MEASURE APPLICATIONS PARTNERSHIP

MAP 2018 Considerations for Implementing Measures in Federal Programs: Hospitals

FINAL REPORT

FEBRUARY 15, 2018

NATIONAL QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2017-00060I, Task Order HHSM-500-T0003.

CONTENTS

GUIDANCE ON CROSS-CUTTING ISSUES

Summary

- MAP recognized the need for parsimony and harmonization of measures across programs.
- As CMS continues to transition to value-based purchasing and alternative payment models, appropriate evidence must inform the measures chosen for use, and those measures must be shown to be reliable and valid.
- MAP supported the measure removal criteria that CMS suggested. MAP put forward related considerations regarding unintended consequences, provider burden and operational issues, appropriate risk adjustment, and consumer value.

The Measure Applications Partnership (MAP) Hospital Workgroup reviewed nine measures under consideration (MUCs) for five hospital and setting-specific programs:

- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)
- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Hospital Outpatient Quality Reporting (OQR)
- Hospital Inpatient Quality Reporting (IQR) and Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs) (Meaningful Use)

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

- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Readmissions Reduction Program (HRRP)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR)
- Hospital Value-Based Purchasing (VBP)

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

OVERARCHING THEMES

Promoting Alignment and Harmonization to Reduce Provider Burden and Provide Better Information to Patients

MAP's Measure Selection Criteria highlight the need for parsimonious measure sets that provide meaningful information to both patients and providers. When reviewing measures under consideration, MAP strives to balance the need to address a cost or quality issue with the burden measurement can place on clinicians and providers, while remaining cognizant of limited measurement resources. This year, MAP built on the foundation provided by the Measure Selection Criteria while also incorporating guidance from other initiatives to promote alignment throughout the system.

CMS introduced its Meaningful Measures Framework to MAP as part of the pre-rulemaking deliberations. The goal of the framework is to focus improvement efforts on key quality issues and lend specificity to areas identified for improvement. The framework aims to address high impact measure areas, focus on outcome-based measures where possible, minimize the burden for providers by removing measures where performance is already very high, and align measures across programs and/or other payers, including Medicaid and commercial payers. The Meaningful Measures framework seeks to achieve high-quality healthcare and meaningful outcomes for patients by using criteria meaningful for patients and actionable for providers.

MAP's deliberations emphasized the importance of addressing the meaningful measures objectives to: (1) promote effective communication and coordination of care, (2) promote effective prevention and treatment of chronic disease, (3) work with communities to promote best practices of healthy living, (4) make care affordable, (5) make care safer by reducing harm caused in the delivery of care, and (6) strengthen person & family engagement as partners in their care.

To provide guidance on operationalizing the Meaningful Measures framework, MAP noted the importance of aligning the measures in use, both across CMS programs and across public- and private-sector payers. MAP noted that aligned measures could reduce the reporting burden on health systems that participate in multiple CMS programs. Aligned measures could also help consumers make more informed choices about where to seek high-quality care, especially for treatments that could be provided in different settings. Increased alignment of the measures used across programs could reduce burden on providers, as they are required to report to private payers as well as CMS. Alignment across payers could help to harness market forces and incentivize more rapid quality improvement.

MAP also recognized concerns about the challenges for patients and providers when measure specifications are not harmonized or when there is variation in how an NQF-endorsed measure is implemented. For example, when discussing MUC17-176 *Medication Reconciliation for Patients Receiving Care at Dialysis Facilities,* MAP noted that there is a lack of consistency in how medication reconciliation is defined across measures—and noted differences between current NQF-endorsed medication reconciliation measures developed for different settings. MAP discussed the variation in what is measured, for example: Is it a check-box criterion assessing only if medication reconciliation was conducted, or does the measure evaluate different processes related to medication reconciliation? Other identified differences

included what information is collected and who is responsible for conducting the reconciliation. MAP suggested increased harmonization of measures that evaluate similar constructs across settings and programs.

