NATIONAL QUALITY FORUM

MEASURE APPLICATIONS PARTNERSHIP

MAP 2015 Considerations for Implementing Measures in Federal Programs

DRAFT FOR PUBLIC COMMENT

December 2014

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NATIONAL QUALITY FORUM

MEASURE APPLICATIONS PARTNERSHIP

Process and Approach for MAP Pre-Rulemaking Deliberations 2015

DRAFT FOR PUBLIC COMMENT

December 2014

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Contents

Summary

- **There were a number of process improvements to MAP this year, including the addition of a preliminary analysis of measures, examining the needs and objectives of the programs, a consistent approach to measure deliberations, and expanded public comment.**
- **This year, MAP examined 199 unique measures for potential use in 20 different federal health programs.**

During the annual pre-rulemaking review cycle, the federal government seeks input from the Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF), to provide recommendations to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. Under statute, HHS is required to publish annually a list of measures under consideration for future federal rulemaking and to consider MAP's recommendations on these measures during its later formal rulemaking process. This process affords MAP the opportunity to promote alignment across HHS programs and with private sector efforts, incorporate measure use and performance information into MAP decision-making, as well as provide specific recommendations on the best use of available measures and on ways to fill identified measure gaps.

Process and Approach

Overall Approach

With 2014-2015 being its fourth cycle, MAP has revised its approach to pre-rulemaking deliberations. This new approach to the analysis and selection of measures follows a three-step process:

1. **Define critical program objectives**. Taking into account the structure and goals of each federal health program, MAP describes its perspective on critical program objectives. This input is updated based on the most recent changes for federal programs, and MAP also considers its prior strategic input and prior pre-rulemaking decisions. The critical program objectives help to establish a framework for the future direction of measurement within each program.
2. **Evaluate measures under consideration for potential inclusion in particular programs**. MAP received a preliminary analysis to assist in deliberations. Prepared by NQF staff, the analysis used a pre-defined decision algorithm (described below) based on the MAP Measure Selection Criteria. In their December in-person meetings, MAP workgroups considered the results of the preliminary analysis when making their recommendations to the Coordinating Committee.
3. **Identify and prioritize measurement gaps for programs and settings.** MAP continues to identify gaps in measurement capabilities for each program; in some cases, it may also suggest measure concepts that could help fill those gaps. Furthermore, MAP considers measurement gaps across settings, prioritizing by importance and feasibility when possible.

Review of Needs and Objectives for Federal Health Programs Under Consideration

In October, MAP workgroups convened via web meeting to consider each programs in its setting with the goal of identifying its specific measurement needs and critical program objectives. The workgroup recommendations on critical program objectives were reviewed by the Coordinating Committee in a November web meeting.

Review of Specific Measures Under Consideration

MAP workgroups met in person in December to evaluate the measures under consideration and make recommendations about their potential use in federal programs. MAP reviewed 199 unique measures for potential inclusion in 20 federal health programs. Since some measures were considered for multiple programs, MAP made 637 recommendations on using a particular measure in a particular program.[a] To assist in their deliberations, MAP members received detailed materials, encompassing all measures and their specifications, preliminary analysis of the measures, and any public comments received.

The workgroup recommendations will be reviewed by the MAP Coordinating Committee in January. During its meeting, the Coordinating Committee will review the measure recommendations of the workgroups, as well as the public and member comments received on those recommendations. The Coordinating Committee may elect to agree with the workgroup recommendations or modify the recommendations based on its analysis. After deliberations are complete, the Coordinating Committee finalizes MAP's recommendations for consideration by HHS.

Improvements This Year

NQF undertook an improvement effort to address areas identified by feedback from external stakeholders, MAP members, and NQF members. This section summarizes several major improvements resulting from that effort to restructure this work, improve the process for those involved in deliberations, and strengthen the deliverables.

Preliminary Analysis

To support members for decisions on individual measures, staff provided a preliminary analysis of all measures under consideration based on a pre-defined and standard algorithm derived from the MAP Measure Selection Criteria and other prior guidance. The preliminary analysis is based on the identified

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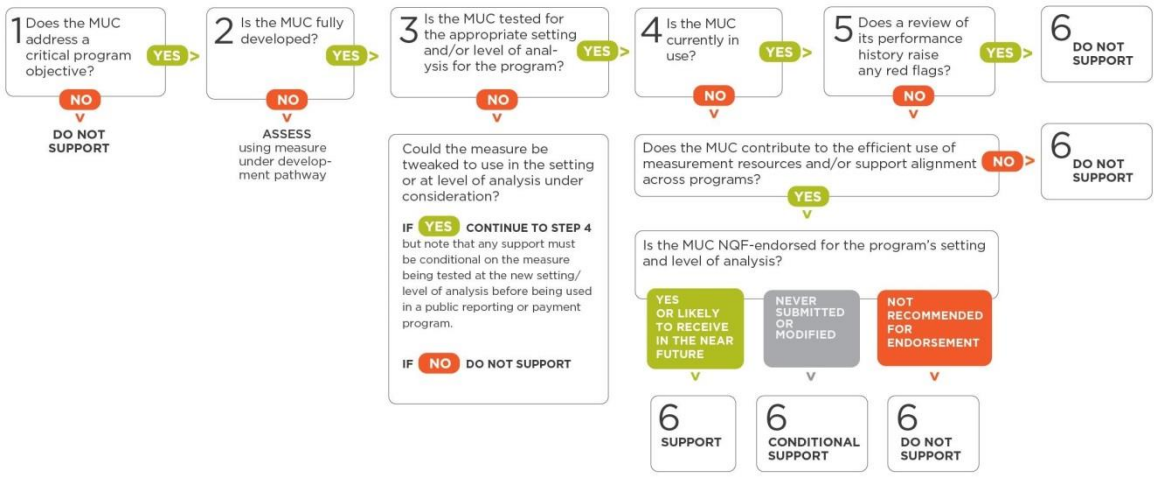
[a] The official Measures under Consideration list received on November 28, 2014 contained 203 unique measures for 20 different federal health programs. As some measures were considered for multiple programs, the list described 650 different situations where a particular measure could be selected for a particular program. Since its publication, CMS officially requested that MAP not consider measures for the Hospital Inpatient Quality Reporting Program (E0349, E2104, X0352, and X0356), Hospital Value-Based Purchasing Program (X0351, X0352, X0353, X0354, X0355, X0356, X2698), Inpatient Rehabilitation Facility Quality Reporting Program (E0141), and Long-Term Care Hospital Quality Reporting Program (E0141).

critical program objectives and is intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions. As illustrated in Figure 1, the preliminary analysis algorithm asks a series of questions about each measure under consideration (MUC):

- Does the measure under consideration meet a critical program objective as defined by MAP?
- Is the measure under consideration fully developed?
- Is the measure under consideration tested for the appropriate setting and/or level of analysis for the program? If no, could the measure be adjusted to use in the program's setting or level of analysis?
- Is the measure under consideration currently in use? If yes, does a review of its performance history raise any red flags?
- Does the measure under consideration contribute to the efficient use of measurement resources for data collection and reporting and support alignment across programs?
- Is the measure under consideration NQF-endorsed for the program's setting and level of analysis?

