

MEASURE APPLICATIONS PARTNERSHIP

# Cross-Cutting Challenges Facing Measurement: MAP 2015 Guidance

FINAL REPORT

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NATIONAL  
QUALITY FORUM

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## SUMMARY

- Improvements are required in moving toward “measures that matter” in health programs, such as measures of health outcomes, composite measures, care coordination, cost and resource use, and patient safety.
- MAP has identified a number of critical measurement gap areas that continue to inform its recommendations to CMS on measure use.
- While progress has been made in aligning measures between public- and private-sector programs, additional efforts are necessary.
- MAP emphasized the Medicare Shared Savings Program’s focus on encouraging coordination, which can be done by including measures relevant to individuals with multiple chronic conditions, measures in all settings in which patients receive care (including ambulatory, acute, and post-acute settings), and measures that span across settings.

When deliberating on specific measures during the pre-rulemaking process, the Measure Applications Partnership (MAP) identifies broader issues, including measurement gaps, implementation challenges, and unintended consequences. This synthesis across programs is one of the ways in which MAP captures the expertise of the multistakeholder group. This document outlines several cross-cutting themes across federal programs MAP examined this year, along with issues that were identified for the cross-cutting Medicare Shared Savings Program.

## OVERARCHING THEMES

### Moving Towards Measures that Matter

Over the course of its work, MAP has made substantial progress in identifying “high value” measures or “measures that matter” that are important to those affected by different federal health programs. During its deliberations, MAP tended to define high-value measures as outcome measures, process measures that are closely linked by empirical evidence to outcomes, cost and resource use measures, appropriate use measures, care coordination measures, and patient safety measures. For example, MAP examined high-value measures in clinician programs, which included whether the measures assessed an important health issue (based on its prevalence, cost, or resulting harm), addressed an opportunity for improvement in care quality or people’s health, or whether the measures had demonstrated an ability to change performance. However, there were multiple viewpoints on what was a measure that mattered, with some recognizing the importance of process and structural measures, and stakeholders did not establish consensus on which measures are most valuable in driving results.

At a time when healthcare resources are under intense scrutiny, focusing on measures that matter would ensure that measurement efforts are targeted at areas that will truly drive the most meaningful improvements to promote care coordination and reduce reporting burden. Public comments supported this premise, with several highlighting opportunities to improve quality by focusing on critically important areas that

could significantly improve patient outcomes. However, other commenters disagreed with MAP’s assessment that high-value measures would reduce reporting burden, and that moving towards these measures will spur increased development. Instead, they emphasized that reporting requirements across programs may pose a challenge in truly identifying these measures, creating a disconnect between what is deemed “high value” and individual reporting structures.

With measure sets that change over time, there is a challenge in ensuring measures continue to assess important areas. In this year’s MAP deliberations, members noted that measurement gaps could arise when measures were removed from programs. This discussion was motivated by changes that have recently occurred in federal programs; for example, this year 50 measures were removed from the Physician Quality Reporting System across a variety of condition areas. Measures may be removed from programs for a variety of reasons, such as when all providers achieve a high level of performance on the measure (a “topped out” measure) or when evidence and guidelines change. However, these removals could lead to measurement gaps, and the programs have to be analyzed to ensure that they continue to assess important areas. This is of particular importance for clinician programs, which seek to have relevant measures across all clinical specialties. Public commenters echoed these concerns and suggested prudent monitoring as well as a flexible approach to ensuring that relevant measures are available to as many clinicians as possible.

MAP also had an important discussion on the need to better assess disparities. While there are some measures that can directly quantify disparities in care quality or health outcomes, many measures could be stratified for different populations or conditions to understand variations. One related challenge is whether data are available to support stratification; for example, healthcare claims may not contain the demographic information necessary for analyzing many types of disparities. Further work is needed to build the data infrastructure needed to fully understand variations and disparities in care and outcomes.

Each year during pre-rulemaking, MAP specifically examines the use of measures relevant to the Medicare-Medicaid dual eligible beneficiary population. These consumers experience disproportionately high rates of both medical and social complexity, complicated by low income and lack of access to other supports. Guided by the most [recent version of the Family of Measures for Dual Eligible Beneficiaries](#), MAP encouraged the use of measures that match the unique needs of this and other vulnerable populations. For example, MAP supported the use of a measure of antipsychotic use among persons with dementia within the Medicare Shared Savings Program, measures of care coordination and brief intervention for alcohol use within the Inpatient Psychiatric Facility Quality Reporting

Program, and further development of measures of functional status assessment and goal-setting for the Meaningful Use program. The use of these and other measures would partially address measure gaps that MAP has consistently identified.

Finally, comments stressed the need for greater alignment and a preference for a parsimonious set of measures that target the core objectives of federal programs. This would help minimize cost and provider burden, establishing shared incentives that focus on achieving the most appropriate resource use for each individual patient.

## Progress on Filling Critical Measure Gaps

During this year's pre-rulemaking, the MAP continued to assess measurement gaps for each program being considered. The 2014-2015 pre-rulemaking process supplemented that work with the gaps identified by other MAP projects, NQF endorsement projects, and NQF gap identification projects, and this compiled measure gap list is included in [Appendix A](#). To illustrate the range of gaps identified, Table 1 highlights important gaps in a specific area—person- and family-centered care—that has consistently had fewer measures available.

**TABLE 1. IDENTIFIED MEASUREMENT GAPS FOR ONE EXAMPLE TOPIC AREA:  
Person- and Family-Centered Care**

Category	Measurement Gap
Person-Centered Communication	<ul style="list-style-type: none"> <li>• Information provided at appropriate times.</li> <li>• Information is aligned with patient preferences.</li> <li>• Patient understanding of information, not just receiving information (considerations for cultural sensitivity, ethnicity, language [such as patients who may not speak English], religion, multiple chronic conditions, frailty, disability, medical complexity).</li> <li>• Outreach to patients to ensure they have the tools and resources needed to self-manage their care.</li> </ul>
Shared Decisionmaking, Care Planning, and Other Aspects of Person-Centered Care	<ul style="list-style-type: none"> <li>• Person-centered care plan, created early in the care process, with identified goals for all people.</li> <li>• Integration of patient/family values in care planning.</li> <li>• Plan agreed to by the patient and provider and given to patient, including advanced care plan.</li> <li>• Plan shared among all providers seeing the patient (integrated); multidisciplinary.</li> <li>• Identified primary provider responsible for the care plan.</li> <li>• Fidelity to care plan and attainment of goals.                             <ul style="list-style-type: none"> <li>- Treatment consistent with advanced care plan.</li> </ul> </li> <li>• Social care planning addressing social, practical, and legal needs of patient and caregivers.</li> <li>• Grief and bereavement care planning.</li> <li>• Patient activation/engagement.</li> </ul>
Advanced Illness Care	<ul style="list-style-type: none"> <li>• Symptom management (pain, nausea, shortness of breath).</li> <li>• Comfort at end of life.</li> </ul>
Quality of Life and Functional Status	<ul style="list-style-type: none"> <li>• Functional status.                             <ul style="list-style-type: none"> <li>- Particularly for individuals with multiple chronic conditions.</li> <li>- Optimal functioning (e.g., improving when possible, maintaining, managing decline).</li> </ul> </li> <li>• Pain and symptom management.</li> <li>• Health-related quality of life.</li> </ul>
Cross-Cutting Themes	<ul style="list-style-type: none"> <li>• How measures can be adapted to or developed for different care settings, such as rehabilitation facilities.</li> <li>• Understanding how measures may apply to different subpopulations (such as pediatrics, maternity, behavioral health).</li> </ul>

Beyond identifying specific gaps, MAP members have been interested in tracking progress in addressing previously identified measurement gap areas. As a first step in monitoring gap-filling, this year MAP developed a scorecard approach, shown in Figure 1, which quantifies the number

of MAP-recommended measures in gap areas. Organized by the priority areas of the National Quality Strategy, the scorecard shows that MAP has had the opportunity to recommend multiple measures in some areas, while underscoring that measures are still needed in several important areas.

**FIGURE 1. SCORECARD APPROACH FOR MONITORING PROGRESS IN GAP FILLING, ORGANIZED BY NATIONAL QUALITY STRATEGY PRIORITY AREAS**

Affordability	LEGEND
Efficient use of services <sup>a</sup>	<sup>a</sup> >5 measures potentially addressing gap
Costs for Special Populations <sup>b</sup>	<sup>b</sup> 1-5 measures potentially addressing gap
Out-of-Pocket Costs <sup>b</sup>	<sup>c</sup> No measures appear to address gap
Total Costs <sup>b</sup>	
Employer/Purchaser Costs <sup>c</sup>	
Care Coordination	
Communication <sup>a</sup>	
System and Infrastructure <sup>b</sup>	
Avoidable Admissions and Readmissions <sup>c</sup>	
Healthy Living	
Healthy Behaviors <sup>c</sup>	
General - Public Health <sup>c</sup>	
Health/Wellness Status <sup>c</sup>	
Social and Environmental Determinants of Health <sup>c</sup>	
Prevention and Treatment for the Leading Causes of Mortality	
Special Populations <sup>a</sup>	
Depression <sup>b</sup>	
Musculoskeletal <sup>b</sup>	
Cardiovascular <sup>c</sup>	
Diabetes <sup>c</sup>	
Cancer <sup>c</sup>	
Primary and Secondary Prevention <sup>c</sup>	
Safety	
Perioperative/Procedural Safety <sup>a</sup>	
General <sup>b</sup>	
Healthcare Acquired Infection (HAI) <sup>b</sup>	
Medication/Infusion Safety <sup>b</sup>	
Obstetrical Adverse Events <sup>c</sup>	
Pain Management <sup>c</sup>	
Falls and Immobility <sup>c</sup>	
Venous Thromboembolism <sup>c</sup>	
Person- and Family-Centered Care	
Shared Decisionmaking, Care Planning, and Other Aspects of Person-Centered Care <sup>a</sup>	
Person-Centered Communication <sup>b</sup>	
Advanced Illness Care <sup>b</sup>	
Quality of Life and Functional Status <sup>b</sup>	

This high-level summary provided by the scorecard could help identify which gaps are starting to be addressed and where more work still remains. The scorecard approach will continue to evolve, and MAP members outlined several ways to strengthen the gap-filling approach in its deliberations. These include (1) identifying where measures are not available or inadequately assess performance; (2) prioritizing gaps by importance, impact, and feasibility; and (3) highlighting barriers to gap-filling, such as infrastructure support needed, and offering potential solutions to these barriers. In addition, MAP members identified additional measure gap strategies, which may provide helpful information for tracking progress by analyzing measure gaps by clinical area, data source, and setting.

## Progress in Aligning Measurement Requirements

Data continue to show the critical need for greater alignment in measurement requirements. For example, an analysis of almost 50 state and regional measure sets found over 500 unique measures were in use, with only one-fifth used in more than one program.<sup>1</sup> In the second quarter of 2014, 33 different CMS programs used over 850 unique measures, with only one-third used in more than 2 different CMS programs.<sup>2</sup> MAP can help further alignment given its unique position and ability to look at measure use across programs.

During this year's deliberations, the MAP discussions centered on the need for measurement alignment across multiple programs by focusing on comparable performance across care settings, data sources, and measure elements to initiate information exchange. For example, this year MAP members highlighted the importance of aligning measures across settings, as patients and consumers often have a choice of receiving the same care in multiple different settings. In addition, MAP noted the usefulness of expanding certain hospital programs to allow small and rural hospitals the ability to report measures, thus closing potential "reporting gaps" across the healthcare system. By including small and rural

hospitals, the programs can provide patients and consumers with meaningful and comparable data on providers in that setting. Finally, MAP noted that true alignment goes beyond having similar concepts, but requires aligned technical specifications. For example, providers can now report performance on measures using multiple data sources (from EHR-based measures to registries to claims-based measures), and alignment would ensure that results are comparable regardless of the data source used. MAP will continue to monitor the work coming out of the AHRQ- and CMS-convened HHS Measurement Policy Council, an interagency workgroup with representatives from across HHS tasked with providing ongoing guidance on measurement development and alignment.

