health Advisory Group Review of MUCs

- The Rural Health Advisory Group reviewed all the MUCs and provided feedback to the setting-specific Workgroups on:
  - Relative priority/utility in terms of access, cost, or quality issues encountered by rural residents
  - Data collection and/or reporting challenges for rural providers
  - Methodological problems of calculating performance measures for small rural facilities
  - Potential unintended consequences related to rural health if the measure is included in specific programs
  - Gap areas in measurement relevant to rural residents/providers for specific programs
- The Rural Health Advisory Group was polled on whether the measure is suitable for use with rural providers within the specific program of interest

MAP Health Equity Advisory Group Charge

- Provide input on MUCs with a lens to measurement issues impacting health disparities and the over 1,000 United States critical access hospitals
- Provide input on MUCs with the goal to reduce health differences closely linked with social, economic, or environmental disadvantages

Health Equity Advisory Group Review of MUCs

- The Health Equity Advisory Group reviewed all the MUCs and provided feedback to the setting-specific Workgroups on:
  - Relative priority in terms of advancing health equity for all
  - Data collection and/or reporting challenges regarding health disparities
  - Methodological problems of calculating performance measures adjusting for health disparities
  - Potential unintended consequences related to health disparities if the measure is included in specific programs
  - Gap areas in measurement relevant to health disparities and critical access hospitals for specific programs
- The Health Equity Advisory Group was polled on the potential impact on health disparities if the measure is included within the specific program of interest

Feedback from the Advisory Groups' Review of MUCs

- Feedback from both Advisory Groups is provided to the setting-specific Workgroups through the following mechanisms:
  - The preliminary analyses (PAs):
    - » A qualitative summary of the discussion of the MUCs
    - » Average polling results that quantify:
      - *The Rural Health Advisory Group's perception of suitability from a rural perspective of including the measure within the program*
      - *The Health Equity Advisory Group's perception of the potential impact on health disparities if the measure is included within the program*
  - A summary of each Advisory Group's discussion will be provided during the review of the MUC during the setting-specific Workgroup pre-rulemaking meetings

Review of Programs and MUCs

Cross-Cutting Measure: MUC2021-118 Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

Public Comment: MUC2021-118 Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)

- **Program Type:** Pay-for-Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

MUC2021-118: Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) (Hospital IQR Program)

- **Description:** The measure estimates a hospital-level risk-standardized complication rate (RSCR) associated with elective primary THA and/or TKA. The outcome (complication) is defined as any one of the specified complications occurring from the date of index admission to 90 days post-date of the index admission (the admission included in the measure cohort).
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Janis Orlowski, Association of American Medical Colleges
  - Karen Shehade, Medtronic
  - Jennifer Lundblad, Stratis Health

Hospital Value-Based Purchasing (VBP) Program

- **Program Type:** Pay for Performance
- **Incentive Structure:** The amount equal to 2.0% of base operating diagnosis related group (DRG) is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments
- **Program Goal:** Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards

MUC2021-118: Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) (VBP Program)

- **Description:** The measure estimates a hospital-level risk-standardized complication rate (RSCR) associated with elective primary THA and/or TKA. The outcome (complication) is defined as any one of the specified complications occurring from the date of index admission to 90 days post-date of the index admission (the admission included in the measure cohort).
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Janis Orlowski, Association of American Medical Colleges
  - Karen Shehade, Medtronic
  - Jennifer Lundblad, Stratis Health

Lunch

Cross-Cutting Measure: MUC2021-131 Medicare Spending Per Beneficiary (MSPB) Hospital

Public Comment: MUC2021-131 Medicare Spending Per Beneficiary (MSPB) Hospital

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)[2]

- **Program Type:** Pay-for-Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

MUC2021-131: Medicare Spending Per Beneficiary (MSPB) Hospital (Hospital IQR Program)

- **Description:** The measure evaluates hospitals' efficiency relative to the efficiency of the national median hospital and assesses the cost to Medicare for Part A and Part B services performed by hospitals and other healthcare providers during an MSPB Hospital episode, which is comprised of the periods 3-days prior to, during, and 30-days following a patient's hospital stay. The measure is not condition specific and uses standardized prices when measuring costs. Eligible beneficiary populations include beneficiaries enrolled in Medicare Parts A and B who were discharged between January 1 and December 1 in a calendar year from short-term acute hospitals paid under the Inpatient Prospective Payment System.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Aisha Pittman, Premier Healthcare Alliance
  - Cristie Upshaw Travis, Memphis Business Group on Health
  - Jackson Williams, Dialysis Patient Citizens

Hospital Value-Based Purchasing (VBP) Program[2]

- **Program Type:** Pay for Performance
- **Incentive Structure:** The amount equal to 2.0% of base operating DRG is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments
- **Program Goal:** Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards

MUC2021-131: Medicare Spending Per Beneficiary (MSPB) Hospital (VBP Program)

- **Description:** The measure evaluates hospitals' efficiency relative to the efficiency of the national median hospital and assesses the cost to Medicare for Part A and Part B services performed by hospitals and other healthcare providers during an MSPB Hospital episode, which is comprised of the periods 3-days prior to, during, and 30-days following a patient's hospital stay. The measure is not condition specific and uses standardized prices when measuring costs. Eligible beneficiary populations include beneficiaries enrolled in Medicare Parts A and B who were discharged between January 1 and December 1 in a calendar year from short-term acute hospitals paid under the Inpatient Prospective Payment System.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Support for Rulemaking
- **Lead Discussants:**
  - Aisha Pittman, Premier Healthcare Alliance
  - Cristie Upshaw Travis, Memphis Business Group on Health
  - Jackson Williams, Dialysis Patient Citizens

VBP Program

- What are the gaps in the program measure set that CMS should consider addressing?

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VBP Current Measures

Type	NQF #	Measure Title	NQF Status
Efficiency and Cost Reduction	2158	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	Endorsed
Person and Community Engagement	0166 (0228)	HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems Survey (including Care Transition measure 0228)	Endorsed
Clinical Care	0230	Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	Endorsed
Clinical Care	0229	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) hospitalization.	Endorsed
Clinical Care	0468	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization	Endorsed
Clinical Care	1893	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Endorsed
Clinical Care	1550	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA).	Endorsed

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VBP Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Clinical Care	2558	Hospital 30-Day All-Cause Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (CABG)	Endorsed
Safety	0138	NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed
Safety	1717	NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed
Safety	0139	NHSN Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed
Safety	0753	ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed
Safety	1716	NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed
Safety	0531*	CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	Endorsed

*Measure finalized for removal beginning with the FY 2023 program year

Hospital IQR Program Measures

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)[3]

- **Program Type:** Pay-for-Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

Public Comment: Hospital IQR Measures Under Consideration

MUC2021-122: Excess days in acute care (EDAC) after hospitalization for acute myocardial infarction (AMI)

- **Description:** This measure estimates days spent in acute care within 30 days of discharge from an inpatient hospitalization for AMI. This measure is intended to capture the quality of care transitions provided to discharged patients hospitalized with AMI by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: 1) emergency department (ED) visits, 2) observation stays, and 3) unplanned readmissions at any time during the 30 days post-discharge. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm (PRA). Days spent in each care setting are aggregated for the 30 days post-discharge with a minimum of half-day increments.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Support for Rulemaking
- **Lead Discussants:**
  - Linda Van Allen, American Case Management Association
  - Martin Hatlie, Project Patient Care
  - Suellen Shea, Subject Matter Expert

MUC2021-121: Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip and/or total knee arthroplasty (THA/TKA)

- **Description:** This measure estimates hospital-level, risk-standardized payments for an elective primary total THA/TKA episode of care, starting with an inpatient admission to a short-term acute care facility and extending 90 days post admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Janice Donis, UPMC Health Plan
  - Sarah Nolan, Service Employees International Union
  - Zeynep Sumer King, Greater New York Hospital Association

MUC2021-106: Hospital Commitment to Health Equity

- **Description:** Among Medicare beneficiaries, racial and ethnic minority individuals, individuals with limited English proficiency or disabilities often receive lower quality of care and higher rates of readmission and complications than beneficiaries without these characteristics. Strong and consistent hospital leadership can be instrumental in setting specific, measurable, and attainable goals to advance equity priorities and improve care for all beneficiaries. This includes promoting an organizational culture of equity through equity-focused leadership, commitment to robust demographic data collection, and active review of disparities in key quality outcomes, which are assessed in this measure.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Do Not Support for Rulemaking
- **Lead Discussants:**
  - Tejal Gandhi, Press Ganey
  - Janis Orlowski, Association of American Medical Colleges
  - Santosh Mudiraj, Henry Ford Health System

MUC2021-134: Screen Positive Rate for Social Drivers of Health

- **Description:** Percent of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety.
- **Level of Analysis:** Clinician; Group; Facility; Other: Beneficiary, Population
- **NQF Recommendation:** Do Not Support for Rulemaking
- **Lead Discussants:**
  - Jennifer Lundblad, Stratis Health
  - Maryellen Guinan, America's Essential Hospitals
  - Sarah Nolan, Service Employees International Union

MUC2021-136: Screening for Social Drivers of Health

- **Description:** Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.
- **Level of Analysis:** Clinician; Group; Facility; Other: Beneficiary, Population
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Vilma Joseph, American Society of Anesthesiologists
  - Zeynep Sumer King, Greater New York Hospital Association
  - Tejal Gandhi, Press Ganey