Figure 1. MAP Preliminary Analysis Algorithm for Fully Developed Measures

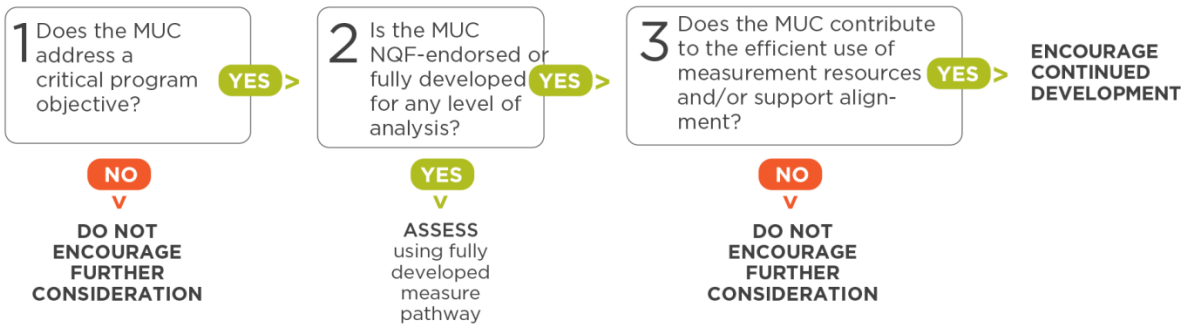


For measures that are earlier in development, MAP may not have the information to answer all of the questions listed above. In addition, early stage measures may change as they undergo testing and further development. Therefore, MAP evaluated these measures using an abbreviated algorithm, which sought to encourage the development of innovative new measures while maintaining rigor. This is intended to provide CMS and measure developers with upstream information on the further development and potential applications for these measures. As illustrated in Figure 2, the preliminary analysis algorithm asks:

- Does the measure under consideration meet a critical program objective as defined by MAP?
- Is the measure under consideration fully developed?

- Does the measure under consideration contribute to the efficient use of measurement resources and support alignment across programs?

Figure 2. MAP Preliminary Analysis Algorithm for Earlier Stage Measures



Consent Calendar

The measures were presented to the workgroups in a consent calendar format that groups together similar measures. After being presented the set of measures, members may identify specific measures within these calendars that require further discussion. The goal was to allow the groups to spend more time on measures where there are differing stakeholder perspectives and to review more rapidly the measures where consensus already exists. The new process also established that consensus was reached when more than 60 percent of MAP workgroup members vote in favor of the measure decision, and all recommendations required consensus support by the group.

NQF Member and Public Comment Periods

One major priority of the improvement efforts was to ensure that there was broad input into the deliberations on measures. To encourage early input, MAP formalized a process in which stakeholders could provide feedback on individual measures immediately after HHS provided that year's measures under consideration. These public comments were taken into account when MAP workgroups reviewed the measures under consideration in their December in-person meetings. After those meetings, there was another opportunity for public comment. That public comment period allowed stakeholders to provide feedback on the individual workgroup measure recommendations as well as MAP's broader measurement guidance for federal programs. These comments will be considered by the MAP Coordinating Committee when deciding to approve the final decisions on measures and strategic input to the programs.

Both NQF members and any interested party can comment on the list of measures under consideration, on individual workgroup decisions, and on broader measurement guidance for federal programs. To provide a transparent process, all submitted comments were posted on the NQF website for public viewing.

Background on Recommendations

MAP's recommendations on individual measures for particular programs are provided in an accompanying spreadsheet. Each decision is accompanied by one or more statements of rationale that explain why the decision was reached. Table 1 outlines the recommendation categories along with sample rationales for each category.

Table 1. MAP Decision Categories and Example Rationales

MAP Decision Category	Rationale (Examples)
Support	• Meets a critical program objective • Addresses a previously identified measure gap • Core measure not currently included in the program measure set • Promotes alignment across programs and settings
Conditional support	• Not ready for implementation; should be submitted for and receive NQF endorsement • Not ready for implementation; measure needs further experience or testing before being used in the program.
Do not support	• Overlaps with a previously finalized measure • A different NQF-endorsed measure better addresses the needs of the program. • Does not meet a critical program objective
Encourage continued development	• Addresses a critical program objective, and the measure is in an earlier stage of development. • Promotes alignment, and the measure is in an earlier stage of development
Do not encourage further consideration	• Overlaps with finalized measure for the program, and the measure is in an earlier stage of development. • Does not address a critical objective for the program, and the measure is in an earlier stage of development.
Insufficient information	• Measure numerator/denominator not provided

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MEASURE APPLICATIONS PARTNERSHIP

Cross-Cutting Challenges Facing Measurement: MAP 2015 Guidance

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Contents

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 continuously emphasized the need to promote efforts to identify and fill critical measurement gaps.**
- **While progress has been made in aligning measures between public- and private-sector programs, additional efforts are necessary.**

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 the 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 who are affected by the federal health programs being examined. However, there is not uniform agreement on which measures matter the most or are more valuable in driving results. This year's MAP discussions explored the characteristics of measures that matter [**see table in Clinician section as an example**], such as whether the measures assessed an important health issue (based on its prevalence, cost, or resulted in harm), addressed an opportunity for improvement in care quality or people's health, or whether the measures had demonstrated an ability to change performance. Other discussions noted a preference for outcome measures (or intermediate outcomes or process measures closely tied to outcomes), patient-reported outcomes, composite measures, cost and resource use, appropriate use, care coordination, and patient safety. The results of these discussions informed MAP's deliberations on the measures under consideration.

Progress on Filling Critical Measure Gaps

As a first step to reviewing the measures under consideration, MAP examines the current measures in the federal program being examined, along with any measures planned for future use. This review is necessary for understanding how the measures under consideration complement measures currently in use. In addition to helping MAP review measures, this analysis also reveals gaps in the programs' measurement capabilities.