The Meaningful Measures framework aims to prioritize and aggregate measures to address critical areas of improvement. MAP members noted that aggregating measures is a way to enhance parsimony and harmonization, but cautioned that this may lead to concerns that the validity and performance of individual measures may be hidden by higher level data. Overall, MAP noted the growing importance of considering parsimony, alignment, and measure harmonization in their discussions. As MAP process continues to mature, members supported an active MAP role in examining the measures used in CMS programs more broadly, noting that measures used by CMS are often implemented by other payers and purchasers, amplifying the impact of the measures. Finally, while MAP members emphasized the importance of engaging patients and families in efforts to improve measure harmonization, MAP also acknowledged that measures, such as patient-reported outcome measures, require more work to collect data but are often the most meaningful to consumers.

Balancing the Need to Address Quality Concerns with the Need to Ensure Fair Measurement

MAP is tasked with providing recommendations to CMS about which measures to use in its reporting and payment programs. MAP recognizes the need to address quality concerns in a timely manner and that some programs may require multiple years between MAP input and measure implementation. This timing challenge can lead to MAP providing input on measures that are currently under development and testing or have not been reviewed for NQF endorsement. MAP members expressed concerns regarding how best to provide recommendations to CMS on these measures that are not fully developed and tested or measures that have not been examined for their scientific acceptability. MAP struggled with balancing critical quality issues and addressing patient outcomes against ensuring measures are reliable, valid, and actionable for providers. In this year's pre-rulemaking deliberations, MAP reviewed measures assessing patient outcomes such as mortality and being waitlisted for a kidney transplant. MAP attempted to balance driving improvements in these areas with fair attribution for providers and the use of measures that are reliable and valid. MAP also stressed the importance of NQF endorsement as a mechanism to ensure that a measure is evidence-based, reliable, and valid.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

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

The End-Stage Renal Disease Quality Incentive Program (ESRD QIP) is a value-based purchasing program established to promote high-quality services in outpatient dialysis facilities treating patients with ESRD. Payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions are on a sliding scale, which could amount to a maximum of 2 percent per year. In its 2017-2018 pre-rulemaking deliberations, MAP reviewed three measures under consideration for the ESRD QIP program.

MAP supported MUC17-176 *Medication Reconciliation for Patients Receiving Care at Dialysis Facilities* for rulemaking. This NQF-endorsed measure addresses both patient safety and care coordination. MAP previously noted medication reconciliation as a gap area for this program and emphasized that this measure would contribute to improved outcomes for patients with ESRD, especially those with multiple comorbidities. MAP members noted that medication reconciliation is an important issue for ESRD patients who see multiple clinicians and providers and may require numerous medications. MAP also reiterated that medication errors can have grave consequences for an ESRD patient. Additionally, MAP noted that there is support for this measure across stakeholders and that dialysis facilities and nephrologists have noted the need for this measure. MAP noted that future measurement should address full medication management and provide greater clarity about which clinical staff are being measured for performing medication reconciliation. MAP members emphasized that medication management should be done in a way that considers the total health of the patient.

MAP conditionally supported two related measures for rulemaking, MUC17-241 *Percentage of Prevalent Patients Waitlisted (PPPW)* and MUC17-245 *Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients (SWR)*. These measures were the subject of in-depth discussion by MAP. MAP noted the critical need to help patients receive kidney transplants to improve their quality of life and reduce their risk of mortality. MAP also noted that disparities based on race, income-level, and facility characteristics lead to differences in kidney transplantation rates. As a result, there is a need to incentivize dialysis facilities to educate and assist patients in meeting waitlist processes and requirements. MAP noted that both measures have the potential to incentivize facilities to enhance efforts to ensure patients are appropriately waitlisted and improve care coordination between transplant surgery centers, nephrologists, and dialysis centers. MAP noted that dialysis facilities and their staff, as a primary providers of care for dialysis patients, share responsibility for care with other providers.