In their discussions, MAP members noted the limits of alignment, as it is one important goal among many. For example, some measurement programs may have specific purposes or address specific clinical areas which necessitate using specialized measures. Fit-for-purpose balances measure alignment against the needs of the particular program. Others indicated the need to balance standardization against the potential for innovation. Moreover, there were questions about what constituted alignment, such as whether measures needed to be exactly the same or could differ slightly. MAP will continue to explore this important issue in future work.

Public commenters appreciated MAP's recognition of alignment, further emphasizing the need to establish alignment by simplifying measures across settings however noting therein lie tradeoffs—such as tailoring a measure for its use or program, or allowing for flexibility and innovation. Other comments centered on the importance of aligning measures on the national and the state/regional level. This can be done by instituting a formal process where alignment is discussed among multistakeholder groups (e.g., clinicians, hospitals, consumers and purchasers) within various care settings to truly drive this priority area.



## CONSIDERATIONS FOR SPECIFIC PROGRAMS ACROSS SETTINGS

### Medicare Shared Savings Program

The Medicare Shared Savings Program is a pay-for-reporting and pay-for-performance program that encourages Accountable Care Organizations (ACOs) to improve the health of a population of Medicare patients while reducing the rate of growth in healthcare spending. This program, first established in 2012, is undergoing multiple changes this year (as described in the 2015 Physician Fee Schedule final rule).<sup>3</sup> While recent proposals will keep the total number of quality measures the same, eight measures will be retired and eight will be added. In addition, CMS will modify the benchmarking approach for measures that have uniformly high levels of performance (“topped out” measures), with new benchmarks established every two years. Furthermore, CMS has indicated its intention to align this program with others, such as the Value-Based Payment Modifier and EHR Incentive Program.

MAP’s previous assessments of the Medicare Shared Savings Program’s measure set found it to be comprehensive, addressing cross-cutting measurement priorities including patient experience, high-impact conditions, and key quality outcomes. Additionally, observing that the measure set places heavy emphasis on ambulatory

care, MAP has recommended that adding measures relevant to individuals with multiple chronic conditions could enhance it.

This year, MAP assessed this program within the clinician, hospital, and post-acute care/long-term care settings, identifying cross-cutting themes emphasized by the workgroups. MAP highlighted the challenges of improving care and health outcomes for a broader population and ensuring that these improvements and health gains are widely shared for multiple subpopulations. MAP emphasized the program’s focus on encouraging coordination, which can be done by including measures relevant to individuals with multiple chronic conditions, measures for all settings where patients receive care (including ambulatory, acute, and post-acute settings), and measures that span across settings. In addition, MAP noted that many condition-specific measures could be rolled up into composite measures to provide a broader view of the quality of care for specific conditions. MAP members also discussed potentially including measures of diagnostic accuracy, the performance of screening methods (e.g., mammography, colonoscopy), health risks, cost and resource use, overuse, and appropriate use.

## ENDNOTES

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- 1** Bazinsky K, Bailit M. The significant lack of alignment across state and regional health measure sets: health care performance measurement activity: an analysis of 48 state and regional measure sets [issue brief]. Needham, MA: Bailit Health Purchasing; September 10, 2013. Available at <http://www.buyingvalue.org/wp-content/uploads/2014/02/buying-value-common-measures-Bailit-State-Measure-Set-Brief-9-10-13-FINAL-FINAL.docx>. Last accessed December 2014.
- 2** CMS website. CMS Measures Inventory. Baltimore, MD:2014. Analysis of measure inventory data. Available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html>. Last accessed December 2014.
- 3** 2014, Final Rule, *Fed Regist.* 2014. 79: 67547-68010. Available at <https://www.federalregister.gov/articles/2014/11/13/2014-26183/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory>. Last accessed February 2015.

## APPENDIX A: Measurement Gaps Identified by MAP

Condition/Topic Area	Measurement Gap
<b>Affordability</b>	
Costs for Special Populations	<p>End-of-life care including inappropriate nonpalliative services at the end of life</p> <p>Chemotherapy appropriateness, including dosing</p> <p>Use of radiographic imaging in the pediatric population</p> <p>Addressing intense needs for care and support of medically complex populations (e.g., ability to obtain preventive services, medications, mental health, oral health, and specialty services)</p>
Efficient Use of Services	<p>Appropriateness for admissions, treatment, over-diagnosis, under-diagnosis, misdiagnosis, imaging, and procedures</p> <p>AHRQ ambulatory sensitive conditions measures</p> <p>Utilization benchmarking</p> <p>Potentially inappropriate medication use: Antibiotic use for sinusitis</p> <p>Unwarranted maternity care interventions (C-section)</p> <p>Measures derived from Choosing Wisely</p> <p>Availability of lower cost alternatives</p>
Employer/Purchaser Costs	<p>Employer spending on employee health benefits</p> <p>Measure of lost productivity</p>
Patient Costs	<p>Consideration of patient out-of-pocket cost.</p> <p>Ability to obtain follow-up care</p>
Total Costs	<p>Per capita total cost for attributed patients</p> <p>Converging macro/national total cost data with provider-/setting-/service area-specific/patient-/third-party payer total cost</p>
<b>Care Coordination</b>	
Avoidable Admissions and Readmissions	Shared accountability and attribution across the continuum
Communication	<p>Bi-directional sharing of relevant/adequate information across all providers and settings</p> <p>Measures of patient transition to next provider/site of care across all settings, as well as transitions to community services</p>
System and Infrastructure	<p>Interoperability of EHRs to enhance communication</p> <p>Structures to connect health systems and benefits</p> <p>Emergency department overcrowding/wait times (focus on disproportionate use by vulnerable populations)</p>

Healthy Living	
Behaviors	Healthy lifestyle behaviors (i.e., avoiding excessive alcohol use, avoiding tobacco, improving nutrition, engaging in physical activity, etc.)
General	Public health preparedness
Health/Wellness Status	Sense of control/autonomy/self-determination/well-being Treatment burden (i.e., difficulty with healthcare management tasks)
Social and Environmental Determinants of Health	Community role; patient’s ability to connect to available resources. Social connectedness for people with long-term services and supports needs Nutrition/Food Security
Prevention and Treatment for the Leading Causes of Mortality	
Special Populations	Pediatric measures
General	Complications such as febrile neutropenia and surgical site infection
Cancer	Outcome measures for cancer patients (e.g., cancer- and stage-specific survival as well as patient-reported measures) Transplants: bone marrow and peripheral stem cells. Staging measures for lung, prostate, and gynecological cancers Marker/drug combination measures for marker-specific therapies, performance status of patients undergoing oncologic therapy/pre-therapy assessment Disparities measures, such as risk-stratified process and outcome measures, as well as access measures
Cardiovascular	Clinical preventive services – assessing cardio-metabolic risk factors across all levels of analysis and settings Appropriateness of coronary artery bypass graft and PCI at the provider and system levels of analysis Early detection of heart failure decompensation Medication management and adherence as part of follow-up care for secondary prevention
Depression	Suicide risk assessment for any type of depression diagnosis Assessment and referral for substance use. Medication adherence and persistence for all behavioral health conditions
Diabetes	Measures addressing glycemic control for complex patients across settings and level of analysis Sequelae of diabetes
General	Measures of diagnostic accuracy Behavioral health assessments and care
Musculoskeletal	Evaluating bone density, and prevention and treatment of osteoporosis in ambulatory settings.
Primary and Secondary Prevention	Outcomes of smoking cessation interventions Lifestyle management (e.g., physical activity/exercise, diet/nutrition) Modify Prevention Quality Indicators (PQI) measures to assess accountable care organizations; modify population to include all patients with the disease (if applicable)

Safety	
Falls and Immobility	<p>Standard definition of falls across settings to avoid potential confusion related to two different fall rates</p> <p>Structural measures of staff availability to ambulate and reposition patients, including home care providers and home health aides</p>
General	<p>Composite measure of most significant Serious Reportable Events</p> <p>Measures for antibiotic stewardship</p>
HAI	<p>Pediatric population: special considerations for ventilator-associated events and C. difficile</p> <p>Infection measures reported as rates, rather than ratios</p> <p>Sepsis (healthcare-acquired and community-acquired) incidence, early detection, monitoring, and failure to rescue related to sepsis</p> <p>Ventilator-associated events across settings</p> <p>Post-discharge follow-up on infections in ambulatory settings</p> <p>Vancomycin Resistant Enterococci (VRE) measures (e.g., positive blood cultures, appropriate antibiotic use)</p>
Medication/Infusion Safety	<p>Potentially inappropriate medication use</p> <p>Medication management: Medication documentation, including appropriate prescribing and comprehensive medication review</p> <p>Adverse Drug Events: Total number of adverse drug events that occur within all settings</p> <p>Role of community pharmacist or home health provider in medication reconciliation</p>
General	Blood incompatibility
Obstetrical Adverse Events	<p>Obstetrical adverse event index</p> <p>Measures using National Health Safety Network (NHSN) definitions for infections in newborns</p>
Pain Management	<p>Effectiveness of pain management balanced by monitoring for potentially inappropriate use of opioids</p> <p>Assessment of depression with pain</p>
Perioperative/Procedural Safety	<p>Air embolism.</p> <p>Perioperative respiratory events, blood loss, and unnecessary transfusion</p> <p>Altered mental status in perioperative period.</p> <p>Anesthesia events (inter-operative myocardial infarction, corneal abrasion, broken tooth, etc.)</p>
Venous Thromboembolism	<p>VTE outcome measures for ambulatory surgical centers and post-acute care/long-term care settings.</p> <p>Adherence to VTE medications, monitoring of therapeutic levels, medication side effects, and recurrence</p>

Person- and Family-Centered Care	
Person-Centered Communication	<ul style="list-style-type: none"> <li>Information provided at appropriate times</li> <li>Information is aligned with patient preferences</li> <li>Patient understanding of information</li> <li>Outreach to ensure ability for care self-management</li> </ul>
Shared Decisionmaking, Care Planning, and Other Aspects of Person-Centered Care	<ul style="list-style-type: none"> <li>Person-centered care plan</li> <li>Integration of patient/family values in care planning</li> <li>Plan agreed to by the patient and provider and given to patient</li> <li>Care plan shared among all involved providers</li> <li>Identified primary provider responsible for the care plan</li> <li>Fidelity to care plan and attainment of goals</li> <li>Social care planning addressing all needs for patient and caregiver</li> <li>Grief and bereavement care planning</li> <li>Patient activation/engagement</li> </ul>
Advanced Illness Care	<ul style="list-style-type: none"> <li>Symptom management</li> <li>Comfort at end of life</li> </ul>
Quality of Life and Functional Status	<ul style="list-style-type: none"> <li>Functional status</li> <li>Pain and symptom management</li> <li>Health-related quality of life</li> <li>Achievement of goals (i.e., experience, progression towards goals, efficiency)</li> <li>Step down care</li> </ul>

## APPENDIX B: Summary Information on Federal Health Programs

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### Medicare Shared Savings Program Summary (MSSP)

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#### Program Type

MSSP is a combination pay for reporting and pay for performance program.

#### Incentive Structure

Option for one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) or a two-sided risk model (sharing of savings and losses for all three years).

#### Program Goals

“Facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs.”

#### Program Update

For 2014, the MSSP program has 33 measures that may be submitted through a CMS web interface, currently the group practice reporting (GPRO) web interface, calculated by CMS from internal and claims data, and collected through a patient and caregiver experience of care survey.