One of the challenges identified this year is that measurement gaps could arise when measures are removed from programs. This discussion was motivated by changes that have occurred recently in federal programs; for example, this year 50 measures were removed from the Physician Quality Reporting System across a variety of condition areas. While measures may be removed from programs for good reason, such as when a measure assesses a concept that has achieved a high level of performance (a "topped out" measure) or as the evidence and guidelines underlying a measure change, there are challenges in ensuring that gaps do not occur as a result. This is of particular importance for eligible professionals with limited access to few or no relevant measures to report.

Another important discussion centered on the ability of measures to assess disparities. While there are some measures that can quantify disparities in care quality or health outcomes, many measures can be stratified for different populations or for different conditions to understand variations. The challenge is whether data are available for doing so, with the example that 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 in care and outcomes.

Similarly, MAP encouraged the expansion of certain hospital programs to allow small and rural hospitals the ability to report measures, thus closing potential "reporting gaps" across the healthcare system. Including small and rural hospitals will further alignment efforts and provide meaningful, as well as comparable data, across care settings, such as data quantifying disparities.

During this year's pre-rulemaking, the MAP continued to assess measurement gaps for each program being considered. The 2014 pre-rulemaking process supplemented that work with measurement gaps identified in prior MAP reports along with gaps identified by other NQF projects, specifically projects endorsing measures. A full listing of measure gaps identified this year will be included in the appendix of the final version of this report; Table 1 highlights important gaps in a specific area—patient- and family-centered care—that has consistently had fewer measures available.

In addition to identifying gaps, MAP also has contributed to filling them by recommending measures that focus on these areas. Table 2 include examples within the patient- and family-centered care topic area where MAP has contributed to filling gaps through its recommendation of measures that were adopted into federal programs. When selecting patient- and family-centered care measures, MAP discussions have generally favored measures that capture a comprehensive picture of person-centered quality care and cautioned against measures that may increase measurement burden without driving towards results.

Table 1. Identified Measurement Gaps for One Example Topic Area: Patient- and Family-Centered Care

Category	*Measurement Gap*
Person-Centered Communication	• Information provided at appropriate times. • Information is aligned with patient preferences. • 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). • Outreach to patients to ensure they have the tools and resources needed to self-manage their care.
Shared Decisionmaking, Care Planning, and Other Aspects of Person-Centered Care	• Person-centered care plan, created early in the care process, with identified goals for all people. • Integration of patient/family values in care planning. • Plan agreed to by the patient and provider and given to patient, including advanced care plan. • Plan shared among all providers seeing the patient (integrated); multidisciplinary. • Identified primary provider responsible for the care plan. • Fidelity to care plan and attainment of goals. ○ Treatment consistent with advanced care plan. • Social care planning addressing social, practical, and legal needs of patient and caregivers. • Grief and bereavement care planning. • Patient activation/engagement.
Advanced Illness Care	• Symptom management (pain, nausea, shortness of breath). • Comfort at end of life.

Quality of Life and Functional Status	• Functional status.
	  ○ Particularly for individuals with multiple chronic conditions.
	  ○ Optimal functioning (e.g., improving when possible, maintaining, managing decline).
	• Pain and symptom management.
	• Health-related quality of life.

Cross-Cutting Themes	• How measures can be adapted to or developed for different care settings, such as rehabilitation facilities. • Understanding how measures may apply to different subpopulations (such as pediatrics, maternity, behavioral health).

Table 2. MAP's Contribution Toward Filling Measurement Gaps, Organized According to MAP's Previously Identified Measurement Gaps for One Example Topic Area

Category	*Examples of MAP's Contribution to Filling Measurement Gaps (MAP-supported measures adopted by federal programs)*	*Current MAP Recommendations for This Measurement Gap Area*
Person-Centered Communication	• 3-Item Care Transition Measure (CTM-3) [IQR (2012): Support; Hospital VBP (2013): Support; LTCH (2013): Conditional Support] – *NQF #0228* • Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions [PQRS (2012/2013): Conditional Support] – *Measure #0325: Not Endorsed*	• *Measures to be updated based on final MAP decisions*
Shared Decisionmaking, Care Planning, and Other Aspects of Person-Centered Care	• CG-CAHPS Clinician/Group Survey [PQRS (2012): Support; Meaningful Use -EP (2012): Support); VBPM (2012): Support): Support; VBPM (2013): Support; Physician Compare (2014): Support; MSSP (2014): Support] – *NQF #0005* • HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems Survey [PPS-Exempt Cancer (2013): Conditional Support; LTCH (2013): Conditional Support] – *NQF #0166* • CAHPS In-Center Hemodialysis Survey [ESRD (2013): Support] – *NQF #0258* • Percentage of Patients With Chart Documentation of Preferences for Treatments. [Hospice (2013): Support; PQRS (2013): Support; PPS-Exempt Cancer (2014): Support] – *NQF #1641* • Discussion and Shared Decision Making Surrounding Treatment Options [PQRS (2014): Conditional Support] – Not endorsed	• *Measures to be updated based on final MAP decisions*
Advanced Illness Care	• Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment [PQRS (2013): Support)] – *NQF #0209*	• *Measures to be updated based on final MAP decisions*
Quality of Life and Functional Status	• Depression Remission at Twelve Months [MU-EP (2012): Support; PQRS (2012): Support; Physician Compare (2014): Support); VBPM (2014): Support] – *NQF #0710* • Depression Utilization of the PHQ-9 Tool [MU-EP (2012): Support; PQRS (2012): Support; Physician Compare (2014): Support; VBPM (2014): Support] – *NQF#0712*	• *Measures to be updated based on final MAP decisions*

Progress in Aligning Measurement Requirements

Data continue to show the critical need for greater alignment in measurement requirements. An analysis of almost 50 state and regional measure sets found that over 500 unique measures were in use, with only one-fifth used in more than one program.[1] In the second quarter of 2014, 33 different CMS programs used approximately 1,676 measures, with 863 unique measures.[2] Approximately 50 percent are used in more than one CMS program, and approximately one-third are used in more than two CMS programs. A study of almost 30 private health plans identified approximately 550 distinct measures in use, with little overlap between the measures used for private programs and those used by public programs.[3] As a result of these measurement requirements, one northeastern academic health system noted that it used 1 percent of its net patient service revenue for measurement and reporting.[4]

While alignment is important, there is the technical challenge of understanding how close is close enough for alignment, or how similar measures have to be in order to be considered aligned. This is an important question as even when using standardized measures, many programs modify some of their measures. An analysis of state and regional measure sets found that 80 percent of the measure sets had at least one modified measure; about a quarter of the identified standardized measures were modified in some way.[5] It is unknown how close a measure needs to be to promote alignment. Some modifications may cause substantial changes in overall result or ranking, while others cause only small changes.