Break 1

Cross-Cutting Measure: MUC2021-084 Hospital Harm – Opioid-Related Adverse Events

Public Comment: MUC2021-084 Hospital Harm – Opioid-Related Adverse Events

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)[4]

- **Program Type:** Pay-for-Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

MUC2021-084: Opioid-Related Adverse Events (Hospital IQR Program)

- **Description:** This measure assesses the proportion of inpatient hospital encounters where patients ages 18 years of age or older have been administered an opioid medication, subsequently suffer the harm of an opioid-related adverse event, and are administered an opioid antagonist (naloxone) within 12 hours. This measure excludes opioid antagonist (naloxone) administration occurring in the operating room setting.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Support for Rulemaking
- **Lead Discussants:**
  - Anna Legreid Dopp, American Society of Health-System Pharmacists
  - Richard Gelb, Subject Matter Expert
  - Frank Ghinassi, National Association for Behavioral Healthcare

Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

MUC2021-084: Opioid-Related Adverse Events (Medicare Promoting Interoperability Program for Hospitals)

- **Description:** This measure assesses the proportion of inpatient hospital encounters where patients ages 18 years of age or older have been administered an opioid medication, subsequently suffer the harm of an opioid-related adverse event, and are administered an opioid antagonist (naloxone) within 12 hours. This measure excludes opioid antagonist (naloxone) administration occurring in the operating room setting.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Support for Rulemaking
- **Lead Discussants:**
  - Anna Legreid Dopp, American Society of Health-System Pharmacists
  - Richard Gelb, Subject Matter Expert
  - Frank Ghinassi, National Association for Behavioral Healthcare

Cross-Cutting Measure: MUC2021-104 Severe Obstetric Complications

Public Comment: MUC2021-104 Severe Obstetric Complications

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)[5]

- **Program Type:** Pay-for-Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

MUC2021-104: Severe Obstetric Complications (Hospital IQR Program)

- **Description:** Proportion of patients with severe obstetric complications which occur during the inpatient delivery hospitalization.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Kelly Gibson, Society for Maternal-Fetal Medicine
  - Lindsey Wisham, Subject Matter Expert
  - Donna Bednarski, Kidney Care Partners

Medicare Promoting Interoperability Program for Hospitals[2]

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

MUC2021-104: Severe Obstetric Complications (Medicare Promoting Interoperability Program for Hospitals)

- **Description:** Proportion of patients with severe obstetric complications which occur during the inpatient delivery hospitalization.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Kelly Gibson, Society for Maternal-Fetal Medicine
  - Lindsey Wisham, Subject Matter Expert
  - Donna Bednarski, Kidney Care Partners

Cross-Cutting Measure: MUC2021-098 National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure

Public Comment: MUC2021-098 NHSN Healthcare-associated Clostridioides difficile Infection Outcome Measure

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)[6]

- **Program Type:** Pay-for-Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

MUC2021-098: NHSN Healthcare-associated Clostridioides difficile Infection Outcome Measure (Hospital IQR Program)

- **Description:** This measure tracks the development of new Clostridioides difficile infection among patients already admitted to healthcare facilities, using algorithmic determinations from data sources widely available in electronic health records. This measure improves on the original measure by requiring both microbiologic evidence of C. difficile in stool and evidence of antimicrobial treatment.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Suellen Shea, Subject Matter Expert
  - Maryellen Guinan, America's Essential Hospitals
  - Martin Hatlie, Project Patient Care

Medicare Promoting Interoperability Program for Hospitals[3]

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

MUC2021-098: NHSN Healthcare-associated Clostridioides difficile Infection Outcome Measure (Medicare Promoting Interoperability Program for Hospitals)

- **Description:** This measure tracks the development of new Clostridioides difficile infection among patients already admitted to healthcare facilities, using algorithmic determinations from data sources widely available in electronic health records. This measure improves on the original measure by requiring both microbiologic evidence of C. difficile in stool and evidence of antimicrobial treatment.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Do Not Support for Rulemaking
- **Lead Discussants:**
  - Suellen Shea, Subject Matter Expert
  - Maryellen Guinan, America's Essential Hospitals
  - Martin Hatlie, Project Patient Care

Hospital-Acquired Condition Reduction Program (HACRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.
- **Program Goal:** Encourage hospitals to reduce HACs through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

MUC2021-098: NHSN Healthcare-associated Clostridioides difficile Infection Outcome Measure (HACRP)

- **Description:** This measure tracks the development of new Clostridioides difficile infection among patients already admitted to healthcare facilities, using algorithmic determinations from data sources widely available in electronic health records. This measure improves on the original measure by requiring both microbiologic evidence of C. difficile in stool and evidence of antimicrobial treatment.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Suellen Shea, Subject Matter Expert
  - Maryellen Guinan, America's Essential Hospitals
  - Martin Hatlie, Project Patient Care

Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare
- **Program Goal:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program, and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices

MUC2021-098: NHSN Healthcare-associated Clostridioides difficile Infection Outcome Measure (PCHQR)

- **Description:** This measure tracks the development of new Clostridioides difficile infection among patients already admitted to healthcare facilities, using algorithmic determinations from data sources widely available in electronic health records. This measure improves on the original measure by requiring both microbiologic evidence of C. difficile in stool and evidence of antimicrobial treatment.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Suellen Shea, Subject Matter Expert
  - Maryellen Guinan, America's Essential Hospitals
  - Martin Hatlie, Project Patient Care

Break 2

Cross-Cutting Measure: MUC2021-100 National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure

Public Comment: MUC2021-100 NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)[7]

- **Program Type:** Pay-for-Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure (Hospital IQR Program)

- **Description:** This measure tracks the development of new bacteremia and fungemia among patients already admitted to acute care hospitals, using algorithmic determinations from data sources widely available in electronic health records. This measure includes many healthcare-associated infections not currently under surveillance by the Center for Disease Control and Prevention (CDC)'s National Healthcare Safety Network (NHSN). Ongoing surveillance also requires minimal data collection burden for users.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Santosh Mudiraj, Henry Ford Health System
  - Lindsey Wisham, Subject Matter Expert
  - Denise Morse, City of Hope

Medicare Promoting Interoperability Program for Hospitals[4]

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

MUC2021-100: NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure (Medicare Promoting Interoperability Program for Hospitals)

- **Description:** This measure tracks the development of new bacteremia and fungemia among patients already admitted to acute care hospitals, using algorithmic determinations from data sources widely available in electronic health records. This measure includes many healthcare-associated infections not currently under surveillance by the Center for Disease Control and Prevention (CDC)'s National Healthcare Safety Network (NHSN). Ongoing surveillance also requires minimal data collection burden for users.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Do Not Support for Rulemaking
- **Lead Discussants:**
  - Santosh Mudiraj, Henry Ford Health System
  - Lindsey Wisham, Subject Matter Expert
  - Denise Morse, City of Hope

Hospital-Acquired Condition Reduction Program (HACRP)[2]

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.
- **Program Goal:** Encourage hospitals to reduce HACs through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure (HACRP)

- **Description:** This measure tracks the development of new bacteremia and fungemia among patients already admitted to acute care hospitals, using algorithmic determinations from data sources widely available in electronic health records. This measure includes many healthcare-associated infections not currently under surveillance by the Center for Disease Control and Prevention (CDC)'s National Healthcare Safety Network (NHSN). Ongoing surveillance also requires minimal data collection burden for users.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Santosh Mudiraj, Henry Ford Health System
  - Lindsey Wisham, Subject Matter Expert
  - Denise Morse, City of Hope

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)[2]

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare
- **Program Goal:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program, and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices

MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure (PCHQR)

- **Description:** This measure tracks the development of new bacteremia and fungemia among patients already admitted to acute care hospitals, using algorithmic determinations from data sources widely available in electronic health records. This measure includes many healthcare-associated infections not currently under surveillance by the Center for Disease Control and Prevention (CDC)'s National Healthcare Safety Network (NHSN). Ongoing surveillance also requires minimal data collection burden for users.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussants:**
  - Santosh Mudiraj, Henry Ford Health System
  - Lindsey Wisham, Subject Matter Expert
  - Denise Morse, City of Hope

Program Gaps: Hospital IQR Program, Medicare Promoting Interoperability Program for Hospitals, and HACRP

Hospital IQR Program

- What are the gaps in the program measure set that CMS should consider addressing?

NATIONAL QUALITY FORUM

Hospital IQR Program Current Measures

Type	NQF #	Measure Title	NQF Status
Hybrid-Outcome*	3502	Hybrid Hospital-Wide All- Cause Risk Standardized Mortality (Hybrid HWM)	Endorsed
Claims-based Outcome	N/A	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke	Not Endorsed
Claims-based Outcome	1789	Hospital-Wide All-Cause, Unplanned Readmission Measure (HWR)	Endorsed
Claims-based Outcome	2881	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	Endorsed
Claims-based Outcome	2880	Excess Days in Acute Care after Hospitalization for Heart Failure	Endorsed
Claims-based Outcome	2882	Excess Days in Acute Care after Hospitalization for Pneumonia	Endorsed

*The hybrid measure adds 10 clinical risk variables, derived from a set of core clinical data elements (CCDE) extracted from the EHR.