However, MAP members had divergent opinions on the ability of these measures to address these important quality gaps. MAP noted factors that must be balanced when implementing these measures. First, MAP members raised concerns that a dialysis facility may not be able to adequately influence this measure compared to a transplant center. MAP noted that numerous factors might influence why a patient is on a waiting list, including the criteria of transplant centers and insurance status, as well as clinical conditions and social risk factors. MAP also recognized the need to ensure that the measure is appropriately risk-adjusted and suggested the exploration of adjustment for social risk factors and proper risk model performance.

Ultimately, MAP conditionally supported these measures pending NQF review and endorsement. Specifically, MAP recommended that measures be reviewed by the Scientific Methods Panel and the Renal Standing Committee. MAP recommended that the endorsement process carefully examine the validity of the measure, particularly the risk-adjustment model and if it appropriately accounts for social risk. Finally, MAP noted the need for the Attribution Expert Panel to provide further guidance on attribution models as well as for the Disparities Standing Committee to provide guidance on potential health equity concerns.

MAP received 13 comments on the proposed measures for the ESRD QIP program. Commenters supported MAP's recommendation on MUC17-176 noting broad support among stakeholders. Commenters noted the importance of improving transplantation rates for all patients with ESRD and recognized the issues of equal access to transplantation. Several commenters did not support MAP's recommendations on MUC17-241 and MUC17-245 due to concerns with attribution to dialysis facilities for successful waitlisting. Several commenters supported the recommendations and the conditions placed on the measure, and encouraged CMS to address them before implementation in federal programs

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

The Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) program is a voluntary quality reporting program. The program's goal is to provide information about the quality of care provided in the 11 cancer hospitals exempt from the Medicare Inpatient Prospective Payment System (IPPS).

In its 2017-2018 pre-rulemaking deliberations, MAP reviewed one measure under consideration for the PCHQR program. MAP supported MUC17-178 *30-Day Unplanned Readmissions for Cancer Patients* for rulemaking. This fully developed and tested measure received endorsement from NQF. It fills a current gap in the PPS-Exempt Cancer Hospital Quality Reporting Program by addressing unplanned readmissions of cancer patients.

MAP received three comments on this measure. Two commenters supported the measure, and one recommended that the measure not be included in the program due to concerns with measure exclusions.

Ambulatory Surgical Center Quality Reporting (ASCQR)

The Ambulatory Surgical Center Quality Reporting (ASCQR) program is a pay-for-reporting program. Ambulatory Surgical Centers (ACSs) that do not participate or fail to meet program requirements, receive a 2 percent reduction in the annual payment update. The goals for the ASCQR program include: (1) promoting higher-quality, more efficient healthcare for Medicare beneficiaries through measurement, and (2) providing consumers with quality information that will allow them to compare the quality of care given at ASCs and help them make informed decisions about where they receive care.

In its 2017-2018 pre-rulemaking deliberations, MAP reviewed one measure under consideration for the ASCQR program: MUC17-233 *Hospital Visits following General Surgery Ambulatory Surgical Center Procedures.* MAP conditionally supported MUC17-233 for the ASCQR program pending NQF review and endorsement. MAP recognized that this measure assesses an important outcome for patients receiving care in ambulatory surgery centers and addresses crucial safety concerns by tracking if a patient requires treatment at an acute care hospital—including emergency department (ED) visits, observation stays, and unplanned inpatient admissions—within seven days of the procedure performed at an ASC. MAP noted that this measure could help balance incentives to perform more procedures on an outpatient basis.

However, MAP acknowledged concerns raised in the initial public commenting period about the measure. Commenters raised concerns about the attribution model of measure, noting that hospital visits after ASC procedures are relatively rare events and could disproportionately affect low-volume or rural ASCs, and that the measure may need risk adjustment for social risk factors. MAP noted that this measure should be submitted for NQF endorsement to assess the potential impact of these concerns on the reliability and validity of the measure.

During the post-meeting comment period, MAP received seven comments on this measure. Most comments supported the MAP's recommendation of conditional support, noting that the measure needs further development, and should be NQF-endorsed before implementation in the ASCQR program. One commenter stated that MAP should issue a "Do Not Support for Rulemaking" recommendation for this measure due to numerous concerns, including the attribution model.