The 2015 Physician Fee Schedule final rule includes the following changes:

- Modifying the measure set (added 8 measures, retired/replaced 8) to be more outcome-oriented and reduce the reporting burden on ACOs;
- Modifying benchmarking approach for topped-out measures;
- Interest in aligning with physician programs (like Value-Based Payment Modifier and EHR incentive program);
- Finalized that CMS will award ACOs for quality improvement and that ACOs entering their

second or subsequent agreement period will be assessed on the quality performance standard that would otherwise apply to an ACO if it were in the third performance year of the first agreement; and

- Sought input on (proposed rule):
  - Measures that might be used to assess the ACO’s performance with respect to care coordination in post-acute care and other settings;
  - Specific caregiver experience of care measures that might be considered in future rulemaking;
  - Suggestions of new measures of the quality of care furnished to the frail elderly population; and
  - Measures/tools to assess changes in physical and mental health over time.

#### MAP’s Suggested Critical Program Objectives

The following are proposed critical program objectives for MSSP:

- Improve the overall health for a population of Medicare Fee-For-Service (FFS) beneficiaries and ensuring that care improvements and health outcomes are widely shared across subpopulations;
- Improve quality and health outcomes while lowering the rate of growth of healthcare spending;
- Encourage coordination and shared accountability by including measures relevant to individuals with multiple chronic condition, measures in all settings that patients receive care (including ambulatory, acute, and post-acute settings), measures that span different parts of the life span and different types of patients (such as including end of

life or patients receiving palliative care), and measures that span across settings;

- Promote alignment across other quality measurement reporting programs;
- Include more high-value measures such as:
  - Patient-reported outcome measures in the areas of depression remission, functional status, and smoking;
  - Patient-reported outcome measures for medically complex patients (e.g., chronically ill or those with multiple chronic conditions);
  - Measure of health risks with follow-up interventions;
  - Cost and resource use measures; and
  - Appropriate use measures.

## MAP Clinician Federal Program Summaries

### Physician Quality Reporting System (PQRS)

#### Program Type

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

#### Incentive Structure

In 2012-2014, EPs could receive an incentive payment equal to a percentage (2% in 2010, gradually decreasing to 0.5% in 2014) of the EP's estimated total allowed charges for covered Medicare Part B services under the Medicare Physician Fee Schedule. Beginning in 2015, EPs and group practices that do not satisfactorily report data on quality measures will receive a reduction (1.5% in 2015 and 2% in subsequent years) in payment.

#### Program Goals

The goal of the PQRS program is to encourage widespread participation by EPs to report quality information. In 2012, only 36% of EPs satisfactorily submitted quality information to PQRS.

#### Program Update

For 2014 the PQRS program has 285 measures that may be submitted through a variety of mechanisms: claims, qualified registry, EHRs and the group reporting web interface (GPRO).

The most recent 2012 PQRS participation report reported:

- Participation increased from 29% of EPs in 2011 to 36% of EPs in 2012.
- PQRS participation is highest among EPs who see the most Medicare patients.
- Emergency physicians (64%) and anesthesiology (57%) had the high participation rates among the specialties using the individual claims reporting mechanism.
- Internal medicine and family practice had the highest numbers of EPs participating via the registry mechanism.
- Family practice, internal medicine, nurse practitioner, and cardiology were also the top four specialties using the EHR reporting mechanism.

The final 2015 Physician Fee Schedule rule includes the following updates:

- Beginning in 2015, a downward payment adjustment of -2 percent will apply to EPs who do not satisfactorily report data on quality measures for covered professional services or satisfactorily participate in a qualified clinical data registry
- Identification of 19 cross-cutting measures that can be used by all EPs – based on the recommendation of a core set from the MAP.
- For the 12-month reporting period (2015) for the 2017 PQRS payment adjustment EPs reporting by claims, EHR or registry would report at least 9 measures, covering at least 3 of the National Quality Strategy domains.
  - For individual EPs reporting via EHR: if the EHR does not contain data for 9 measures,



then report on all measures with Medicare patient data (aligns with Medicare EHR Incentive Program).

- Qualified Clinical Data Registries (QCDRs) must report at least 2 outcome measures or 1 outcome and 1 other (resource use, patient experience with care, efficiency/appropriate use or patient safety) measure; QCDRs may report up to 30 non-PQRS measures; QCDRs must public report measure results beginning in 2015 (except new measures that are not required to report in the first year)
- Group practices of 100 or more EPs that report via PQRS must report CAHPS for PQRS GPRO
- Changes to the total number of PQRS measures:
  - Addition of 20 new individual measures and two measures groups to fill existing measure gaps;
  - Removal of 50 measures for a variety of reasons:
    - » Measure steward will no longer maintain the measure
    - » Performance rates consistently close to 100%, i.e., “topped out”
    - » Measure does not add clinical value to PQRS
    - » Measures a standard of care
    - » Evidence and guideline change
    - » Duplicative measures
  - The measures to be removed include 8 hypertension measures, 3 stroke measures, 4 back pain measures, , 4 inflammatory bowel disease measures, 3 emergency medicine measures

CMS has an ongoing Call for Measures to solicit new measures for possible inclusion in PQRS. Aside from NQF endorsement, submitters are asked to consider the following:

- Measures that are not duplicative of existing or proposed measures.
- Measures that are further along in development than a measure concept.
- CMS is not accepting claims-based-only reporting measures.
- Measures that are outcome-based rather than clinical process measures.
- Measures that address patient safety and adverse events.
- Measures that identify appropriate use of diagnosis and therapeutics.
- Measures that include the NQS domains of care coordination, communication, patient experience and patient-reported outcomes.
- Measures that address efficiency, cost and resource use.

#### MAP's Suggested Critical Program Objectives

- To encourage widespread participation many measures are needed for the variety of EPs specialties and sub-specialties.
- The measures chosen by EPs to submit for PQRS will be reported on Physician Compare and used to determine the Value Based Payment Modifier; therefore all PQRS measures will be used for accountability purposes.
- Include more high value measures, e.g., outcomes, patient-reported outcomes, composites, intermediate outcomes, process measures close to outcomes, cost and resource use measures, appropriate use measures, care coordination measures, patient safety, etc.
- Include NQF-endorsed measures relevant to clinician reporting to encourage engagement Measures selected for the program that are not NQF-endorsed should be submitted for endorsement.
- For measures that are not endorsed, include measures under consideration that are fully specified and that:

- Support alignment (e.g., measures used in other programs, registries)
- Are outcome measures that are not already addressed by outcome measures included in the program
- Are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures

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## Value-Based Payment Modifier and Physician Feedback of Quality Resource and Use Reports (QRURs)

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### Program Type

**Physician Feedback of QRURs** provides comparative performance information via Quality Resource and Use Reports (QRURs) to physicians as one part of Medicare's efforts to improve the quality and efficiency of medical care.

**Value Based Payment Modifier** assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule. High-quality and/or low-cost groups can qualify for upward adjustments. Low-quality and/or high-cost groups and groups that fail to satisfactorily report PQRS are subject to downward adjustments

### Incentive Structure

The Physician Value Based Payment Modifier is being phased in over the three years 2015-2017:

CY 2015: VM will apply to physicians in groups with 100 or more eligible professionals (EPs) based on 2013 performance.

CY 2016: VM will apply to physicians in groups with 10 or more EPs based on 2014 performance.

CY 2017: VM will apply to physician solo practitioners and physicians in groups with 2 or more EPs based on 2015 performance. An estimated 900,000 physicians will be affected.

CY 2018: VM will apply to physicians **and non-physician** EPs who are solo practitioners or are in groups with 2 or more EPs based on 2016 performance

### Program Goals

- The QRURs provide information about performance on the quality and cost measures used to calculate the Value Modifier. They allow eligible professionals to understand and improve the care they provide to Medicare beneficiaries and their performance under the Value Modifier Program.
- The VM is an adjustment made on a per claim basis to Medicare payments for items and services furnished under the Medicare Physician Fee Schedule, based on performance on cost and quality measures during a performance period. The goal of the program is to encourage and reward physicians for furnishing high-quality, efficient, patient-centered clinical care.
- Alignment of federal programs – the VM is aligned with the Physician Quality Reporting System (PQRS) and provides an additional incentive to physicians and groups to report quality measures through PQRS.
- The program also seeks to align measures, and consequently align incentives to improve care, with the Hospital VBP Program in the future, to the extent possible.

### Program Update

- In 2017, the Value Modifier applies to all physician solo practitioners and physicians in groups of all sizes.
- In 2018, the Value Modifier applies to all physician and non-physician eligible professionals.
- Quality tiering is the method by which quality and cost performance that is substantially better than or worse than average is recognized through payment adjustments. Quality tiering is mandatory for all groups and solo practitioners subject to the 2017 Value Modifier but smaller groups of one to nine eligible professionals can only earn upward or neutral (no) payment adjustments under this methodology.

### MAP's Suggested Critical Program Objectives

- NQF-endorsed measures are strongly preferred for pay-for-performance programs; measures that are not NQF-endorsed should be submitted for endorsement or removed.
- Include measures that have been reported in a national program for at least one year (e.g., PQRS) and ideally can be linked with particular cost or resource use measures to capture value.
- Focus on outcomes, composites, process measures that are proximal to outcomes, appropriate care (e.g., overuse), and care coordination measures (measures included in the MAP Families of Measures generally reflect these characteristics).
- Monitor for unintended consequences to vulnerable populations (e.g., through stratification).

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### Physician Compare Initiative

#### Program Type

Physician Compare is the federal website that reports information on physicians and other clinicians. The purpose of the web site is public reporting of information and quality measures that are meaningful to patients.

#### Incentive Structure

There is no incentive specific to public reporting. The information reported on the web site is derived from other programs that have various incentives.

#### Program Goals

- Providing consumers with quality of care information that will help them make informed decisions about their health care.
- Encourage clinicians to improve the quality of care they provide to their patients and create incentives to maximize performance.

#### Program Update

The website was launched on December 30, 2010

providing information about Medicare physicians and other health care professionals including an indication of participation in Physician Quality Reporting System (PQRS). Public reporting of performance measure results is being employed via a phased approach. In February 2014, the first set of measure data were posted on Physician Compare. These data included a sub-set of the 2012 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) Diabetes Mellitus (DM) and Coronary Artery Disease (CAD) measures for the 66 group practices and 141 Accountable Care Organizations (ACOs) that successfully reported via the Web Interface. In late 2014, a similar subset of 2013 group-level measures will be reported. In 2015, the first individual eligible professional-level measures available for public reporting will be a sub-set of twenty 2014 PQRS measures and measures from the Cardiovascular Prevention measures group in support of the Million Hearts campaign.

By statute, the following types of measures are encouraged to be included for public reporting:

- PQRS measures
- Patient health outcomes and functional status of patients
- Continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use
- Efficiency
- Patient experience and patient, caregiver, and family engagement
- Safety, effectiveness, and timeliness of care

The final 2015 Physician Fee Schedule rule notes that beginning in 2015 all PQRS measures and all QCDR measures will be available for public reporting. Measures that are new to PQRS or a QCDR will not be publicly reported in the first year. All valid and reliable measures will be available in a downloadable file. Only those measures that are accurately understood and interpreted by consumers will be available on Physician Compare

profile pages. Measures from QCDRs will be held to the same qualifications as PQRS measures, i.e., a minimum sample size of 20 and successful testing for reliability and validity.

For data collected in 2015, for publication on Physician Compare in 2016:

- PQRS, PQRS GPRO, EHR and Million Hearts: include an indicator of satisfactory participation
- PQRS GPRO and ACO GPRO: all PQRS GPRO measures for groups of 2 or more; all measures reported by ACOs with minimum sample size of 20.
- CAHPS for PQRS for all groups of 2 or more and CAHPS for ACOs for all measures that meet sample size
- PQRS: All PQRS measures for individual EPs collected through registry, EHR or claims.
- QCRD data: All individual EP-level 2015 QCDR data.