Hospital IQR Program Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Claims-based Outcome	0351	Death among Surgical Inpatients with Serious, Treatable Complications	Endorsed
Cost/ Resource Use	2431	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	Endorsed
Cost/ Resource Use	2436	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF)	Endorsed
Cost/ Resource Use	2579	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode -of Care for Pneumonia	Endorsed
Cost/ Resource Use	N/A	Hospital-Level, Risk-Standardized Payment Associated with a 90-Day Episode -of Care for Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)	Endorsed
Process	N/A	Maternal Morbidity Structural Measure	Not Endorsed
Process	N/A	COVID-19 Vaccination Coverage Among Healthcare Personnel	Not Endorsed

NATIONAL QUALITY FORUM

Hospital IQR Program Current Measures (Continued 2)

Type	NQF #	Measure Title	NQF Status
eCQM Process**	3503e	Hospital Harm—Severe Hypoglycemia	Endorsed
eCQM Process**	3533e	Hospital Harm—Severe Hyperglycemia	Endorsed
eCQM Process*	0435/3042	Discharged on Antithrombotic Therapy	Endorsed-Reserve
eCQM Process*	0436/3043	Anticoagulation Therapy for Atrial Fibrillation/Flutter	Endorsed-Reserve
eCQM Process*	0438/3045	Antithrombotic Therapy by the End of Hospital Day Two	Endorsed-Reserve
eCQM Process*	0371	Venous Thromboembolism Prophylaxis	Endorsed
eCQM Process*	0372/ 2933	Intensive Care Unit Venous Thromboembolism Prophylaxis	Endorsed

*In CY 2022/FY 2024 hospitals are required to report three self-selected calendar quarters of data for 3 self-selected eCQMs and the Safe Use of Opioids eCQM
**Data collection beginning with the CY 2023 reporting period/FY 2025 payment determination

NATIONAL QUALITY FORUM

Hospital IQR Program Current Measures (Continued 3)

Type	NQF #	Measure Title	NQF Status
eCQM Process*	3316e	Safe Use of Opioids – Concurrent Prescribing	Endorsed
eCQM Process***	0439	Discharged on Statin Medication	Endorsed
eCQM Process***	0497	Admit Decision Time to ED Departure Time for Admitted Patients	Endorsed
eCQM Process***	0480	Exclusive Breast Milk Feeding	Endorsed
Chart-abstracted Composite	0500	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	Endorsed
Chart-abstracted Process	0469	Elective Delivery	Endorsed
Patient Survey	0166 (0228)	HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems Survey (including Care Transitions Measure)	Endorsed
Process	0431	Influenza Vaccination Coverage Among Healthcare Personnel	Endorsed

*In CY 2022/FY 2024 hospitals are required to report three self-selected calendar quarters of data for 3 self-selected eCQMs and the Safe Use of Opioids eCQM
***Finalized for removal beginning with the CY 2024 reporting period/FY 2026 payment determination

Medicare Promoting Interoperability Program for Hospitals (Gaps)

- What are the gaps in the program measure set that CMS should consider addressing?

Medicare Promoting Interoperability Program for Hospitals Current Measures

Type	NQF #	Measure Title	NQF Status
eCQM Process**	3503e	Hospital Harm—Severe Hypoglycemia	Endorsed
eCQM Process**	3533e	Hospital Harm—Severe Hyperglycemia	Endorsed
eCQM Process*	0435/3042	Discharged on Antithrombotic Therapy	Endorsed-Reserve
eCQM Process*	0436/3043	Anticoagulation Therapy for Atrial Fibrillation/Flutter	Endorsed-Reserve
eCQM Process*	0438/3045	Antithrombotic Therapy by the End of Hospital Day Two	Endorsed-Reserve
eCQM Process*	0371	Venous Thromboembolism Prophylaxis	Endorsed
eCQM Process*	0372/ 2933	Intensive Care Unit Venous Thromboembolism Prophylaxis	Endorsed

*In the CY 2022 EHR reporting period, hospitals are required to report three self-selected calendar quarters of data for 4 self-selected eCQMs of the eight available eCQMs, and the Safe Use of Opioids eCQM

**Data collection beginning with the CY 2023 EHR reporting period

Medicare Promoting Interoperability Program for Hospitals Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
eCQM Process*	3316e	Safe Use of Opioids – Concurrent Prescribing	Endorsed
eCQM Process***	0439	Discharged on Statin Medication	Endorsed
eCQM Process***	0497	Admit Decision Time to ED Departure Time for Admitted Patients	Endorsed
eCQM Process***	0480	Exclusive Breast Milk Feeding	Endorsed

*In CY 2022/FY 2024 hospitals are required to report three self-selected calendar quarters of data for 4 self-selected eCQMs of the eight available eCQMs, and the Safe Use of Opioids eCQM

***Finalized for removal beginning with the CY 2024 EHR reporting period

HACRP

- What are the gaps in the program measure set that CMS should consider addressing?