Hospital Outpatient Quality Reporting (OQR)

The Hospital Outpatient Quality Reporting Program (OQR) is a pay-for-reporting program. Hospitals that do not report data on required measures receive a 2 percent reduction in the annual payment update. The goals of the program are to establish a system for collecting and providing quality data to hospitals providing outpatient services and to provide consumers with quality-of-care information to make more informed decisions about their healthcare options.

In the 2017-2018 pre-rulemaking deliberations, MAP reviewed one measure under consideration for the OQR program. MAP recommended that MUC17-223 *Lumbar Spine Imaging for Low Back Pain* not be supported for rulemaking. MAP noted that this measure was not recommended for continued endorsement by the NQF Musculoskeletal Standing Committee in 2017.

When reviewing this measure for endorsement maintenance, the Standing Committee agreed that it did not meet the validity subcriterion. The Standing Committee expressed concerns including a potential misalignment between this measure being specified for Medicare fee-for-service beneficiaries and the inclusion of "elderly individuals" as one of the red-flag conditions in the appropriate use guidelines. Further, the use of evaluation and maintenance visits as a proxy for antecedent conservative care was a concern, as this may not capture all types of conservative care that cannot be captured in claims data (e.g., telephone visits, the use of NSAIDs, acupuncture or massage). Finally, MAP raised concerns about coding and appropriate look-back periods for exclusions for this measure.

MAP received one comment on this measure in agreement with the MAP recommendation to Do Not Support the measure for rulemaking.

Inpatient Quality Reporting Program (IQR)/Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals

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

MAP reviewed three measures for rulemaking for the IQR and the EHR Incentive Program. MAP conditionally supported two related measures

for rulemaking: MUC17-195 *Hospital-Wide All-Cause Risk Standardized Mortality* and MUC17-196 *Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure* pending NQF review and endorsement. MAP recommended that one measure, MUC17-210 *Hospital Harm Performance Measure: Opioid Related Adverse Respiratory Events*, be revised and resubmitted prior to rulemaking.

MAP had an extensive discussion regarding these measures. Beginning with MUC17-195, MAP members noted that the measure addressed an important topic for patients. MAP noted that this measure promotes patient safety and could help reduce deaths due to medical errors. MAP also noted that this measure has the potential to encourage facilities to work more closely with other providers and improve continuity of care. Finally, MAP suggested that the measure would encourage hospitals to improve the quality of documentation, specifically concerning patients' comorbid conditions. MAP members agreed that IQR was an appropriate place for the measure as it involves pay for reporting, as compared to pay for performance.

MAP did raise potential concerns about MUC17-195 that should be vetted through the NQF endorsement process. First, MAP recognized that some patients, by virtue of their health status, are expected to have higher mortality rates. Some MAP members also raised concerns about the information on risk factors available in claims data to support adequate risk adjustment of this measure. MAP recommended that the relevant NQF standing committee ensure that the measure has appropriate clinical and social risk factors in its risk-adjustment model and addresses necessary exclusions. MAP reiterated that appropriate risk adjustment and exclusions are necessary to ensure the measure does not disproportionately penalize facilities who may see more complex and vulnerable patients (e.g., academic medical centers or safety net providers) or who may have smaller volumes of patients (e.g., rural providers or critical access hospitals). Without adequate risk adjustment, the measure may not be an appropriate indicator of quality for hospitals serving rural areas or at-risk populations.

MAP also raised concerns that the measure may have unintended consequences for end-of-life care such as delayed referrals to hospice or palliative care or increased rates of unnecessary interventions at the end of a person's life.

Finally, MAP noted some implementation concerns with MUC17-195. Specifically, condition-specific mortality measures already in the IQR may be more actionable for hospitals because they provide more detailed information to support consumer decision making. MAP members cautioned that performance on this measure could be potentially misleading to consumers, as a good performance on mortality may reflect a lower acuity facility. Additionally, internal variation in mortality rates between service lines within a hospital could obscured by the global nature of the measure. Hospitals should be monitoring their performance and examining every death and responding quickly with changes and improvements to improve quality of care. Finally, MAP members noted concern that the measure was developed using ICD-9 codes and not tested using ICD-10 codes. The measure developer clarified that it intended to submit the measure for NQF endorsement using ICD-10 specifications.