CMS has indicated an interest in MAP identifying those PQRS measure that are most meaningful to consumers.

### MAP's Suggested Critical Program Objectives

- Focus on outcome measures and measures that are meaningful to consumers (i.e., have face validity) and purchasers.
- Focus on patient experience, patient-reported outcomes (e.g., functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care measures.
- Public reporting of PQRS measures for:
  - Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
  - Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse

midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists

- Therapists—physical therapist, occupational therapist, qualified speech-language therapist
- Reporting of physicians in groups and ACOs is included.
- NQF-endorsed measures are preferred for public reporting programs over measures that are not endorsed or are in reserve status (i.e., topped out); measures that are not NQF-endorsed should be submitted for endorsement or removed.
- To generate a comprehensive picture of quality, measure results should be aggregated (e.g., composite measures), with drill-down capability for specific measure results.
- Alignment of measures in federal programs.

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## Medicare and Medicaid EHR Incentive Programs for Eligible Professionals

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### Program Type

The Medicare and Medicaid Electronic Health Care Record (EHR) Incentive Programs provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

### Incentive Structure

The incentive structure varies by program:

- Medicare: Up to \$44,000 over 5 continuous years. The last year to begin the program is 2014. Penalties take effect in 2015 and in each year hereafter where EPs are eligible but do not participate.
- Medicaid: Up to \$63,750 over 6 years. The last year to begin the program is in 2016. Payment adjustments do not apply to Medicaid.

### Program Goals

- Promote widespread adoption of certified EHR technology by providers.
- Incentivize “meaningful use” of EHRs by providers to:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and family
  - Improve care coordination, and population and public health
  - Maintain privacy and security of patient health information

### Program Update

- The three main components of Meaningful Use:
  - The use of a certified EHR in a meaningful manner, such as e-prescribing;
  - The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and
  - The use of certified EHR technology to submit clinical quality and other measures.
- Meaningful Use Stage 2:
  - The earliest providers will demonstrate Stage 2 of meaningful use is 2014.
  - For Stage 2 (2014 and beyond): Eligible Professionals must report on 9 total clinical quality measures that cover 3 of the National Quality Strategy Domains (selected from a set of 64 clinical quality measures).
  - CMS is not requiring the submission of a core set of electronic CQMs (eCQMs). Instead, CMS has identified two recommended core sets of eCQMs—one for adults and one for children—that focus on high-priority health conditions and best-practices for care delivery.

- The program has several options that align with other programs:
  - Report individual eligible professionals’ eCQMs through PQRS Portal
  - Report group’s eCQMs through PQRS Portal
  - Report group’s eCQMs through Pioneer ACO participation or Comprehensive Primary Care Initiative participation.
- Measures under consideration for the current pre-rulemaking cycle are for Meaningful Use Stage 3. CMS has determined that the measures under consideration (MUC) for the EHR Incentive Programs are appropriately specified as “electronic Clinical Quality Measures (eCQMs)” or “eMeasures”. While some testing may have been done, the eMeasures under consideration are being revised to meeting the most recent standards and have not been used in the field. CMS agrees the eCQMs on the MUC list are “Measures Under Development”.

### MAP’s Suggested Critical Program Objectives

- Include endorsed measures that have eMeasure specifications available.
- Over time, as health IT becomes more effective and interoperable, focus on:
  - Measures that reflect efficiency in data collection and reporting through the use of health IT
  - Measures that leverage health IT capabilities (e.g., measures that require data from multiple settings/providers, patient-reported data, or connectivity across platforms to be fully operational)
  - Innovative measures made possible by the use of health IT
- Alignment with other federal programs, particularly PQRS.

## MAP Hospital Federal Program Summaries

### Ambulatory Surgical Centers Quality Reporting Program

#### Program Type

Pay for Reporting – Performance information is currently reported to the Centers for Medicare & Medicaid Services (CMS) but it is expected to be publicly available in the future.

#### Incentive Structure

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

#### Program Goals

- Promote higher quality, more efficient care for Medicare beneficiaries.
- Establish a system for collecting and providing quality data to ASCs.
- Provide consumers with quality of care information that will help them make informed decisions about their health care.

#### Program Update

- For fiscal year (FY) 2017, CMS proposed the following measure: OP-32 Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy
- CMS proposed criteria for determining when a measure is “topped-out”. Two criteria were proposed: 1) statistically indistinguishable performance at the 75th and 90th percentiles, and 2) a truncated coefficient of variation less than or equal to 0.10.

#### MAP’s Suggested Critical Program Objectives

- Include measures that have high impact and are meaningful to patients.
- Align measures with CMS’ various quality reporting programs, particularly the Hospital

Outpatient Quality Reporting program, to facilitate comparisons across care settings, and to reduce burden for facilities that participate in these programs.

- Priority measure gap areas for the ASCQR program include surgical care quality, infection rates, follow-up after procedures, complications including anesthesia related complications, cost, and patient and family engagement measures including an ASC-specific CAHPS module and patient-reported outcome measures.

### Hospital-Acquired Condition (HAC) Reduction Program

#### Program Type

Pay-for-Performance and Public Reporting. HAC scores will be reported on the Hospital Compare website beginning December 2014.

#### Incentive Structure

- The 25% 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%.
- The measures in the program are classified into two domains: Domain 1 includes the Patient Safety Indicator (PSI) 90 measure, a composite of eight administrative claims based measures and Domain 2 includes infection measures developed by the Centers for Disease Control and Prevention’s (CDC) National Health Safety Network (CDC NHSN). Each domain will be weighted to determine the total score.
- In the FY 2014 IPPS/LTCH PPS rule, measures for FY 2015, FY 2016 and FY 2017 HAC Reduction Program were finalized.
  - FY 2015: PSI 90 (domain 1) and CDC NHSN’s Central-line Association Bloodstream Infection (CLABSI and CAUTI measures (domain 2).
  - FY 2016: CDC NHSN surgical site infection

measure (infections following abdominal hysterectomy and colon procedures) will be added to domain 2

- FY 2017: CDC NHSN MRSA and C. difficile measures will be added to domain 2.
- The weight that each domain contributes to the total HAC score has been finalized for FY 2015 and FY 2016.
  - FY 2015: Domain 1 is 35% and Domain 2 is 65% of the Total HAC Score.
  - FY 2016: Domain 1 will be 25% and Domain 2 will be 75% of the Total HAC score.

### Program Goals

- Heighten awareness of HACs and eliminate the incidence of HACs that could be reasonably prevented by applying evidence-based clinical guidelines.
- Provide motivation to reduce the incidence of HACs, improve patient outcomes, and reduce the cost of care.
- Support a broader public health imperative by helping to raise awareness and action by prompting a national discussion on this important quality problem.
- 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.

### Program Update

- No new measures were added in the FY 2015 IPPS/LTCH PPS rule to allow hospitals time to gain experience with the measures that were finalized in the FY 2014 IPPS/LTCH PPS rule.
- PSI-90 is currently undergoing review by NQF. AHRQ is considering the addition of three additional measures for the composite, PSI #9 Perioperative Hemorrhage or Hematoma Rate, PSI #10 Postoperative Physiologic and Metabolic Derangement Rate, and PSI #11 Postoperative Respiratory Failure Rate. CMS

believes this change to be significant and will propose the change in the rulemaking process prior to requiring reporting of the revised measure.

- The CDC NHSN CLABSI and CAUTI measures also recently underwent NQF review. These measures were recommended for continued endorsement.

### MAP's Suggested Critical Program Objectives

- Focus on reducing the major drivers of patient harm.
- Overlap in measures between the HAC Reduction Program and the Hospital Value-Based Purchasing Program can help to focus attention on critical safety issues.
- In its 2013-14 round of pre-rulemaking, MAP noted a number of gaps for this program: PSI-5 to address foreign bodies retained after surgery, and development of measures to address wrong site/wrong side surgery and sepsis beyond post-operative infections.

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## Hospital Value-Based Purchasing Program

### Program Type

Pay for Performance

### Incentive Structure

Medicare bases a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing Program (VBP). Medicare withholds its regular hospital reimbursements from all hospitals paid under its inpatient prospective payment system (IPPS) to fund a pool of VBP incentive payments. The amount withheld from reimbursements increases over time:

- FY 2015: 1.5%
- FY 2016: 1.75%
- FY 2017 and future fiscal years: 2%

Hospitals are scored based on their performance on each measure within the program relative

to other hospitals as well as on how their performance on each measure has improved over time. The higher of these scores on each measure is used in determining incentive payments.

Measures selected for the VBP program must be included in IQR and reported on the Hospital Compare website for at least 1 year prior to use in the VBP program.

### Program Goals

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

### Program Update

- For the FY 2017 Measure Set:
  - Six measures were removed from the FY 2017 program measure set because they were topped out.
  - Three additional measures were added to the program measure set: NQF#0469 PC-01 Elective Delivery Prior to 39 Weeks Gestation, NQF #1716 Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia, and NQF #1717 Clostridium difficile (C. difficile) Infection
- For the FY 2019 Measure Set:
  - NQF #1550 Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) was added to the program measure set.

### MAP's Suggested Critical Program Objectives

- Include measures where there is a need and opportunity for improvement.
- Emphasize areas of critical importance for high performance and quality improvement, and ideally, link clinical quality and cost measures to capture value.
- NQF-endorsed measures are strongly preferred.

- Keep the program measure set parsimonious to avoid diluting the payment incentives.
- MAP identified a number of gap areas that should be addressed within the VBP program measure set, including medication errors, mental and behavioral health, emergency department throughput, a hospital's culture of safety, and patient and family engagement.

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## Hospital Readmission Reduction Program

### Program Type

Pay for Performance and Public Reporting – Payments are based on information publicly reported on the Hospital Compare website.

### Incentive Structure

Diagnosis-related group (DRG) payment rates will be reduced based on a hospital's ratio of actual to expected readmissions. The maximum payment reduction is 2 percent, and will increase to 3% beginning October 2014.

### Program Goals

- Reduce readmissions in acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), which is approximately 4000 hospitals in the U.S.
- Provide consumers with quality of care information that will help them make informed decisions about their health care. Hospitals' readmissions information, including their risk-adjusted readmission rates, is available on the Hospital Compare website.

### Program Update

- The Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary Artery Bypass Graft (CABG) Surgery was added to the program measure set for implementation in FY 2017.
- The planned readmission algorithm for the acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, and total hip arthroplasty/ total knee



arthroplasty measures was updated.

### MAP's Suggested Critical Program Objectives

- Reduce the number of admissions to an acute care hospital following discharge from the same or another acute care hospital.
- Engage patients and their families as partners in care.
- Improve patient care and reduce overall healthcare costs.
- Exclude planned readmissions from the measures in the program.
- Encourage hospitals to take a leadership role in improving care beyond their walls through care coordination across providers since the causes of readmissions are complex and multifactorial.
- Improve care transitions by decreasing readmission rates through optimizing processes under the hospital's control. For example, improving communication of important inpatient information to those who will be taking care of the patient post-discharge.
- Acknowledge that factors affecting readmissions are complex, and may include environmental, community-level, and patient-level factors, including socio-demographic factors.
- Recognize that multiple entities across the health care system, including hospitals, post-acute care facilities, skilled nursing facilities, and others, all have a responsibility to ensure high quality care transitions to reduce unplanned readmissions to acute care hospitals.

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## Inpatient Psychiatric Facilities Quality Reporting Program

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### Program Type

Pay for Reporting – Information will be reported on the Hospital Compare website.