Considerations for Specific Programs

Medicare Shared Savings Program

This year, the MAP considered the further evolution of the Medicare Shared Savings Program. This program, which seeks to encourage a focus on improving the health of a population of Medicare patients while reducing the rate of growth in healthcare costs, is undergoing multiple changes (as described in the 2015 Physician Fee Schedule final rule).[6] 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, there is an interest in aligning with other CMS programs, such as the Value-Based Payment Modifier and EHR Incentive Program.

MAP's previous assessments of the measure set of the Medicare Shared Savings Program 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 it could be enhanced by adding and post-acute care measures and measures relevant to individuals with multiple chronic conditions.

As MAP reviewed the program this year, it emphasized the importance of the program's improving the health of a population of Medicare fee-for-service patients, improving care quality and health outcomes, and lowering the rate of growth of healthcare spending. The MAP discussions highlighted the challenges of improving care and health outcomes for a broader population and ensuring that those care

improvements and health gains are widely shared for multiple subpopulations. In addition, MAP emphasized the program's focus on encouraging coordination, which can be done by including measures relevant to individuals with multiple chronic conditions, measures in all settings that patients receive care (including ambulatory, acute, and post-acute settings), and measures that span across settings. Furthermore, there was an interest in including measures in the program that could assess important areas, such as patient-reported outcomes, health risks, cost and resource use, and appropriate use. MAP's guidance in these areas will be used in recommending measures under consideration for the Medicare Shared Savings Program.

Endnotes

[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] Higgins A, Veselovskiy G, McKown L. Provider performance measures in private and public programs: achieving meaningful alignment with flexibility to innovate. *Health Aff (Milwood)*. 2013; 32:1453-61.

[4] Meyer GS, Nelson EC, Pryor DB, et al. More quality measures versus measuring what matters: a call for balance and parsimony. *BMJ Qual Saf*. 2012; 21:964-68.

[5] 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.

[6] https://www.federalregister.gov/articles/2014/11/13/2014-26183/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory

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MAP 2015 Considerations for Implementing Measures in Federal Programs: Hospitals

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Contents

Guidance on Cross-Cutting Issues

Summary

- **High value measures help consumers get the information that they need to make informed decisions about their healthcare, and help to direct them to facilities with the highest quality care.**
- **A parsimonious set of high value measures allows providers to focus on high priority aspects of healthcare where performance varies or is less than optimal overall.**
- **MAP stressed the importance of aligning measures across programs by focusing on comparable performance across settings and data types.**

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

- Hospital Inpatient Quality Reporting (IQR)
- Hospital Value-Based Purchasing (VBP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital-Acquired Condition Reduction Program (HAC)
- Hospital Outpatient Quality Reporting (OQR)
- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs) (Meaningful Use)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR)

MAP's pre-rulemaking recommendations for measures in these programs reflect the MAP Measure Selection Criteria, how well the measures address the identified program goals, and NQF's prior work to identify families of measures. Through the discussion of the individual measures across the nine programs, MAP identified several overarching issues. These overarching issues include: (1) the need for high value measures, and (2) the need to increase alignment across programs by focusing on comparable performance across settings and data types. These themes are explored in more detail below.

Overarching Themes

High Value Measures

MAP encouraged the use of high value performance measures in the nine hospital and setting-specific programs. The programs should include measures that help consumers get the information that they need to make informed decisions about their healthcare, and help to direct them to facilities with the highest quality care. Further, by working toward a parsimonious set of high value measures, within and

across the nine programs, MAP noted that facilities can focus on high priority aspects of healthcare where performance varies or is less than optimal overall. This focus on a parsimonious set of high value measures can also help to reduce measurement burden from data collection and reporting of performance measures.

Alignment Across Programs

MAP stressed the importance of aligning measures across programs by focusing on comparable performance across settings and data types. Care for particular conditions can be provided in settings covered by different programs, thus making it difficult to compare providers across settings if measures are not aligned. For example, cancer care can be provided in either a general acute care hospital or a PPS-exempt cancer facility and, thus, it is important to align measures between the Inpatient Quality Reporting Program and the PPS-Exempt Cancer Hospital Quality Reporting program. MAP also noted that healthcare traditionally provided in one particular care setting is now increasingly being provided in multiple care settings. For example, in some communities inpatient care is shifting to outpatient and ambulatory care settings. MAP encouraged that when possible, the similar measures should be used across settings and programs to allow quality comparisons between setting types.

Finally, MAP encouraged the Centers for Medicare & Medicaid Services (CMS) to expand programs, such as IQR and OQR, to allow small and rural hospitals to report measures and close "reporting gaps" across the healthcare system. Including small and rural hospitals in these programs will help to align measures and provide consumers with comparable data across care settings.

In addition to using similar measures across settings, alignment of additional measurement elements should be considered. MAP noted that alignment of reporting periods and timelines across settings will help to ensure that consumers will have data about quality performance across settings when making decisions about where to seek care. Additionally, alignment in measure results across data types is important as well. CMS allows providers to report performance on measures in multiple data types, for example, measures generated from paper chart abstraction or from the use of electronic clinical data systems. MAP noted that it is important that measures generate reliable, valid, and comparable results from both of these two data types.

Considerations for Specific Programs

This section provides an overview of MAP's 2014-2015 pre-rulemaking recommendations for each program. This section introduces each of the programs, outlines MAP's critical program objectives, highlights important measure gaps, and provides a high level insight into the 2014-2015 MAP recommendations on the measures under consideration. Details on specific measures can be found in the accompanying table.