Ultimately, MAP supported this measure for rulemaking with the condition that it be submitted to NQF for review and endorsement. More specifically, MAP recommended that the NQF committee reviewing this measure ensure that there is appropriate, validated evidence supporting the measure. MAP also recommended that the committee reviewing this measure explicitly consider the importance of this measure and potential unintended consequences. Finally, MAP recommended that this measure be brought to the NQF Disparities Standing Committee when evaluating the appropriateness of adjusting for social risk factors.

The discussion for MUC17-196 *Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure* addressed many of the same issues as the preceding measure. MAP noted that this measure used EHR data to support additional factors in the risk-adjustment model. MAP recognized the need to balance better information to support the accuracy of the risk-adjustment model with the challenges of extracting EHR data. MAP noted that EHR fragmentation may lead to issues in implementation, but noted that the measure could drive alignment, encouraging hospitals to better harmonize EHRs and improve care coordination between providers.

Ultimately, MAP conditionally supported this measure for rulemaking pending NQF review and endorsement. MAP recommended that the standing committee focus on the evidence supporting the measure, the threats to the validity of the measure including risk adjustment and exclusions, and potential unintended consequences. Additionally, MAP recommended that the Disparities Standing Committee consider the appropriateness of adjustment for social risk factors. Given the variability in EHR systems, MAP also recommended that the standing committee reviewing this measure pay special attention to the ability to consistently obtain EHR data across hospitals. Finally, MAP recommended a voluntary reporting period for the measure before it is finalized in the program to allow providers to test the extraction of electronic data elements.

MAP recommended that MUC17-210 *Hospital Harm Performance Measure: Opioid Related Adverse Respiratory Events* be revised and resubmitted prior to rulemaking. MAP noted that this measure concept assesses a critical patient safety issue that should be addressed with urgency. However, MAP raised concerns that the measure has not been tested in enough hospitals to assess measure reliability and validity across facilities, and noted that further testing should be completed before it is implemented in the program. As the measure developer completes testing of the measure, MAP requested that the developer consider the impact of chronic opioid users and patients receiving Suboxone (buprenorphine and naloxone). MAP noted that the completed testing should demonstrate reliability and validity before the measure is submitted to NQF for review and endorsement. MAP recommended that the Patient Safety Standing Committee pay special attention to potential unintended consequences and noted there may be a need to balance this measure with measures assessing appropriate use of naloxone and adequate pain control.

MAP received a total of 20 comments on the proposed measures for the IQR program. Comments on MUC17-195 and MUC17-196 varied. Some comments supported the conditions placed on the measure, while others did not support the inclusion of the measure in program. Commenters generally agreed that the measures required further work before implementation. Commenters also noted concerns with the data sources, potential unintended consequences, the scope of further measure development needed, and duplicity with measures currently in program as concerns. Five of six comments for MUC17-210 supported MAP's recommendation, noting that the measure is in an early stage of development and requires further development before implementation. One commenter recommended that the Coordinating Committee to consider a Do Not Support recommendation, and suggested that CMS gather stakeholder input into the measure development process to refocus this work in a more meaningful way.

Hospital-Acquired Condition (HAC) Reduction Program and Discussion of Future Measures

CMS asked for input on the HAC reduction program and which criteria CMS should consider when adding new measures to the program. CMS representatives noted that the program is aiming to incorporate new measures that are low burden for implementation, but address key safety issues

for patients such as falls with injury, glycemic events, adverse drug events, and increased use of electronic clinical quality measures (eCQMs) in HAC reduction.

MAP noted the need for a global harm measure derived from the electronic health record. MAP also recommended that measures that evaluate the outcomes of antimicrobial stewardship programs should be included in the HAC reduction program. MAP noted concerns in the implementation of eCQMs, explaining that in concept they supported these measures, but wanted to see them successfully implemented before they are included in a public reporting or pay-for-performance program.