### Incentive Structure

- Inpatient psychiatric hospitals or psychiatric units that do not report data on the required measures will receive a 2 percent reduction in their annual federal payment update.
- The IPFQR Program applies to freestanding psychiatric hospitals, government-operated psychiatric hospitals, and distinct psychiatric units of acute care hospitals and critical access hospitals. This program does not apply to children's hospitals, which are paid under a different system.

### Program Goals

- Provide consumers with quality information to help inform their decisions about their healthcare options.
- Improve the quality of inpatient psychiatric care by ensuring providers are aware of and reporting on best practices.
- Establish a system for collecting and providing quality data for inpatient psychiatric hospitals or psychiatric units.

### Program Update

- For FY 2016:
  - Two structural measures regarding routine assessment of patient experience of care and use of an electronic health records were added to the program measure set for FY 2016.
- For FY 2017:
  - NQF #1654 Tobacco Use Treatment Provided or Offered (TOB-2) and Tobacco Use Treatment (TOB-2a) was added to the program measure set for FY 2017.
  - Two influenza measures, NQF #0431 (Influenza Vaccination Coverage Among Healthcare Personnel and #1659 (Influenza Immunization) were added to the program measure set.

### MAP's Suggested Critical Program Objectives

- Ensure measures in the program are meaningful to patients.
- Improve person-centered psychiatric care, such as assessing patient and family/caregiver experience and engagement and establishing relationships with community resources, are priority measure gap areas.
- Measure gaps in the IPFQR program include step down care, behavioral health assessments and care in the ED, readmissions, identification and management of general medical conditions, partial hospitalization or day programs, and a psychiatric care module for CAHPS.

### Inpatient Quality Reporting Program (IQR)

#### Program Type

Pay-for-Reporting and Public Reporting. A subset of the measures in the program are publicly reported on the Hospital Compare web site.

#### Incentive Structure

Hospitals that do not report data on the required measures will receive a 2 percent reduction in their annual Medicare payment update.

#### Program Goals

- Provide an incentive for hospitals to publicly report quality information about their services
- Provide consumers information about hospital quality so they can make informed choices about their care.

#### Program Update

- For FY 2017, CMS has finalized a total of 63 measures for the program measure set.
  - 11 new measures were added for FY 2017.
    - » These measures address coronary artery bypass graft (CABG) surgery readmissions and mortality, pneumonia and heart failure episode of care payments, severe sepsis and septic shock management, newborn screening for hearing, exclusive breast

feeding, child asthma home management plan of care, and healthy term newborns.

- » Two measures were readopted as voluntary electronic clinical quality measures to support alignment with the Medicare EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals. These measures are NQF #0142 AMI-2 Aspirin Prescribed at Discharge and NQF #0639 AMI-10 Statin Prescribed at Discharge.

- 19 measures were removed for FY 2017. These measures were removed because they were topped out. However, to continue aligning the IQR and Medicare EHR Incentive Program, 10 measures will be retained on a voluntary basis to allow hospitals an opportunity to test the accuracy of the electronic health record reporting systems.

### MAP's Suggested Critical Program Objectives

- Choose high impact measures that will improve both quality and efficiency of care and are meaningful to consumers.
- Move towards more outcome measures rather than structure or process measures.
- Align reporting requirements with other clinical programs where appropriate to reduce the burden on providers and support efficient use of measurement resources.
- Engage patients and families as partners in their care.
- Expand the program to include measures that allow rural and other small hospitals to participate.
- In the 2013-14 pre-rulemaking process, MAP recommended the rapid filling of the following fairly extensive gap list for this program: pediatrics, maternal/child health, cancer, behavioral health, affordability/cost, care transitions, patient education, palliative and end of life care, medication reconciliation, a

culture of safety, pressure ulcer prevention, and adverse drug events. MAP suggested that HHS could look to existing measures in the PPS-Exempt Cancer Hospital Quality Reporting Program, the Inpatient Psychiatric Facility Quality Reporting Program, and Hospice Quality Reporting Programs to begin to fill these gaps.

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## Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)

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### Program Type

Pay for Reporting. The Medicare and Medicaid EHR Incentive Programs provide incentives to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

### Incentive Structure

For the Medicare Incentive Program (hospitals), incentive payments began in 2011 and are comprised of an Initial Amount, Medicare Share, and Transition Factor. The CAH EHR Incentive payment is based on a formula for Allowable Costs and the Medicare Share. The Medicaid Incentive program includes an Overall EHR Amount and Medicaid Share. Medicare payment penalties will take effect in 2015 for providers who are eligible but do not participate. Payment penalties do not apply to Medicaid.

For Stage 1, eligible facilities must report on all 15 total clinical quality measures. For Stage 2 (2014 and beyond) eligible facilities must report on 16 clinical quality measures that cover 3 of the National Quality Strategy domains. Measures are selected from a set of 29 clinical quality measures that includes the 15 measures from Stage 1.

### Program Goals

- Promote widespread adoption of certified EHR technology by providers.
- Incentivize “meaningful use” of EHRs by hospitals to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

### Program Update

- The three main components of Meaningful Use:
  - The use of a certified EHR in a meaningful manner, such as e-prescribing;
  - The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and
  - The use of certified EHR technology to submit clinical quality and other measures.
- For Stage 1 (2014):
  - Removal of clinical quality measures (CQMs) as a separate core objective for Stage 1 for eligible professionals, eligible hospitals, and CAHs. Reporting CQMs will still be required in order to achieve meaningful use.
  - For Stage 2 (2014):
    - The earliest Hospitals and Critical Access Hospitals will demonstrate Stage 2 of meaningful use is October 2014.
- For Stage 2 (2014 and beyond):
  - Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 19 core objectives.
  - New Core Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)

### MAP’s Suggested Critical Program Objectives

- Preference should be given to NQF-endorsed quality measures.

- Select measures that represent the future of measurement (facilitating information exchange between institutions and longitudinal tracking of care, such as measures that monitor incremental changes in a patient's condition over time).
- Align the measure set with other hospital performance measurement programs.
- Ensure e-measures in the program are reliable and provide comparable results to paper-based measures.

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## Hospital Outpatient Quality Reporting Program

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### Program Type

Pay for Reporting – Information on measures is reported on the Hospital Compare website.

### Incentive Structure

Hospitals that do not report data on the required measures will receive a 2 percent reduction in their annual Medicare payment update.

### Program Goals

- Establish a system for collecting and providing quality data to hospitals providing outpatient services such as clinic visits, emergency department visits, and critical care services.
- Provide consumers with quality of care information that will help them make informed decisions about their health care.

### Program Update

- For FY 2017, CMS proposed the following measure: OP-32 Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy
- CMS proposed criteria for determining when a measure is "topped-out". Two criteria were proposed: 1) statistically indistinguishable performance at the 75th and 90th percentiles and 2) a truncated coefficient of variation less than or equal to 0.10.

- CMS proposed removal of the following measures:
  - OP-4 Aspirin on arrival
  - OP-6 Timing to Prophylactic Antibiotics
  - OP-7 Prophylactic Antibiotic Selection for Surgical Patients

## MAP's Suggested Critical Program Objectives

- Focus on measures that have high impact and support national priorities
- Align the OQR measures with ambulatory care measures
- Specific gap areas for the OQR program measure set include measures of emergency department (ED) overcrowding, wait times, and disparities in care—specifically, disproportionate use of EDs by vulnerable populations. Other gaps include measures of cost, patient-reported outcomes, patient and family engagement, follow-up after procedures, fostering important ties to community resources to enhance care coordination efforts, and an outpatient CAHPS module.

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

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### Program Type

Reporting: Information will be publicly reported beginning in 2014.

### Incentive Structure

There is currently no financial incentive for the 11 hospitals in this program to report quality measures. CMS plans to create an incentive structure in the future.

### 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

### Program Update

- NQF #1822 External Beam Radiotherapy for Bone Metastases was added to the program beginning in October 2017. MAP supported this measure for the PCHQR program, noting that it helps to fill a gap in palliative care.
- CMS noted that future measure topics may include patient-centered care planning and care coordination, shared decision making, measures of quality of life outcomes, and measures of admissions for complications of cancer and treatment for cancer.
- CMS will make the results of NQF #220 Adjuvant Hormonal Therapy publicly available in 2015. The results of NQF #138 NHSN Catheter-Associated Urinary Tract Infections (CAUTI) Outcome Measure and NQF #139 NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome measure will be made available by 2017.

### MAP's Suggested Critical Program Objectives

- Include measures appropriate to cancer hospitals that reflect the highest priority services provided by these hospitals.
- Align measures with the Inpatient Quality Reporting Program and Outpatient Quality Reporting Program where appropriate and relevant.
- The measures should address gaps in cancer care quality. MAP has previously identified pain screening and management, patient and family/caregiver experience, patient-reported symptoms and outcomes, survival, shared decision making, cost, care coordination and psychosocial/supportive services as gap areas for this program

## MAP Post-Acute Care/Long-Term Care Federal Program Summaries

### Nursing Home Quality Initiative

#### Program Type

Public Reporting

#### Incentive Structure

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. Part of this requirement includes completing the Minimum Data Set (MDS), a clinical assessment of all residents in Medicare- or Medicaid-certified nursing facilities. Quality measures are reported on the Nursing Home Compare website using a Five-Star Quality Rating System, which assigns each nursing home a rating of 1 to 5 stars, with 5 representing highest standard of quality, and 1 representing the lowest.<sup>1</sup>

#### Program Goals

The overall goal of NHQI is to improve the quality of care in nursing homes using CMS' informational tools. The objective of these informational tools is to share quality information with consumers, health care providers, intermediaries and other key stakeholders to help them make informed decisions about nursing home care (e.g., Nursing Home Compare, Nursing Home Checklist).<sup>2</sup>

#### Program Update

None

### MAP's Suggested Critical Program Objectives

#### Statutory Requirements

- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs<sup>3</sup>:
  - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures

- Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
- Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
- Applicable PAC programs are defined as: 1) HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
- Establishes a new “SNF Quality Reporting Program” at the start of FY 2019 and directs the Secretary to reduce by 2% the update to the market basket percentage for skilled nursing facilities which do not report assessment and quality data under this program.
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
  - » New quality measures will address, at a minimum, the following domains:
    - functional status and changes in function;
    - skin integrity and changes in skin integrity;
    - medication reconciliation;
    - incidence of major falls; and
    - accurately communicating health information and care preferences when a patient is transferred
  - » Resource use measures will address the following:
    - efficiency measures to include total Medicare spending per beneficiary;
    - discharge to community; and
    - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.
- The Protecting Access to Medicare Act of 2014 (PAMA)<sup>4</sup>:
  - Directs the Secretary to establish a skilled nursing facility value-based purchasing (SNF VBP) program under which value-based incentive payments are made in a fiscal year to skilled nursing facilities, beginning in fiscal year 2019.
    1. Readmission measure - Not later than October 1, 2015, the Secretary shall specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such a measure).
    2. Resource use measure - Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities.
  - Directs the Secretary to: (1) provide confidential feedback reports to SNFs on their performance with respect to a measure specified for this program [under paragraph (1) or (2)], beginning October 1, 2016 and every quarter thereafter; and (2) establish procedures for making available to the public by posting on the Nursing Home

Compare Medicare website (or a successor website) information on the performance of SNF with respect to a measure specified under paragraph (1) and a measure specified under paragraph (2) beginning not later than October 1, 2017.