Inpatient Quality Reporting Program

The Inpatient Quality Reporting (IQR) program is a pay-for-reporting and public reporting program that authorizes CMS to pay hospitals a higher annual update to their payment rates if they successfully

report designated quality measures. CMS also provides these data to consumers through the Hospital Compare website to help them make more informed healthcare decisions.[a]

MAP developed critical objectives for each program to develop a vision for where it would like to see each program evolve and to guide its pre-rulemaking deliberations. The Inpatient Quality Reporting program critical objectives are to support alignment across programs by selecting high impact measures that are meaningful to consumers and will drive improvements in the quality and efficiency of care. MAP encouraged a movement toward more comprehensive measures of provider performance, such as all-cause harm measures to ensure the program is improving care broadly. MAP noted the importance of moving towards measuring patient outcomes rather than healthcare structures or processes. The program should continue to evolve by allowing all relevant providers to participate, including rural and small hospitals. Further, the IQR program should use measurement to engage consumers, patients, and their families as partners in their care. In addition to selecting and aligning high impact measures, IQR should work to align reporting requirements with other clinical programs, where appropriate, to reduce the burden on providers and support efficient use of measurement resources.

Previously, MAP recommended filling the following gap list for measures: pediatrics, maternal/child health, cancer, behavioral health, affordability/cost, care transitions, patient education, palliative and end-of-life care, medication reconciliation, safety culture, pressure ulcer prevention, and adverse drug events. A number of measures under consideration could begin to fill some of these gaps including of maternal/child health, affordability/cost, safety culture, and adverse drug events once they are fully specified and NQF endorsed. Additionally, MAP suggested that HHS look to existing measures and measures under consideration for the PPS-Exempt Cancer Hospital Quality Reporting Program, the Inpatient Psychiatric Facility Quality Reporting Program, and Hospice Quality Reporting Programs to fill additional gaps in the IQR measure set and promote alignment across programs.

MAP recognized a number of challenges in the current measurement environment. MAP noted that several outcome measures, particularly those measuring hospital readmissions, should be reviewed in the upcoming NQF trial period to determine if socio-demographic (SDS) adjustment is appropriate. If there is a conceptual and empirical relationship between SDS factors and these outcomes, these measures should be updated. MAP emphasized the need to continue to explore the issues of shared accountability and attribution, particularly for measures addressing the cost of care and care transitions. Additionally, MAP noted for measures that use registries as the data source, CMS should collect data directly from the registries for hospitals that participate. For hospitals that do not participate, CMS should create a pathway to allow them to submit this data directly to CMS without the cost of participation in the registry.

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[a] Centers for Medicare & Medicaid (CMS) website. Baltimore, MD: 2014. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html. Last accessed November 2014.

Hospital Value-Based Purchasing Program

The Hospital Value-Based Purchasing (VBP) program is a pay-for-performance program that aims to improve healthcare quality by providing incentive payments to hospitals that meet or exceed performance standards. Medicare bases a portion of hospital reimbursement on performance through the Hospital VBP. Medicare withholds a portion of 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 from 1.5 percent in fiscal year (FY) 2015, to 1.75 percent in FY 2016, to 2 percent in FY 2017 and future fiscal years. 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 one year prior to use in the VBP program.

The Hospital VBP critical program objectives emphasize measuring high impact areas for performance and quality improvement with a strong preference for NQF-endorsed® measures. This program seeks to profile the value of healthcare services delivered by providers by linking clinical quality measures and cost measures. MAP noted the importance of keeping the program measure set parsimonious to avoid diluting the payment incentives. Previously, MAP identified a number of measurement gap areas that should be addressed within the VBP program measure set, including medication errors, mental and behavioral health, emergency department throughput, safety culture, and patient and family engagement.

In its 2014-2015 pre-rulemaking work, MAP welcomed the opportunity to review updated and improved versions of existing measures. MAP noted that measurement is a constantly changing and improving field; however the group expressed caution on how these revised measures are phased into the program. MAP iterated the importance of publically reporting the updated measures prior to use in pay for performance applications. MAP also noted that CMS should carefully consider how updated measures are phased in to payment and reporting programs to minimize confusion for providers, consumers, and purchasers trying to interpret the results of the measures.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction program is a pay-for-performance and public reporting program aimed at reducing hospital readmissions for the more than three-quarters of U.S. hospitals paid under the inpatient prospective payment system (IPPS). The risk-adjusted readmissions rates are publicly reported on the CMS Hospital Compare website to provide consumers with hospital performance information. Furthermore, the incentive structure has been designed so that diagnosis-related group (DRG) payment rates will be reduced based on a hospital's ratio of actual to expected readmissions. The maximum payment reduction until October 2015 is 2 percent, after which the payment reduction will be capped at 3 percent.

The Hospital Readmissions Reduction program critical objectives are to reduce the number of readmissions to an acute care hospital following discharge from the same or another acute care

hospital. MAP noted that the program should recognize that not all readmissions are markers of poor quality, and thus planned and unrelated readmissions should be excluded from the measures in the program. The causes of readmissions are complex and multifactorial including environmental, community-level, and patient-level factors, as well as sociodemographic factors. Therefore, multiple entities across the healthcare 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 the hospital. This program seeks to encourage hospitals to take a leadership role in improving care beyond their walls through care coordination across providers, while recognizing that patient and family engagement is critical to improving these care transitions, and ultimately, patient care and healthcare costs. MAP also recommended that measures included in the HRRP should be considered in the upcoming NQF SDS trial period to review whether there is a conceptual and empirical relationship between the outcomes and SDS factors. MAP highlighted that if measures are updated they should be evaluated through the NQF endorsement process and carefully phased into programs.

Hospital Acquired Condition Reduction Program

The Hospital Acquired Condition (HAC) Reduction program is a pay-for-performance and public reporting program that supports the broader public health imperative to raise awareness and reduce the incidence of preventable HACs by applying evidence-based clinical guidelines. The purpose of this program is to 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. The incentive structure is designed so that the 25 percent of hospitals that have the highest rates of HACs, as determined by the measures in the program, will have their Medicare payments reduced by 1 percent.

The HAC Reduction program critical objectives are focused on minimizing the major drivers of patient harm. The measures in this program overlap with those in the Hospital VBP program, helping to support alignment and focus attention on these critical safety issues. MAP noted gaps for this program include adverse drug events and sepsis beyond post-operative infections. MAP also highlighted the need for greater antibiotic stewardship as programs such as the HAC Reduction Program increase attention on infection rates.

In its 2014-2015 pre-rulemaking activities, MAP supported updates to the NHSN CAUTI and CLABSI measures currently in the program. This update was recently reviewed and recommended by the NQF Safety Standing Committee. Implementing this updated measure would extend the measure to hospital settings outside the ICU and add another risk adjustment methodology. As with other updated measures, MAP applauded improvements to the measures but cautioned that they should be implemented carefully to minimize confusion and burden.