Input on Measure Removal Criteria

During the MAP meeting, CMS asked for input on which criteria CMS should consider when removing measures from its quality reporting and value-based purchasing programs. MAP supported the removal criteria provided by CMS as a starting point, and offered several additional suggestions and items to consider:

- **Unintended consequences**. MAP suggested that CMS pay special attention to unintended consequences of implemented measures—such as encouraging unnecessary treatment or worsening access issues for vulnerable patients—and remove measures with negative unintended consequences as needed.
- **Provider burden and operational issues**. MAP noted that there would be cases in which the suggested criteria may contradict each other. For example, CMS may need to reconcile a measure that provides meaningful information but is burdensome to implement and maintain. In these cases, CMS should consider both criteria when considering the possible removal of measures. MAP also suggested a preference for keeping measures that are easily operational, and that can be applied across settings, especially measures that can be implemented for internal quality improvement efforts.
- **Risk adjustment**. MAP emphasized the evaluation of outcome measures to ensure proper risk adjustment. For example, MAP recommended that developers test the impact of a broader set of social risk factors, beyond dual eligible status.
- **Consumer value**. MAP supported the consideration of 'meaningful to patients and providers' as a criterion. For example, process measures might not provide as much meaningful information to patients as a well-designed patient-reported outcome. MAP members emphasized the importance of providing sufficient information for patients to make healthcare decisions

MAP noted other considerations when removing measures. MAP members noted that focusing too heavily on any one criterion might have negative unintended consequences. For example, while alignment of measures is beneficial, it may also reduce opportunities for innovation. Overall, MAP supported the Meaningful Measures framework presented by CMS and encouraged further iteration based on the MAP feedback.

MAP also noted the need to ensure that measures in the CMS program sets are high-value; however, MAP cautioned that CMS should balance removing measures with the importance of maintaining a focus on important quality and public health issues and ensuring progress among low performers. MAP members also pointed out the value of consistency in the program measure sets and cited the costs associated with adapting to changing measures and shifting the focus of quality improvement efforts.

Finally, MAP stressed the importance of defining value from the patient perspective, emphasizing the need to ensure that measures address the issues that patients and consumers find most important. MAP also noted the importance of engaging patients and their families in the measure development and selection process.

APPENDIX A:
Program Summaries

The material in this appendix was extracted from the CMS Program Specific Measure Priorities and Needs document, which was released in April 2017, as well as the CMS website.

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

Program Type

- Pay for performance

Incentive Structure

- Payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions will be on a sliding scale, which could amount to a maximum of 2 percent per year.

Program Goals

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

Measure Requirements

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

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

Program Type

- Quality reporting program

Incentive Structure

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

Program Goals

- Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the inpatient prospective payment system and the Inpatient Quality Reporting program.
- Encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices.

Measure Requirements

- Measures must adhere to CMS statutory requirements.
  - Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act.

  - The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed by the entity with a contract under Section 1890(a) of the Social Security Act, as long as endorsed measures have been given due consideration.

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

Ambulatory Surgical Center Quality Reporting (ASCQR)

Program Type

- Pay for reporting

Incentive Structure

- Ambulatory surgical centers (ACSs) that treat Medicare beneficiaries and fail to report data will receive a 2 percent reduction in their annual payment update. The program includes ASCs operating exclusively to provide surgical services to patients not requiring hospitalization.

Program Goals

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

Measure requirements

- Measure must adhere to CMS statutory requirements, including specification under the Hospital IQR program and posting dates on the Hospital Compare website.
  - Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act, currently the National Quality Forum (NQF).
  - The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed, by the entity with a contract under Section 1890(a) of the Social Security Act, as long as endorsed measures have been given due consideration.

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

Inpatient Psychiatric Facilities Quality Reporting (IPFQR)

Program Type

- Pay for reporting

Incentive Structure

- Inpatient psychiatric facilities (IPFs) that do not submit data on all required measures receive a 2 percent reduction in annual payment update.