#### *MAP Previous Recommendation*

- Determine whether (1) there are opportunities to combine the long-stay and short-stay measures using risk adjustment and/or stratification to account for patient variations and (2) any of the measures could be applied to other PAC/LTC programs to align measures across settings.<sup>5</sup>
- Add measures that assess discharge to the community and the quality of transition planning.<sup>6</sup>
- Include Nursing Home-CAHPS measures in the program to address patient experience.<sup>7</sup>

## **Home Health Quality Reporting Program**

### **Program Type**

Pay for Reporting, Public Reporting

### **Incentive Structure**

Medicare-certified<sup>8</sup> home health agencies (HHAs) are required to collect and submit the Outcome and Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.<sup>9</sup> Home health agencies meet their quality data reporting requirements through the submission of OASIS assessments and Home Health CAHPS. HHAs that do not submit data will receive a 2 percentage point reduction in their annual HH market basket percentage increase.<sup>10</sup> Subsets of the quality measures generated from OASIS are reported on the Home Health Compare website, which provides information about the quality of care provided by HHAs throughout the country.<sup>11</sup>

### **Program Goals**

As home health quality goals, CMS has adopted the mission of The Institute of Medicine (IOM) which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness.<sup>12</sup>

### **Program Update**

- Updates listed in the CY 2015 Home Health Final Rule:<sup>13</sup>
  - Specified the adoption of two claims based measures in the CY 2014 HH PPS final rule and the beginning date of CY 2014 for reporting. These claims based measures supported by MAP in the past pre-rulemaking cycle are: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH. These measures will be added to HH Compare for public reporting in CY 2015.
  - Set a date of October 2014 for removal of the 9 episode stratified process measures in the CASPER reports. In addition, five short stay measures which had previously been reported on HH Compare were recently removed from public reporting and replaced with non-stratified “all episodes of care” versions of these measures.
  - Finalized a new pay-for-reporting performance requirement for OASIS reporting. For episodes beginning on or after July 1st, 2015 and before June 30th, 2016, HHAs must score at least 70 percent on the Quality Assessments Only (QAO) metric of pay-for-reporting performance requirement or be subject to a 2 percentage point reduction to their market basket update for CY 2017.
  - Will continue to require HHCAHPS

## MAP's Suggested Critical Program Objectives

### *Statutory Requirements*

- Home health is a covered service under the Part A Medicare benefit. It consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician.<sup>14</sup>
- Two categories of quality measures used in HH QRP are outcome measures and process measures. There are three types of outcome measures used including: <sup>15</sup>
  - Improvement measures (i.e., measures describing a patient's ability to get around, perform activities of daily living, and general health);
  - Measures of potentially avoidable events (i.e., markers for potential problems in care); and
  - Utilization of care measures (i.e., measures describing how often patients access other health care resources either while home health care is in progress or after home health care is completed).
- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs<sup>16</sup>:
  - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
  - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
  - Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
- Applicable PAC programs are defined as: 1) HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
  - » New quality measures will address, at a minimum, the following domains:
    - functional status and changes in function;
    - skin integrity and changes in skin integrity;
    - medication reconciliation;
    - incidence of major falls; and
    - accurately communicating health information and care preferences when a patient is transferred
  - » Resource use measures will address the following:
    - efficiency measures to include total Medicare spending per beneficiary;
    - discharge to community; and
    - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.



*MAP Previous Recommendation*

- MAP noted that the large measure set reflects the heterogeneity of home health population; however, the measure set could be more parsimonious.<sup>17</sup>

*Future Direction of the Program*

- CMS will conduct a thorough analysis of the measure set to identify priority gap areas, measures that are topped out, and opportunities to improve the existing measures.

## Inpatient Rehabilitation Facilities Quality Reporting Program

**Program Type**

Pay for Reporting, Public Reporting

**Incentive Structure**

For fiscal year of 2014, and each year thereafter, Inpatient Rehabilitation Facility providers (IRFs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive annual payment updates. Failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year.<sup>18</sup> The data must be made publicly available, with IRF providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.<sup>19</sup>

**Program Goals**

Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.<sup>20</sup>

**Program Update**

- IRF Prospective Payment System for Federal Fiscal Year 2015 final rule:<sup>21</sup>
  - For the FY 2017 adjustments to the IRF PPS annual increase factor, in addition to retaining the previously finalized measures, CMS adopted two new quality measures:

- » Measure NQF#1717 NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (supported by MAP in the 2014 pre-rulemaking report)
- » Measure NQF #1716 NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (conditionally supported by MAP in the 2014 pre-rulemaking report)

**MAP's Suggested Critical Program Objectives***Statutory Requirements*

- Measures should align with the National Quality Strategy (NQS), be relevant to the priorities of IRFs (such as patient safety, reducing adverse events, better coordination of care, and person- and family-centered care.<sup>22</sup>
- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a. "IMPACT ACT of 2014" provisions for PAC programs<sup>23</sup>:
  - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
  - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
  - Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
  - Applicable PAC programs are defined as: 1) HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program;

- 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
    - » New quality measures will address, at a minimum, the following domains:
      - functional status and changes in function;
      - skin integrity and changes in skin integrity;
      - medication reconciliation;
      - incidence of major falls; and
      - accurately communicating health information and care preferences when a patient is transferred
    - » Resource use measures will address the following:
      - efficiency measures to include total Medicare spending per beneficiary;
      - discharge to community; and
      - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
  - Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

*MAP Previous Recommendation*

- Program measure set is too limited and could be enhanced by addressing core measure concepts not currently addressed in the set such as care coordination, functional status, and medication reconciliation and the safety

issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and C. difficile.<sup>24</sup>

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## Long-Term Care Hospitals Quality Reporting Program

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### Program Type

Pay for Reporting, Public Reporting

### Incentive Structure

For fiscal year 2014, and each year thereafter, Long-Term Care Hospital providers (LTCHs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive full annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual payment update.<sup>25</sup> The data must be made publicly available, with LTCH providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.<sup>26</sup>

### Program Goals

Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).<sup>27</sup>

### Program Update

- Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System FY 2015 Final Rule: <sup>28</sup>
  - For the FY 2018 payment determination and subsequent years, in addition to retaining the previously finalized measures, CMS adopted three new quality measures:
    - » Percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function (conditionally supported by MAP in the 2014 pre-rulemaking report )
    - » Functional Outcome Measure: change in mobility among patients requiring ventilator support (conditionally

supported by MAP in the 2014 pre-rulemaking report)

- » Ventilator-Associated Event (supported by MAP in the 2014 pre-rulemaking report)

### MAP's Suggested Critical Program Objectives

#### *Statutory Requirements*

- Measures should align with the National Quality Strategy (NQS), promote enhanced quality with regard to the priorities most relevant to LTCHs (such as patient safety, better coordination of care, and person- and family-centered care).<sup>29</sup>
- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a. "IMPACT ACT of 2014" provisions for PAC programs<sup>30</sup>:
  - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
  - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
  - Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
  - Applicable PAC programs are defined as: 1) HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
  - Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.

» New quality measures will address, at a minimum, the following domains:

- functional status and changes in function;
  - skin integrity and changes in skin integrity;
  - medication reconciliation;
  - incidence of major falls; and
  - accurately communicating health information and care preferences when a patient is transferred
- » Resource use measures will address the following:
- efficiency measures to include total Medicare spending per beneficiary;
  - discharge to community; and
  - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

#### *MAP Previous Recommendation*

- Functional status assessment should cover a broad range of mobility issues, such as position changes, locomotion, poor mobility, picking up objects, and chair-to-bed transfers.<sup>31</sup>
- Increased attention should be given to pain, agitation, and delirium among the ventilated population, as these factors are the biggest impediments to mobility.<sup>32</sup>
- Add measures to address cost, cognitive status assessment (e.g., dementia identification),

medication management (e.g., use of antipsychotic medications), and advance directives.<sup>33</sup>

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## End Stage Renal Disease Quality Incentive Program

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### Program Type

Pay for Performance, Public Reporting

### Incentive Structure

Under this program, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions are on a sliding scale, which could amount to a maximum of two percent per year.<sup>34</sup> Facility performance in the End Stage Renal Disease Quality Incentive Program (ESRD QIP) is publicly reported through three mechanisms: Performance Score Certificate, the Dialysis Facility Compare website, and ESRD QIP Dialysis Facility Performance Information.<sup>35</sup>

### Program Goals

Improve the quality of dialysis care and produce better outcomes for beneficiaries.<sup>36</sup>

### Program Update

- Final rule for End-Stage Renal Disease (ESRD) prospective payment system (PPS) for calendar year (CY) 2015:<sup>37</sup>
  - Final measure set for the PY 2017 ESRD QIP
    - » Continue using measures finalized for the PY 2016 program measure set except one measure: the Hemoglobin Greater than 12 g/dl, which CMS has finalized to remove because it is topped out.
    - » Adopt the Standardized Readmission Ratio (SRR) clinical measure, which is currently under review by NQF (NQF#2496) and addresses care coordination. MAP had supported the direction of the measure concept in the 2013 pre-rulemaking.

- Final measure set for the PY 2018 ESRD QIP
  - » Continue using measures finalized for the PY 2017 program measure set with the exception of the ICH CAHPS reporting measure, which will be converted to a clinical measure, O258 In-center hemodialysis CAHPS Survey.
  - » Adopt three new measures which are based on NQF-Endorsed measures that MAP supported in 2014 (NQF #0420, NQF #0418, NQF #0431). CMS is finalizing to adopt the following measures as a reporting measure until such time that they can collect the baseline data needed to score it as a clinical measure:
    - Pain Assessment and Follow-Up, a reporting measure.
    - Depression Screening and Follow-Up, a reporting measure
    - NHSN Healthcare Personnel Influenza Vaccination, a reporting measure
  - » Adopt two additional new measures including: *Percentage of pediatric peritoneal dialysis patient-months with spKt/V greater than or equal to 1.8*, which was conditionally supported by MAP in 2014, and *Standard Transfusion Ratio* which MAP had supported the direction of in the 2013 pre-rulemaking.
- Dialysis Facility Compare Star Ratings<sup>38</sup>
  - CMS has finalized the methodology for its Dialysis Facility Compare (DFC) Star Rating Program and is providing all Medicare-participating dialysis facilities a 15 day review period to review their data and star rating before they are posted on Dialysis Facility Compare in January 2015.
  - The DFC Star Rating is based on the following nine measures, which will be grouped into three domains for evaluation purposes:

- » Standardized Mortality Ratio (SMR) (NQF #0369)
  - » Standardized Hospitalization Ratio (SHR) (NQF#1463)
  - » Standardized Transfusion Ratio (STrR)
  - » Percentage of adult hemodialysis (HD) patients who had enough wastes removed from their blood during dialysis (NQF #0249)
  - » Percentage of pediatric hemodialysis (HD) patients who had enough wastes removed from their blood during dialysis (NQF #1423)
  - » Percentage of adult peritoneal dialysis (PD) patients who had enough wastes removed from their blood during dialysis (NQF #0318)
  - » Percentage of adult dialysis patients who had hypercalcemia (NQF #1454)
  - » Percentage of adult dialysis patients who received treatment through arteriovenous fistula (NQF #0257)
  - » Percentage of adult patients who had a catheter left in vein longer than 90 days for their regular hemodialysis treatment (NQF #0256)
- CMS will stop publicly reporting two quality measures from the DFC website, the URR dialysis adequacy measure and the Hemoglobin greater than 12 g/dl. These measures no longer provide meaningful information because they are topped out.