Hospital Outpatient Quality Reporting Program

The Hospital Outpatient Quality Reporting (OQR) program is a pay-for-reporting program with performance information reported on the Hospital Compare website. The goals of the program are to establish a system for collecting and reporting on quality performance of hospitals that offer outpatient services such as clinical visits, emergency department visits, and critical care services.

The critical program objectives of the Hospital OQR are to align the program with ambulatory care measures in programs such as the Physician Quality Reporting System and Physician Compare. 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, care coordination, and an outpatient CAHPS module.

Many of the measures under consideration for 2014-15 pre-rulemaking attempted to fill these gaps, especially an outpatient CAHPS module, patient reported outcomes, patient and family engagement measures, care coordination measures, and measures of ED care. While MAP was generally supportive of these measures, they did express caution that survey measures should be aligned to reduce undue burden on providers and patients. The Hospital Workgroup had an in-depth discussion about the use of NQF #0326 Advance Care Plan in the OQR program but was unable to come to consensus on a recommendation. The group recognized the importance of advance care planning but some argued that this measure might be more appropriate in primary care settings and other settings where the patient has an established and on-going relationship with the provider. However, the MAP cautioned that not all measure concepts necessarily apply equally across settings.

Ambulatory Surgery Center Quality Reporting Program

The Ambulatory Surgical Center Quality Reporting (ASCQR) program is a pay-for-reporting program with an expectation that performance information would be publicly available in the future. The goals of this program are to promote higher quality and more efficient care for Medicare beneficiaries, to establish a system for collecting and reporting on quality performance of ASCs, and to provide consumers with quality-of-care information that will help them make informed decisions about their healthcare.

The ASCQR critical program objectives are to include measures that are highly impactful and meaningful to patients. This program also aims to align measures with CMS's various quality reporting programs, particularly the Hospital OQR Program, to ensure that quality is measured consistently across care settings to allow consumers, purchasers, and payers to compare providers who may be performing the same procedure. MAP identified priority measure gap areas for the ASCQR program including measures of surgical quality, infections, complications including anesthesia-related complications, post-procedure follow-up, in addition to measures of patient and family engagement including an ASC-specific CAHPS module, patient-reported outcomes, and cost/resource use. In its 2014-2015 pre-rulemaking recommendations, MAP supported a number of measures that could begin to fill the gap around complications. MAP encouraged continuing the development of the Outpatient/Ambulatory Surgery Patient Experience of Care Survey to begin to fill the gap around patient and family engagement.

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

The Medicare and Medicaid EHR Incentive ("Meaningful Use") program provides incentives to eligible professionals, eligible hospitals, and CAHs as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. The goal of this program is to promote the widespread adoption of certified EHR technology by providers and to incentivize the "meaningful use" of EHRs to

improve quality, safety, efficiency, and reduce health disparities, engage patients and their families, improve care coordination, and maintain privacy and security of patient health information. The program defines 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

The Meaningful Use critical program objectives are to select measures that represent the future of measurement (e.g. facilitating information exchange between institutions and longitudinal tracking of care, such as measures that monitor incremental changes in a patient's condition over time). The eMeasures in the program should be reliable and valid with a preference to measures endorsed by NQF. The eMeasures selected for the Meaningful Use program should be assessed for comparability with measures derived from alterative data sources used in programs such as IQR. Further, this program seeks to align with other hospital performance measurement programs to reduce measurement burden on providers and the most appropriate use of measurement resources. MAP supported the direction of a number of encouraging measure concepts during its 2014-2015 pre-rulemaking work. Several of these concepts were electronic versions of existing measures. MAP was hopeful that the collection of reliable clinical data could be enhance the existing measures to better capture patient severity as well as improve the measure reliability.

PPS-Exempt Cancer Hospital Quality Reporting Program

The PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) program allows hospitals to report information about the quality of care in cancer hospitals, particularly the 11 cancer hospitals that are exempt from the IPPS and the IQR program. There is currently no financial incentive for the 11 PPS-exempt cancer hospitals in this program to report quality measures. CMS plans to create an incentive structure in the future. The goal of this program is to encourage PPS-exempt hospitals and clinicians within these institutions to improve the quality of their care, to share best practices, and to learn from each other's experiences.

The PCHQR critical program objectives are to include measures appropriate to cancer hospitals that reflect the highest priority services provided by these hospitals and should align with measures in the Inpatient Quality Reporting program and Outpatient Quality Reporting program, where appropriate and relevant.

The program aims to include measures that address gaps in the quality of cancer care. 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. During its 2014-2015 pre-rulemaking review, MAP conditionally supported a number of measures where the dedicated cancer centers have uniformly high rates of performance. MAP recognized the role these centers could play as benchmarks for general acute care hospitals providing cancer care and recommended CMS consider the adoption of these measures in the IQR program as well. Additionally, MAP noted that measures in the PCHQR set

should move beyond measurement of cancer care to include cross-cutting measures as well to allow for alignment across care settings and programs.

Inpatient Psychiatric Facility Quality Reporting Program

The Inpatient Psychiatric Facility Quality Report (IPFQR) Program is a pay-for-reporting program designed to establish a system for collecting and providing quality data for inpatient psychiatric hospitals or psychiatric units. The performance data collected in this program will be publicly reported on the Hospital Compare website in the future. The goals of the program are to improve the quality of inpatient psychiatric care by providing comparative performance data for consumers, and allow providers to share and report on best practices that result in high performance.

The incentive structure is designed so that 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. However, this program does not apply to children's hospitals, which are paid under a different system.

The IPFQR critical program objectives are to ensure that measures in the program are meaningful to patients. This program aims to improve person-centered psychiatric care by addressing priority measure topics, such as assessing patient and family/caregiver experience and engagement, and establishing relationships with community resources.

MAP previously identified measure gaps in the IPFQR program, including 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. In its 2014-2015 review of measures under consideration MAP strongly supported the need to move beyond the measurement of psychiatric care in inpatient psychiatric facilities (IPFs) into measurement of other important general medical conditions that affect patients with psychiatric conditions. Further MAP noted that the measurement of psychiatric treatment quality should not be limited to inpatient psychiatric hospitals or psychiatric units, but rather be expanded to general medical facilities that are treating these patients as well. MAP noted that this would allow for alignment across settings and providers.