Program Goals

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

Measure Requirements

- Measure must adhere to CMS statutory requirements.
  - Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act.
  - The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed by the entity with a contract under Section 1890(a) of the Social Security Act, as long as endorsed measures have been given due consideration.
- Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
- The measure assesses meaningful performance differences between facilities.
- The measure addresses an aspect of care affecting a significant proportion of IPF patients.
- Measure must be fully developed, tested, and validated in the acute inpatient setting.
- Measure must address an NQS priority/CMS strategy goal, with preference for measures addressing the high-priority domains for future measure consideration.
- Measure must promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Outpatient Quality Reporting (OQR)

Program Type

- Pay for reporting

Incentive Structure

- Hospitals that do not report data on required measures receive a 2 percent reduction in annual payment update.

Program Goals

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

Measure Requirements

- Measure must adhere to CMS statutory requirements.
  - Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act.
  - The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed by the entity with a contract under Section 1890(a) of the Social Security Act, as long as endorsed measures have been given due consideration.
- Measure must address an NQS priority/CMS strategy goal, with preference for measures addressing the high-priority domains for future measure consideration.
- Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
- Measure must be fully developed, tested, and validated in the hospital outpatient setting.
- Measure must promote alignment across HHS and CMS programs.
- Feasibility of Implementation: An evaluation of feasibility is based on factors including, but not limited to:
  - The level of burden associated with validating measure data, both for CMS and for the end user.
  - Whether the identified CMS system for data collection is prepared to accommodate the proposed measure(s) and timeline for collection.
  - The availability and practicability of measure specifications (e.g., measure specifications in the public domain).
  - The level of burden the data collection system or methodology poses for an end user.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and (CAHs)

Program Type

- Pay for reporting

Incentive Structure

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

Program Goals

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

Measure Requirements

- Measure must adhere to CMS statutory requirements.
  - Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act, currently the National Quality Forum (NQF).
  - The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed by the entity with a contract under Section 1890(a) of the Social Security Act, as long as endorsed measures have been given due consideration.
- Measure must be claims-based or an electronically specified clinical quality measure (eCQM). Less immediately burdensome claims-based measures and feasible electronically specified clinical quality measures (eCQMs) are preferred over more burdensome chart-abstracted measures. CMS may consider chart-abstracted measures that address important measurement areas or gaps otherwise not feasibly specified.
  - A Measure Authoring Tool (MAT) number must be provided for all eCQMs, created in the HQMF format.
  - eCQMs must undergo reliability and validity testing including review of the logic and value sets by the CMS partners, including, but not limited to, MITRE and the National Library of Medicine.
  - eCQMs must have successfully passed feasibility testing.
- Measure may not require reporting to a proprietary registry.
- Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
- Measure must be fully developed, tested, and validated in the acute inpatient setting.
- Measure must address a Meaningful Measure Area, with preference for measures addressing the high-priority domains and/or measurement gaps for future measure consideration.
- To the extent possible, a measure should promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Value-Based Purchasing (VBP)

Program Type

- Pay for performance

Incentive Structure

The amount withheld from reimbursements increases over time:

- FY 2016: 1.75 percent
- FY 2017 and future fiscal years: 2.0 percent

Program Goals

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

Measure Requirements

- Measure must adhere to CMS statutory requirements, including specification under the Hospital IQR program and posting dates on the Hospital Compare website.
  - Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act, currently the National Quality Forum (NQF).
  - The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed by the entity with a contract under Section 1890(a) of the Social Security Act, as long as endorsed measures have been given due consideration.
- Measure may not require reporting to a proprietary registry.
- Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
- Measure must be fully developed, tested, and validated in the acute inpatient setting.
- Measure must address a Meaningful Measure Area, with preference for measures addressing the high-priority domains and/or measurement gaps for future measure consideration.
- To the extent possible, a measure should promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Readmissions Reduction Program (HRRP)

Program Type

- Pay for performance

Incentive Structure

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

Program Goals

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

Measure Requirements

- CMS is statutorily required to select measures for applicable conditions, which are defined as conditions or procedures selected by the Secretary in which readmissions are high volume or high expenditure.
- Measures selected must be endorsed by the consensus-based entity with a contract under Section 1890 of the Act. However, the Secretary can select measures which are feasible and practical in a specified area or medical topic determined to be appropriate by the Secretary, that have not been endorsed by the entity with a contract under Section 1890 of the Act, as long as endorsed measures have been given due consideration.