### MAP'S Suggested Critical Program Objectives Statutory Requirements

- Program measure set should include measures of anemia management that reflect labeling approved by the Food and Drug Administration (FDA), dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access.<sup>39</sup>

### MAP Previous Recommendation

- Measure set expand beyond dialysis procedures to include nonclinical aspects of care such as care coordination, medication reconciliation, functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression.<sup>40</sup>
- Explore whether the clinically focused measures could be combined in a composite measure for assessing optimal dialysis care.<sup>41</sup>

### Future direction of the Program

- Outcome measures are preferred
- Inclusion of pediatric measures to assess the pediatric population that has been largely excluded from the existing measures
- Identify appropriate data elements and sources to support measures

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## Hospice Quality Reporting Program

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### Program Type

Pay for Reporting, Public Reporting

### Incentive Structure

Failure to submit required quality data, beginning in FY 2014 and for each year thereafter, shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.<sup>42</sup> The data must be made publicly available, with Hospice Programs having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of hospice quality data.<sup>43</sup>

### Program Goals

Hospice care uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through the use of a broad spectrum of professional and other caregivers and volunteers. The goal of hospice care is to make the hospice patient as physically and emotionally comfortable as possible, with minimal disruption to normal activities, while remaining primarily in the home environment.<sup>44</sup>

### Program Update

- FY 2015 Hospice Final Rule:<sup>45</sup>
  - CMS finalized the Hospice Item Set (HIS) in last year's rule to meet the quality reporting requirements for hospices for the FY 2016 payment determination (data submission takes effect on or after July 1, 2014) and each subsequent year. HIS to be used by all hospices to collect and submit standardized data items about each patient admitted to hospice.
  - The CAHPS Hospice Survey has a Jan 1, 2015 implementation date. (Participation requirements for the survey begin January 1, 2015 for the FY 2017 annual payment update.)

### MAP's Suggested Critical Program Objectives

#### *Statutory Requirements*

- As of July 1, 2014, all Medicare-certified hospices are required to submit an HIS-Admission record and HIS-Discharge record for each patient admission to their hospice.<sup>46</sup>
  - The HIS is a patient-level data collection tool developed as part of the HQRP, which can be used to collect data to calculate 6

#### National Quality Forum-endorsed (NQF) Measures and 1 modified NQF Measure:<sup>47</sup>

1. NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
2. NQF #1634 Pain Screening
3. NQF #1637 Pain Assessment
4. NQF #1638 Dyspnea Treatment
5. NQF #1639 Dyspnea Screening
6. NQF #1641 Treatment Preferences
7. Modified NQF #1647 Beliefs/Values Addressed (if desired by the patient)

#### *MAP Previous Recommendation*

- Include measures addressing concepts such as goal attainment, patient engagement, care coordination, depression, caregiver's role, and timely referral to hospice.<sup>48</sup>

#### *Future Direction of the Program*

- Develop an outcome measure addressing pain.
- Select measures that address care coordination, communication, timeliness/responsiveness of care, and access to the healthcare team on a 24-hour basis.

## ENDNOTES

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- 1 For more information, see [https://www.cms.gov/CertificationandCompliance/13\\_FSQRS.asp#TopOfPage](https://www.cms.gov/CertificationandCompliance/13_FSQRS.asp#TopOfPage). Last accessed January 2015.
- 2 For more information, see [http://hpm.org/en/Surveys/CMWF\\_New\\_York\\_-\\_USA/02/Nursing\\_Home\\_Quality\\_Initiatives.html](http://hpm.org/en/Surveys/CMWF_New_York_-_USA/02/Nursing_Home_Quality_Initiatives.html). Last accessed January 2015.
- 3 For the full text of the legislation, see <https://www.congress.gov/bill/113th-congress/senate-bill/2553>. Last accessed January 2015.
- 4 For the full text of the legislation, see <https://www.govtrack.us/congress/bills/113/hr4302/text>. Last accessed January 2015.
- 5 National Quality Forum (NQF). *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS*. Washington, DC: NQF; 2013. Available at [http://www.qualityforum.org/Publications/2013/02/MAP\\_Pre-Rulemaking\\_Report\\_-\\_February\\_2013.aspx](http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx). Last accessed January 2015.
- 6 National Quality Forum (NQF). *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS*. Washington, DC: NQF; 2013. Available at [http://www.qualityforum.org/Publications/2013/02/MAP\\_Pre-Rulemaking\\_Report\\_-\\_February\\_2013.aspx](http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx). Last accessed January 2015.
- 7 National Quality Forum (NQF). *Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012 Rulemaking*. Washington, DC: NQF; 2012. Available at [http://www.qualityforum.org/Publications/2012/02/MAP\\_Pre-Rulemaking\\_Report\\_\\_Input\\_on\\_Measures\\_Under\\_Consideration\\_by\\_HHS\\_for\\_2012\\_Rulemaking.aspx](http://www.qualityforum.org/Publications/2012/02/MAP_Pre-Rulemaking_Report__Input_on_Measures_Under_Consideration_by_HHS_for_2012_Rulemaking.aspx). Last accessed January 2015.
- 8 “Medicare-certified” means the home health agency is approved by Medicare and meets certain Federal health and safety requirements.
- 9 For more information, see [http://www.cms.gov/OASIS/02\\_Background.asp#TopOfPage](http://www.cms.gov/OASIS/02_Background.asp#TopOfPage). Last accessed January 2015.
- 10 For more information on this program, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html>. Last accessed January 2015.
- 11 For more information on this program, see <http://www.medicare.gov/HomeHealthCompare/About/What-Is-HHC.html>. Last accessed January 2015.
- 12 For more information, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html?redirect=/homehealthqualityinits/>. Last accessed January 2015.
- 13 For the full text of this federal rule, see <https://www.federalregister.gov/articles/2014/11/06/2014-26057/medicare-and-medicaid-programs-cy-2015-home-health-prospective-payment-system-rate-update-home>. Last accessed January 2015.
- 14 For more information, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html>. Last accessed January 2015.
- 15 For more information, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html>. Last accessed January 2015.
- 16 For the full text of this legislation, see <https://www.congress.gov/bill/113th-congress/senate-bill/2553>. Last accessed January 2015.
- 17 National Quality Forum (NQF). *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS*. Washington, DC: NQF; 2013. Available at [http://www.qualityforum.org/Publications/2013/02/MAP\\_Pre-Rulemaking\\_Report\\_-\\_February\\_2013.aspx](http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx). Last accessed January 2015.
- 18 For more information, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html>. Last accessed January 2015.
- 19 For more information, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html>. Last accessed January 2015.
- 20 For the full text of this federal rule, see <https://www.federalregister.gov/articles/2011/08/05/2011-19516/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal>. Last accessed January 2015.
- 21 For the full text of this federal rule, see <https://www.federalregister.gov/articles/2014/08/06/2014-18447/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal>. Last accessed January 2015.

**22** For the full text of this federal rule, see <https://www.federalregister.gov/articles/2011/08/05/2011-19516/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal>. Last accessed January 2015.

**23** For the full text of this legislation, see <https://www.congress.gov/bill/113th-congress/senate-bill/2553>. Last accessed January 2015.

**24** National Quality Forum (NQF). *MAP Pre-rulemaking Report: 2014 Recommendations on Measures for More Than 20 Federal Programs*. Washington, DC: NQF; 2014. Available at [http://www.qualityforum.org/Publications/2014/01/MAP\\_Pre-Rulemaking\\_Report\\_\\_2014\\_Recommendations\\_on\\_Measures\\_for\\_More\\_than\\_20\\_Federal\\_Programs.aspx](http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx). Last accessed January 2015.

**25** For more information on this program, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/>. Last accessed January 2015.

**26** For more information on this program, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/>. Last accessed January 2015.

**27** For the full text of this rule, see <https://www.federalregister.gov/articles/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the>. Last accessed January 2015.

**28** For the full text of this rule, see <https://www.federalregister.gov/articles/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the>. Last accessed January 2015.

**29** For the full text of this rule, see <https://www.federalregister.gov/articles/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the>. Last accessed January 2015.

**30** For the full text of this legislation, see <https://www.congress.gov/bill/113th-congress/senate-bill/2553>. Last accessed January 2015.

**31** National Quality Forum (NQF). *MAP Pre-rulemaking Report: 2014 Recommendations on Measures for More Than 20 Federal Programs*. Washington, DC: NQF; 2014. Available at [http://www.qualityforum.org/Publications/2014/01/MAP\\_Pre-Rulemaking\\_Report\\_\\_2014\\_Recommendations\\_on\\_Measures\\_for\\_More\\_than\\_20\\_Federal\\_Programs.aspx](http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx). Last accessed January 2015.

**32** National Quality Forum (NQF). *MAP Pre-rulemaking Report: 2014 Recommendations on Measures for More Than 20 Federal Programs*. Washington, DC: NQF; 2014. Available at [http://www.qualityforum.org/Publications/2014/01/MAP\\_Pre-Rulemaking\\_Report\\_\\_2014\\_Recommendations\\_on\\_Measures\\_for\\_More\\_than\\_20\\_Federal\\_Programs.aspx](http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx). Last accessed January 2015.

**33** National Quality Forum (NQF). *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS*. Washington, DC: NQF; 2013. Available at [http://www.qualityforum.org/Publications/2013/02/MAP\\_Pre-Rulemaking\\_Report\\_-\\_February\\_2013.aspx](http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx). Last accessed January 2015.

**34** For more information on this program, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/>. Last accessed January 2015.

**35** For additional information, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-QIP-FAQ.pdf>. Last accessed January 2015.

**36** For additional information, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-QIP-FAQ.pdf>. Last accessed January 2015.

**37** For the full text of this rule, see <https://www.federalregister.gov/articles/2014/11/06/2014-26182/medicare-program-end-stage-renal-disease-prospective-payment-system-quality-incentive-program-and>. Last accessed January 2015.

**38** For more information, see <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-11-07.html>. Last accessed January 2015.

**39** For the full text of this rule, see <https://www.federalregister.gov/articles/2014/11/06/2014-26182/medicare-program-end-stage-renal-disease-prospective-payment-system-quality-incentive-program-and>. Last accessed January 2015.



**40** National Quality Forum (NQF). *MAP Pre-rulemaking Report: 2014 Recommendations on Measures for More Than 20 Federal Programs*. Washington, DC: NQF; 2014. Available at [http://www.qualityforum.org/Publications/2014/01/MAP\\_Pre-Rulemaking\\_Report\\_\\_2014\\_Recommendations\\_on\\_Measures\\_for\\_More\\_than\\_20\\_Federal\\_Programs.aspx](http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx). Last accessed January 2015.

**41** National Quality Forum (NQF). *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS*. Washington, DC: NQF; 2013. Available at [http://www.qualityforum.org/Publications/2013/02/MAP\\_Pre-Rulemaking\\_Report\\_-\\_February\\_2013.aspx](http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx). Last accessed January 2015.

**42** For more information on this program, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html>. Last accessed January 2015.

**43** For more information on this program, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html>. Last accessed January 2015.

**44** For the full text of this rule, see <https://www.federalregister.gov/articles/2014/08/22/2014-18506/medicare-program-fy-2015-hospice-wage-index-and-payment-rate-update-hospice-quality-reporting>. Last accessed January 2015.

**45** For the full text of this rule, see <https://www.federalregister.gov/articles/2014/08/22/2014-18506/medicare-program-fy-2015-hospice-wage-index-and-payment-rate-update-hospice-quality-reporting>. Last accessed January 2015.

**46** For more information on this program, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>. Last accessed January 2015.

**47** For more information on this program, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>. Last accessed January 2015.

**48** National Quality Forum (NQF). *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS*. Washington, DC: NQF; 2013. Available at [http://www.qualityforum.org/Publications/2013/02/MAP\\_Pre-Rulemaking\\_Report\\_-\\_February\\_2013.aspx](http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx). Last accessed January 2015.