NATIONAL QUALITY FORUM

MEASURE APPLICATIONS PARTNERSHIP

MAP 2015 Considerations for Implementing Measures in Federal Programs: Post-Acute Care/Long-Term Care

DRAFT FOR PUBLIC COMMENT

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Contents

Guidance on Cross-Cutting Issues

Summary

- Emphasize harmonization of measures to promote patient-centered care across PAC/LTC programs.
- Coordinate efforts between patient assessment instruments used in PAC/LTC settings to maintain competencies and quality of data.
- Align performance measurement across PAC/LTC settings as well as with other settings to ensure comparability of performance and to facilitate information exchange.

The Measure Applications Partnership (MAP) reviewed measures under consideration for five setting-specific federal programs addressing post-acute care (PAC) and long-term care (LTC): the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), the Long-Term Care Hospital Quality Reporting Program (LTCH QRP), the End-Stage Renal Disease Quality Incentive Program (ESRD QIP), the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP), and the Home Health Quality Reporting Program (HH QRP). MAP has previously provided input on measures for the Hospice Quality Reporting Program (Hospice QRP). However, in 2014-2015 there were no measures under consideration for this program as the Centers for Medicare & Medicaid Services (CMS) is launching the new Hospice Item Set. Instead, MAP provided recommendations on additional measurement priorities that could potentially enhance the current program measure set.

MAP's pre-rulemaking recommendations for measures in these programs reflect the MAP Measure Selection Criteria, how well the measures address the identified program goals, and NQF's prior work to identify families of measures. MAP also drew upon its Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement as a guide to inform pre-rulemaking review of measures for the PAC/LTC programs. In the PAC/LTC coordination strategy, MAP defined high-leverage areas for performance measurement and identified 13 core measure concepts to address each of the high-leverage areas.

PAC/LTC Highest-Leverage Measurement Areas and Core Measure Concepts

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental health
Goal Attainment	• Establishment of patient/family/caregiver goals • Advanced care planning and treatment
Patient Engagement	• Experience of care • Shared decisionmaking
Care Coordination	• Transition planning

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions

Through the discussion of the individual measures across the five programs, MAP identified several overarching issues. These themes are explored below.

Overarching Themes Across All Programs

Implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

The IMPACT Act is a bipartisan bill that was passed in September 2014. Under section 1899 (B) Title XVIII of the Social Security Act, PAC providers are now required to report standardized patient assessment data as well as data on quality, resource use, and other measures. The IMPACT Act is an important step toward measurement alignment and shared accountability across the healthcare continuum which MAP has emphasized over the past several years.

According to the IMPACT ACT, the data is required to be interoperable to allow for its exchange among PAC and other providers to facilitate care coordination and improve Medicare beneficiary outcomes. The IMPACT ACT affects PAC programs including: 1) HHA Quality Reporting Program; 2) newly required Skilled Nursing Facility Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program. The legislation calls for modification of PAC assessment instruments used by the above programs to enable the submission of standardized patient assessment data and comparison of assessment data across all such providers.

The new quality measures will address several domains including functional status and changes in function, skin integrity and changes in skin integrity, medication reconciliation, incidence of major falls, and the accurate communication of health information and care preferences when a patient is transferred. The IMPACT Act also requires the implementation of measures to address resource use and efficiency such as total Medicare spending per beneficiary, discharge to community, and risk-adjusted hospitalization rates of potentially preventable admissions and readmissions. The Act also directs the Secretary of the U.S. Department of Health and Human Services to provide confidential feedback reports to PAC providers on their performance with respect to required measures as well as to arrange for public reporting of performance results.

MAP was generally supportive of standardizing patient assessment data across post-acute care settings; however, it noted the importance of aligning measurement with other settings such as long-term care and home- and community-based services. MAP also recommended coordinating efforts between

existing patient assessment instruments such as the Inpatient Rehabilitation Facility Patient Assessment (IRF-PAI) and the CARE tool to avoid duplication of efforts, maintain integrity of data, and reduce burden of maintaining data on different scales.

Ensuring a Person-Centered Approach to PAC/LTC Care

MAP stressed harmonization of measures to promote patient-centered care across PAC/LTC programs. Recognizing the heterogeneity of populations served in each setting, MAP recommended that measures be specified and applicable to specific populations. For example, MAP conditionally supported a measure that addresses venous thromboembolism prevention, an important safety issue for IRFs and LTCHs. However, MAP recommended that the measure be tested and NQF-endorsed for these settings before it is used in the programs to take into account the differences in patient populations. MAP also conditionally supported a pressure ulcer measure for the HH QRP which has been harmonized with the NQF endorsed version of the measure currently in use in SNF, LTCH and IRF settings. Pressure ulcer is a required measurement domain under the IMPACT Act and is an important safety issue for all patient populations across post-acute care settings. MAP stressed that following a person across the care continuum from facility to home-based care or beyond will allow for a better assessment of a person's outcomes and experience across time and settings.

Aligning Across Settings

Once more, MAP emphasized the need to align performance measurement across PAC/LTC settings as well as with other settings to ensure comparability of performance and to facilitate information exchange. To ensure timely receipt of appropriate healthcare services by populations served in PAC/LTC settings, MAP encouraged care coordination and shared accountability among PAC/LTC facilities and other settings. This would allow for a better assessment of a person's outcomes and experience across time and settings. In particular, MAP noted alignment is needed to allow for better communication and information exchange between PAC/LTC settings. One suggestion was to take advantage of opportunities to encourage cooperation on measurement and sharing mutually important measurement data across settings and providers.

Considerations for Specific Programs

Inpatient Rehabilitation Facility Quality Reporting Program

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is a pay for reporting and public reporting program that addresses the rehabilitation needs of individuals including improved functional status and return to the community post-discharge. Inpatient Rehabilitation Facility providers (IRFs) must submit data on quality measures to 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.[1] The data must be made publicly available, with IRF providers having an opportunity to review the data prior to its release.[2]

MAP previously noted that the 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, medication reconciliation, and high-incidence safety issues such as MRSA, falls, CAUTI, and C. difficile.[3]

MAP reviewed and conditionally supported five measures under consideration that addressed patient safety and functional status. MAP recommended submission of the NQF #0371 Venous Thromboembolism Prophylaxis measure to NQF for endorsement after it is expanded and specified for use in IRFs. MAP also noted several concerns about the measure including its exclusions of stroke patients and patients with length of stay longer than 120 days, noting concerns that stroke patients frequently receive care in IRFs and that rehabilitation patients may require longer stays than patients in the acute care hospital setting for which the measures are currently specified. MAP conditionally supported four functional outcome measures under consideration for this program. MAP noted that the measures are meaningful to patients and actionable; however, some MAP members questioned that these measures may be redundant with each other and with information currently collected from the IRF-PAI. MAP ultimately concluded that the two different types of measures under consideration will present a more thorough picture of a patient's progression over the course of their rehab as well as the important change from admission to discharge. MAP raised concerns regarding the potential duplicity between the CARE tool and the IRF-PAI and burden of maintaining data on two scales. MAP recommended coordinating the scales to maintain staff competency and the quality of the data generated.