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HACRP Current Measures

Type	NQF #	Measure Title	NQF Status
Composite	0531	CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	Endorsed
Outcome	0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed
Outcome	0139	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed
Outcome	0753	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed
Outcome	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed
Outcome	1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Measures

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)[3]

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare
- **Program Goal:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program, and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices

Public Comment: PCHQR Program Measures Under Consideration - MUC2021-091 Appropriate Treatment for Patients with Stage I (T1c) through III HER2 Positive Breast Cancer

MUC2021-091: Appropriate Treatment for Patients with Stage I (T1c) through III HER2 Positive Breast Cancer

- **Description:** Percentage of female patients aged 18 to 70 with stage I (T1c) – III HER-2 positive breast cancer for whom appropriate treatment is initiated.
- **Level of Analysis:** Clinician; Group
- **NQF Recommendation:** Conditional Support for Rulemaking
- **Lead Discussant:**
  - Denise Morse, City of Hope
  - Richard Gelb, Subject Matter Expert
  - Vilma Joseph, American Society of Anesthesiologists

PCHQR Program

- What are the gaps in the program measure set that CMS should consider addressing?

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PCHQR Current Measures

Type	NQF #	Measure Title	NQF Status
Outcome	0166	HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems Survey	Endorsed
Intermediate Outcome	0210	Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life	Endorsed
Intermediate Outcome	0213	Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life	Endorsed
Intermediate Outcome	0215	Proportion of Patients Who Died from Cancer Not Admitted to Hospice	Endorsed
Intermediate Outcome	0216	Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days	Endorsed
Outcome	0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection(CAUTI) Outcome Measure	Endorsed
Outcome	0139	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed
Outcome	0753	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed

PCHQR Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Outcome	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed
Outcome	1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed
Outcome	3490	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Endorsed
Process	0431	Influenza Vaccination Coverage among Healthcare Personnel	Endorsed
Outcome	3478	Surgical Treatment Complications for Localized Prostate Cancer	Not Endorsed
Process	1822	External Beam Radiotherapy for Bone Metastases**	Endorsement Removed
Process	N/A	COVID-19 Vaccination Coverage Among HCP	Not Endorsed

**Finalized for removal from the program, under Factor 8, for patients being treated in CY 2020. The removal applies to FY 2022 Program Year and subsequent years.

End-Stage Renal Disease Quality Improvement Program (ESRD QIP) Measures

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

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** As of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions will be on a sliding scale, which could amount to a maximum of 2.0% per year.
- **Program Goal:** Improve the quality of dialysis care and produce better outcomes for beneficiaries

Public Comment: ESRD QIP Measures Under Consideration - MUC2021-101 Standardized Readmission Ratio (SRR) for dialysis facilities

MUC2021-101: Standardized Readmission Ratio (SRR) for dialysis facilities

- **Description:** The Standardized Readmission Ratio (SRR) for a dialysis facility is the ratio of the number of observed index discharges from acute care hospitals to that facility that resulted in an unplanned readmission to an acute care hospital within 4-30 days of discharge to the expected number of readmissions given the discharging hospitals and the characteristics of the patients and based on a national norm. Note that the measure is based on Medicare-covered dialysis patients.
- **Level of Analysis:** Facility
- **NQF Recommendation:** Do Not Support for Rulemaking
- **Lead Discussant:**
  - Cristie Upshaw Travis, Memphis Business Group on Health
  - Jackson Williams, Dialysis Patient Citizens
  - Donna Bednarski, Kidney Care Partners

ESRD QIP

- What are the gaps in the program measure set that CMS should consider addressing?

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ESRD QIP Current Measures

Type	NQF #	Measure Title	NQF Status
Outcome	0258	CAHPS In-Center Hemodialysis Survey	Endorsed
Outcome	1454	Proportion of Patients with Hypercalcemia	Endorsed
Outcome	1463	Standardized Hospitalization Ratio (SHR) Clinical Measure	Endorsed
Outcome	2496	Standardized Readmission Ratio (SRR) for dialysis facilities	Not Endorsed
Outcome	2977	Hemodialysis Vascular Access: Standardized Fistula Rate Clinical Measure	Endorsed
Outcome	2978	Hemodialysis Vascular Access: LongTerm Catheter Rate Clinical Measure	Endorsed
Outcome	2979	Anemia of chronic kidney disease: Dialysis facility standardized transfusion ratio (STrR)	Endorsed
Process	2988	Medication Reconciliation for Patients Receiving Care at Dialysis Facilities (MedRec)	Endorsed

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ESRD QIP Current Measures (Continued)