- Measure methodology must be consistent with other readmissions measures currently implemented or proposed in the HRRP.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Acquired Condition Reduction Program (HACRP)

Program Type

- Pay for reporting

Incentive Structure

- The 25 percent of hospitals that have the highest rates of HACs (as determined by the measures in the program) will have their Medicare payments reduced by 1 percent.

Program Goals

- Provide an incentive to reduce the incidence of HACs to improve both patient outcomes and the cost of care.
- Drive improvement for the care of Medicare beneficiaries, but also privately insured and Medicaid patients, through spill over benefits of improved care processes within hospitals.

Measure Requirements

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

APPENDIX B:
MAP Hospital Workgroup Roster and NQF Staff

WORKGROUP CHAIRS (VOTING)

Christie Upshaw Travis, MSHHA (Co-Chair)

Ronald S. Walters, MD, MBA, MHA, MS (Co-Chair)

ORGANIZATIONAL MEMBERS (VOTING)

American Association of Kidney Patients
Richard Knight

Association of American Medical Colleges
Janis Orlowski, MD MACP

America's Essential Hospitals
Maryellen Guinan, JD

American Hospital Association
Nancy Foster

Baylor Scott & White Health (BSWH)
Marisa Valdes, RN, MSN

Blue Cross Blue Shield of Massachusetts
Wei Ying, MD, MS, MBA

Children's Hospital Association
Andrea Benin, MD

Kidney Care Partners
Keith Bellovich, MD

Geisinger Health Systems
Joan Brennan, DNP

Medtronic-Minimally Invasive Therapy Group
Karen Shehade, MBA

Mothers against Medical Error

Helen Haskell, MA

National Association of Psychiatric Health Systems (NAPHS)
Frank Ghinassi, PhD, ABPP

National Rural Health Association
Brock Slabach, MPH, FACHE

Nursing Alliance for Quality Care
Kimberly Glassman, PhD, RN, NEA-BC, FAAN

Pharmacy Quality Alliance
Anna Dopp, PharmD

Premier, Inc.
Aisha Pittman, MPH

Project Patient Care
Martin Hatlie, JD

Service Employees International Union
Sarah Nolan

The Society of Thoracic Surgeons
Jeff Jacobs, MD

University of Michigan
Marsha Manning

INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

Gregory Alexander, PhD, RN, FAAN

Elizabeth Evans, DNP

Lee Fleisher, MD

Jack Jordan

R. Sean Morrison, MD

Ann Marie Sullivan, MD

Lindsey Wisham, BA, MPA

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

Agency for Healthcare Research and Quality (AHRQ)
Pamela Owens, PhD

Centers for Disease Control and Prevention (CDC)
Daniel Pollock, MD

Centers for Medicare & Medicaid Services (CMS)
Pierre Yong, MD, MPH

MAP MEDICAID WORKGROUP LIAISON (NON-VOTING)

Academy of Managed Care Pharmacy
Marissa Schlaifer, RPh, MS

Boston Children's Hospital
Richard Antonelli, MD

NATIONAL QUALITY FORUM STAFF

Elisa Munthali, MPH
Senior Vice President, Quality Measurement

Melissa Mariñelarena, RN, MPA
Senior Director

Kate McQueston, MPH
Project Manager

Desmirra Quinnonez
Project Analyst

Erin O'Rourke
Senior Director

Taroon Amin, PhD
Consultant

ISBN 978-1-68248-077-9

NATIONAL QUALITY FORUM
1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005

www.qualityforum.org