## APPENDIX C: Measure Applications Partnership (MAP) Rosters

### MAP Coordinating Committee

#### COMMITTEE CO-CHAIRS (VOTING)

---

**George J. Isham, MD, MS**

**Elizabeth A. McGlynn, PhD, MPP**

#### ORGANIZATIONAL MEMBERS (VOTING)

---

##### AARP

Joyce Dubow, MUP

##### Academy of Managed Care Pharmacy

Marissa Schlaifer, RPh, MS

##### AdvaMed

Steven Brotman, MD, JD

##### AFL-CIO

Shaun O'Brien

##### American Board of Medical Specialties

Lois Margaret Nora, MD, JD, MBA

##### American College of Physicians

Amir Qaseem, MD, PhD, MHA

##### American College of Surgeons

Frank G. Opelka, MD, FACS

##### American Hospital Association

Rhonda Anderson, RN, DNSc, FAAN

##### American Medical Association

Carl A. Sirio, MD

##### American Medical Group Association

Sam Lin, MD, PhD, MBA

##### American Nurses Association

Marla J. Weston, PhD, RN

##### America's Health Insurance Plans

Aparna Higgins, MA

##### Blue Cross and Blue Shield Association

Trent T. Haywood, MD, JD

##### Catalyst for Payment Reform

Shaudi Bazzaz, MPP, MPH

##### Consumers Union

Lisa McGiffert

##### Federation of American Hospitals

Chip N. Kahn, III

##### Healthcare Financial Management Association

Richard Gundling, FHFMA, CMA

##### Healthcare Information and Management Systems Society

To be determined

##### The Joint Commission

Mark R. Chassin, MD, FACP, MPP, MPH

##### LeadingAge

Cheryl Phillips, MD, AGSF

##### Maine Health Management Coalition

Elizabeth Mitchell

##### National Alliance for Caregiving

Gail Hunt

##### National Association of Medicaid Directors

Foster Gesten, MD, FACP

##### National Business Group on Health

Steve Wojcik

##### National Committee for Quality Assurance

Margaret E. O'Kane, MHS

##### National Partnership for Women and Families

Alison Shippy

##### Pacific Business Group on Health

William E. Kramer, MBA

##### Pharmaceutical Research and Manufacturers of America (PhRMA)

Christopher M. Dezii, RN, MBA, CPHQ

#### INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

---

**Bobbie Berkowitz, PhD, RN, CNAA, FAAN**

**Marshall Chin, MD, MPH, FACP**

**Harold A. Pincus, MD**

**Carol Raphael, MPA**

#### FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

---

**Agency for Healthcare Research and Quality (AHRQ)**

Richard Kronich, PhD/Nancy J. Wilson, MD, MPH

**Centers for Disease Control and Prevention (CDC)**

Chesley Richards, MD, MH, FACP

**Centers for Medicare & Medicaid Services (CMS)**

Patrick Conway, MD, MSc

**Office of the National Coordinator for Health Information Technology (ONC)**

Kevin Larsen, MD, FACP

## MAP Clinician Workgroup

### COMMITTEE CHAIR (VOTING)

---

#### Mark McClellan, MD, PhD

The Brookings Institution, Engelberg Center for Health Care Reform

### ORGANIZATIONAL MEMBERS (VOTING)

---

#### The Alliance

Amy Moyer, MS, PMP

#### American Academy of Family Physicians

Amy Mullins, MD, CPE, FAAFP

#### American Academy of Nurse Practitioners

Diane Padden, PhD, CRNP, FAANP

#### American Academy of Pediatrics

Terry Adirim, MD, MPH, FAAP

#### American College of Cardiology

*\*Representative to be determined*

#### American College of Emergency Physicians

Jeremiah Schuur, MD, MHS

#### American College of Radiology

David Seidenwurm, MD

#### Association of American Medical Colleges

Janis Orłowski, MD

#### Center for Patient Partnerships

Rachel Grob, PhD

#### Consumers' CHECKBOOK

Robert Krughoff, JD

#### Kaiser Permanente

Amy Compton-Phillips, MD

#### March of Dimes

Cynthia Pellegrini

#### Minnesota Community Measurement

Beth Averbek, MD

#### National Business Coalition on Health

Bruce Sherman, MD, FCCP, FACOEM

#### National Center for Interprofessional Practice and Education

James Pacala, MD, MS

#### Pacific Business Group on Health

David Hopkins, MS, PhD

#### Patient-Centered Primary Care Collaborative

Marci Nielsen, PhD, MPH

#### Physician Consortium for Performance Improvement

Mark L. Metersky, MD

#### Wellpoint

\*Representative to be determined

### INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

---

#### Luther Clark, MD

Subject Matter Expert: Disparities

Merck & Co., Inc

#### Constance Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN

Subject Matter Expert: Palliative Care

Hospice and Palliative Nurses Association

#### Eric Whitacre, MD, FACS; Surgical Care

Subject Matter Expert: Surgical Care

Breast Center of Southern Arizona

### FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

---

#### Centers for Disease Control and Prevention (CDC)

Peter Briss, MD, MPH

#### Centers for Medicare & Medicaid Services (CMS)

Kate Goodrich, MD

#### Health Resources and Services Administration (HRSA)

Girma Alemu, MD, MPH

### DUAL ELIGIBLE BENEFICIARIES WORKGROUP LIAISON (NON-VOTING)

---

#### Humana, Inc.

George Andrews, MD, MBA, CPE, FACP, FACC, FCCP

### MAP COORDINATING COMMITTEE CO-CHAIRS MEMBERS (VOTING, EX-OFFICIO)

---

#### HealthPartners

George J. Isham, MD, MS

#### Kaiser Permanente

Elizabeth A. McGlynn, PhD, MPP

## MAP Hospital Workgroup

### COMMITTEE CHAIRS (VOTING)

---

**Frank G. Opelka, MD, FACS (Chair)**

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

### ORGANIZATIONAL MEMBERS (VOTING)

---

#### Alliance of Dedicated Cancer Centers

Karen Fields, MD

#### American Federation of Teachers Healthcare

Kelly Trautner

#### American Hospital Association

Nancy Foster

#### American Organization of Nurse Executives

Amanda Stefancyk Oberlies, RN, MSN, MBA, CNML, PhD(c)

#### America's Essential Hospitals

David Engler, PhD

#### ASC Quality Collaboration

Donna Slosburg, BSN, LHRM, CASC

#### Blue Cross Blue Shield of Massachusetts

Wei Ying, MD, MS, MBA

#### Children's Hospital Association

Andrea Benin, MD

#### Memphis Business Group on Health

Cristie Upshaw Travis, MHA

#### Mothers Against Medical Error

Helen Haskell, MA

#### National Coalition for Cancer Survivorship

Shelley Fuld Nasso

#### National Rural Health Association

Brock Slabach, MPH, FACHE

#### Pharmacy Quality Alliance

Shekhar Mehta, PharmD, MS

#### Premier, Inc.

Richard Bankowitz, MD, MBA, FACP

#### Project Patient Care

Martin Hatlie, JD

#### Service Employees International Union

Jamie Brooks Robertson, JD

#### St. Louis Area Business Health Coalition

Louise Y. Probst, MBA, RN

### INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

---

**Dana Alexander, RN, MSN, MBA**

**Jack Fowler, Jr., PhD**

**Mitchell Levy, MD, FCCM, FCCP**

**Dolores L. Mitchell**

**R. Sean Morrison, MD**

**Michael P. Phelan, MD, FACEP**

**Ann Marie Sullivan, MD**

### 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

### DUAL ELIGIBLE BENEFICIARIES WORKGROUP LIAISON (NON-VOTING)

---

#### University of Pennsylvania School of Nursing

Nancy Hanrahan, PhD, RN, FAAN

### MAP COORDINATING COMMITTEE CO-CHAIRS MEMBERS (VOTING, EX-OFFICIO)

---

#### HealthPartners

George J. Isham, MD, MS

#### Kaiser Permanente

Elizabeth A. McGlynn, PhD, MPP

## MAP Post-Acute Care/Long-Term Care Workgroup

### COMMITTEE CHAIR (VOTING)

---

**Carol Raphael, MPA**

### ORGANIZATIONAL MEMBERS (VOTING)

---

#### **Aetna**

Joseph Agostini, MD

#### **American Medical Rehabilitation Providers Association**

Suzanne Snyder Kauserud, PT

#### **American Occupational Therapy Association**

Pamela Roberts, PhD, OTR/L, SCFES, CPHQ, FAOTA

#### **American Physical Therapy Association**

Roger Herr, PT, MPA, COS-C

#### **American Society of Consultant Pharmacists**

Jennifer Thomas, PharmD

#### **Caregiver Action Network**

Lisa Winstel

#### **Johns Hopkins University School of Medicine**

Bruce Leff, MD

#### **Kidney Care Partners**

Allen Nissenson, MD, FACP, FASN, FNKF

#### **Kindred Healthcare**

Sean Muldoon, MD

#### **National Consumer Voice for Quality Long-Term Care**

Robyn Grant, MSW

#### **National Hospice and Palliative Care Organization**

Carol Spence, PhD

#### **National Pressure Ulcer Advisory Panel**

Arthur Stone, MD

#### **National Transitions of Care Coalition**

James Lett, II, MD, CMD

#### **Providence Health & Services**

Dianna Reely

#### **Visiting Nurses Association of America**

Margaret Terry, PhD, RN

### INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

---

**Louis Diamond, MBChB, FCP(SA), FACP, FHIMSS**

**Gerri Lamb, PhD**

**Marc Leib, MD, JD**

**Debra Saliba, MD, MPH**

**Thomas von Sternberg, MD**

### FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

---

#### **Centers for Medicare & Medicaid Services (CMS)**

Alan Levitt, MD

#### **Office of the National Coordinator for Health Information Technology (ONC)**

Elizabeth Palena Hall, MIS, MBA, RN

#### **Substance Abuse and Mental Health Services Administration (SAMHSA)**

Lisa C. Patton, PhD

### DUAL ELIGIBLE BENEFICIARIES WORKGROUP LIAISON (NON-VOTING)

---

#### **Consortium of Citizens with Disabilities**

Clarke Ross, DPA

### MAP COORDINATING COMMITTEE CO-CHAIRS MEMBERS (VOTING, EX-OFFICIO)

---

#### **HealthPartners**

George J. Isham, MD, MS

#### **Kaiser Permanente**

Elizabeth A. McGlynn, PhD, MPP

## MAP Dual Eligible Beneficiaries Workgroup

### COMMITTEE CHAIRS (VOTING)

---

**Alice R. Lind, RN, MPH (Chair)**  
**Jennie Chin Hansen, RN, MS, FAAN (Vice-Chair)**

### ORGANIZATIONAL MEMBERS (VOTING)

---

**AARP Public Policy Institute**  
 Susan Reinhard, RN, PhD, FAAN

**American Federation of State, County and Municipal Employees**  
 Sally Tyler, MPA

**American Geriatrics Society**  
 Gregg Warshaw, MD

**American Medical Directors Association**  
 Gwendolen Buhr, MD, MHS, Med, CMD

**America's Essential Hospitals**  
 Steven R. Counsell, MD

**Center for Medicare Advocacy**  
 Kata Kertesz, JD

**Consortium for Citizens with Disabilities**  
 E. Clarke Ross, DPA

**Humana, Inc.**  
 George Andrews, MD, MBA, CPE

**iCare**  
 Thomas H. Lutzow, PhD, MBA

**National Association of Social Workers**  
 Joan Levy Zlotnik, PhD, ACSW

**National PACE Association**  
 Adam Burrows, MD

**SNP Alliance**  
 Richard Bringewatt

### INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

---

**Mady Chalk, MSW, PhD**  
**Anne Cohen, MPH**  
**James Dunford, MD**  
**Nancy Hanrahan, PhD, RN, FAAN**  
**K. Charlie Lakin, PhD**  
**Ruth Perry, MD**  
**Gail Stuart, PhD, RN**

### FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

---

**Administration for Community Living (ACL)**  
 Jamie Kendall, MPP

**Centers for Medicare & Medicaid Services (CMS)**  
 Venesa J. Day

**Office of the Assistant Secretary for Planning and Evaluation**  
 D.E.B. Potter, MS

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