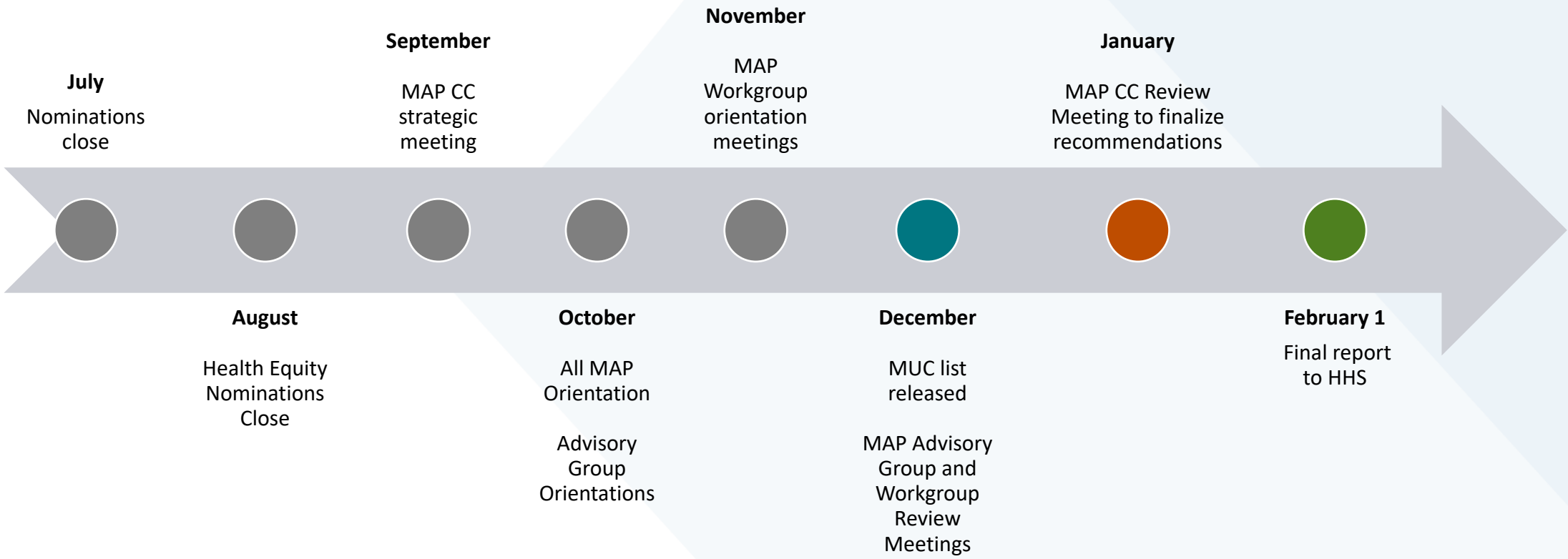
Type	NQF #	Measure Title	NQF Status
Outcome	Based on NQF #1460	National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Patients	Not Endorsed
Outcome	N/A	Kt/V Dialysis Adequacy Comprehensive Clinical Measure	Not Endorsed
Process	Based on NQF #0418	Clinical Depression Screening and Follow-Up Reporting Measure	Not Endorsed
Process	N/A	Ultrafiltration Reporting Measure*	Not Endorsed
Structural	N/A	National Healthcare Safety Network (NHSN) Dialysis Event Reporting Measure	Not Endorsed
Process	N/A	Percentage of Prevalent Patients Waitlisted	Not Endorsed

*Based off NQF #2701 - Avoidance of Utilization of High Ultrafiltration Rate (>/= 13 ml/kg/hour)

Opportunity for Public Comment

Summary of Day and Next Steps

Timeline of MAP Activities



Timeline of Upcoming Activities

- **Workgroup & Coordinating Committee Review Meetings**
  - PAC/LTC Workgroup – **December 16, 2021**
  - Coordinating Committee – **January 19, 2022**
- **Public Comment Period 2** – December 30, 2021 – January 13, 2022
- **Final Recommendations to the U.S. Department of Health & Human Services (HHS)** – By February 1, 2022

Contact Information

- **Project Page:** MAP Hospital Webpage
- **Email: MAP Hospital Project Team** MAPHospital@qualityforum.org

THANK YOU.

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https://www.qualityforum.org

(Time Permitting) Continued Gaps Discussion

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Ambulatory surgical centers (ASCs) that do not participate or fail to meet program requirements receive 2.0% reduction in annual payment update
- **Program Goal:** Promote higher quality, more efficient healthcare for Medicare beneficiaries through measurement, and allow consumers to find and compare the quality of care given at ASCs to inform decisions on where to get care

ASCQR

- What are the gaps in the program measure set that CMS should consider addressing?

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ASCQR Current Measures

Type	NQF #	Measure Title	NQF Status
Outcome	0263	ASC-1: Patient Burn	Endorsement Removed
Outcome	0266	ASC-2: Patient Fall	Endorsement Removed
Outcome	0267	ASC-3:Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	Endorsement Removed
Structural	0265	ASC-4: All-Cause Hospital Transfer/ Admission	Endorsement Removed
Process	0658	ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Endorsed
Outcome	1536	ASC-11: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Endorsement Removed
Outcome	2539	ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Endorsed
Outcome	3357	ASC-19: Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers*	Endorsed

*ASC-19 Will be added and used in 2024

ASCQR Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Outcome	N/A	ASC-13: Normothermia Outcome	Not Endorsed
Outcome	N/A	ASC-14: Unplanned Anterior Vitrectomy	Not Endorsed
Outcome	N/A	ASC-15: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based Measures (ASC-15a-e)	Not Endorsed
Intermediate Outcome	3470	ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures	Not Endorsed
Intermediate Outcome	3366	ASC-18: Hospital Visits after Urology Ambulatory Surgical Center Procedures	Not Endorsed

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Inpatient psychiatric facilities (IPFs) that do not submit data on all required measures receive a 2.0% reduction in annual payment update
- **Program Goal:** Provide consumers with quality-of-care information to make more informed decisions about healthcare options, and encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware of and reporting on best practices

IPFQR

- What are the gaps in the program measure set that CMS should consider addressing?

IPFQR Current Measures

Type	NQF #	Measure Title	NQF Status
Process	N/A	Screening for Metabolic Disorders	Not Endorsed
Process	0640	Hours of Physical Restraint	Endorsed
Process	0641	Hours of Seclusion Use	Endorsed
Process	1654	TOB-2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	Endorsed
Process	1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	Endorsed
Process	1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Endorsed
Process	1664	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Endorsed

IPFQR Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Process	1659	Influenza Immunization	Endorsed
Process	0560	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Endorsed
Process	0647	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Endorsed
Process	N/A	COVID-19 Vaccination Coverage Among HCP	Not Endorsed
Process	N/A	Follow-up After Psychiatric Hospitalization (FAPH)	Not Endorsed
Outcome	2860	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF	Endorsed
Process	3205	Medication Continuation Following Discharge from an Inpatient Psychiatric Facility	Endorsed

Hospital Outpatient Quality Reporting Program (Hospital OQR Program)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not report data on required measures receive a 2.0% reduction in annual payment update
- **Program Goal:** Provide consumers with quality-of-care information to make more informed decisions about healthcare options, and establish a system for collecting and providing quality data to hospitals providing outpatient services such as emergency department visits, outpatient surgery, and radiology services

Hospital OQR Program

- What are the gaps in the program measure set that CMS should consider addressing?

NATIONAL QUALITY FORUM

Hospital OQR Program Current Measures

Type	NQF #	Measure Title	NQF Status
Process	0496	OP-18: Median time from ED Arrival to ED Departure for Discharged ED Patients	Endorsement Removed
Structural	0499	OP-22: Left Without Being Seen	Endorsement Removed
Process	0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Endorsement Removed
Process	0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention	Endorsed
Process	0661	OP-23: ED- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival	Endorsed
Efficiency	N/A	OP-10: Abdomen CT - Use of Contrast Material	Not Endorsed
Efficiency	0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	Endorsement Removed

NATIONAL QUALITY FORUM

Hospital OQR Program Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Outcome	0514	OP-8: MRI Lumbar Spine for Low Back Pain	Endorsement Removed
Process	0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Endorsed
Outcome	2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Endorsed
Outcome	1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Measure)	Endorsed
Outcome	3490	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Endorsed
Outcome	2687	OP-36 Hospital Visits after Hospital Outpatient Surgery	Endorsed
Outcome**	N/A	OP-37 Outpatient CAHPS Facilities and Staff	Not Endorsed

**OP-37 Finalized for the CY 2020 PD (81 FR79784). Implementation delayed beginning with the CY 2020 payment determination (CY 2018 data collection) until further action in future rulemaking (82 FR59433)

Hospital Readmissions Reduction Program (HRRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** Medicare fee-for-service (FFS) base operating diagnosis-related group (DRG) payment rates are reduced for hospitals with excess readmissions. The maximum payment reduction is 3.0%.
- **Program Goal:** Reduce excess readmissions in acute care hospitals and encourage hospitals to improve communication and care coordination to better engage patients and caregivers with post-discharge planning.

HRRP

- What are the gaps in the program measure set that CMS should consider addressing?

NATIONAL QUALITY FORUM

HRRP Current Measures

Type	NQF #	Measure Title	NQF Status
Outcome	0330	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	Endorsed
Outcome	0505	Hospital 30-Day All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	Endorsed
Outcome	0506	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization	Endorsed
Outcome	1551	Hospital-level 30 day, all-cause, risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Endorsed
Outcome	1891	Hospital-Level, 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Endorsed
Outcome	2515	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary Artery Bypass Graft (CABG) Surgery	Endorsed