Long-Term Care Hospital Quality Reporting Program

The Long-Term Care Hospital Quality Reporting Program (LTCH QRP) is a pay for reporting and public reporting program that aims to provide extended medical care to individuals with clinically complex problems (e.g., multiple, acute, or chronic conditions needing hospital-level care for periods of greater than 25 days).[4] LTCH providers must submit data on quality measures to CMS to receive full annual payment updates. Failure to report quality data will result in a 2 percent reduction in the annual payment update.[5] The data must be made publicly available, with LTCHs having an opportunity to review the data prior to its release.

MAP previously recommended that functional status assessment in LTCHs should cover a broad range of mobility issues, such as position changes, locomotion, poor mobility, picking up objects, and chair-to-bed transfers.[6] Additionally, increased attention should be given to pain, agitation, and delirium among the ventilated population, as these factors are the biggest impediments to mobility.[7] MAP also recommended adding measures to the program set that address cost, cognitive status assessment (e.g., dementia identification), medication management (e.g., use of antipsychotic medications), and advance directives.[8]

MAP reviewed three measures under consideration for this program that addressed patient safety priorities for LTCHs. MAP conditionally supported the NQF #0371 Venous Thromboembolism Prophylaxis, which was also under consideration for IRF QRP, and made similar recommendations such as expanding the measure to the LTCH setting and submitting for NQF endorsement. Additionally, MAP encouraged continued development of two measures addressing ventilator issues, emphasizing the importance of ventilator care and successful weaning to improve quality of life and decrease morbidity, mortality, and resource use among patients.

End-Stage Renal Disease Quality Incentive Program

The End-Stage Renal Disease Quality Incentive Program (ESRD QIP) is a pay for performance and public reporting program that aims to improve the quality of dialysis care and produce better outcomes for Medicare beneficiaries.[9] 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 will be on a sliding scale, which could amount to a maximum of 2 percent per year.[10] Facility performance in the ESRD QIP is publicly reported through three mechanisms: the Performance Score Certificate, the Dialysis Facility Compare website, and ESRD QIP Dialysis Facility Performance Information.

In prior years, MAP recommended expanding the program measure set beyond dialysis procedures to include cross-cutting and person-centered care measurement areas such as care coordination, medication reconciliation, functional status, patient engagement, pain, falls, measures covering comorbid conditions such as depression, and measures to assess the pediatric population.[11] MAP also recommended exploring whether the clinically focused measures could be combined in a composite measure for assessing optimal dialysis care.[12] Importantly, as the program evolves, outcome measures are preferred over structural or process measures.

MAP reviewed 7 measures under consideration for this program. MAP conditionally supported the three dialysis adequacy measures as they addressed both adult and pediatric populations, favoring the composite measure over the individual measures to encourage parsimony. MAP did not reach consensus on four measures that addressed cross-cutting measurement areas. These included two measures each for cultural competency and medication documentation, raising concerns about the data collection for both. MAP considered both the reporting and outcome measures for each topic area, noting that the reporting measures provide an important first step to implementing the outcome measures. MAP deferred those measures to the Coordinating Committee to review and provide the final recommendations.

Skilled Nursing Facility Value-Based Purchasing Program

The Protecting Access to Medicare Act (PAMA) of 2014 directs the Secretary to establish a value-based purchasing program for skilled nursing facilities (SNFs). The SNF VBP establishes incentive payments for SNFs based on performance on the measures in the program beginning in fiscal year 2019. The Secretary is required to specify two time-limited measures:

- An SNF all-cause, all-condition hospital readmission measure, or any successor to such a measure, no later than October 1, 2015
- A resource measure to reflect an all-condition, risk-adjusted potentially preventable hospital readmission rate for SNFs no later than October 1, 2016

The Secretary must also provide confidential feedback reports to SNFs on their performance with respect to the above measures, beginning October 1, 2016 and every quarter thereafter. The Secretary must establish procedures for making information publicly available on the performance of SNFs with

respect to the above measures by posting on the Nursing Home Compare Medicare website (or a successor website) beginning not later than October 1, 2017.

This was the first year that MAP was tasked with reviewing a measure under consideration for the newly established SNF VBP. MAP supported the hospital readmission measure for SNFs and noted that this measure is well aligned with readmission measures used in other settings. However, some MAP members raised concerns about potential unintended consequences such as discouraging needed hospitalization and the exclusion of cancer patients from the measure.

Home Health Quality Reporting Program

The Home Health Quality Reporting Program (HH QRP) is a pay for reporting and public reporting program that aims to improve the quality of care provided to patients. CMS has adopted home health quality goals based on the IOM definition of quality as having the following domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness.[13] The incentive structure is designed to require that Medicare-certified[14] home health agencies (HHAs) to collect and submit quality data through the Outcome and Assessment Information Set (OASIS) and Home Health CAHPS. HHAs that do not submit data will incur a 2 percent reduction in their annual HH market basket percentage increase.[15] 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.[16]

In the 2013-2014 pre-rulemaking cycle, MAP noted that the large measure set reflects the heterogeneity of the home health population, but that it could benefit from more parsimony.[17] To enhance the program measure set, CMS is planning to conduct a thorough analysis to identify priority gap areas, measures that are topped out, and opportunities to improve the existing measures.

MAP reviewed one measure under consideration that addressed pressure ulcers, a required measurement domain under the IMPACT Act. MAP conditionally supported this measure as it is harmonized with NQF #0678 Percent of Residents or Patients with Pressure Ulcers that are New or Worsened which is used in the SNF, LTCH, and IRF settings. MAP offered recommendations to enhance the measure such as focusing on consequences of not detecting a pressure ulcer rather than the number of patients that might develop one and excluding hospice patients with ulcers that may be unlikely to heal.

Hospice Quality Reporting Program

The Hospice Quality Reporting Program (HQRP) is a pay for reporting and public reporting program that 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.[18] Under this program, hospice providers are required to submit data on quality measures to CMS. Failure to report quality data will result in a 2 percent reduction to the market basket

percentage increase for that fiscal year.[19] The data must be made publicly available, with hospice programs having an opportunity to review the data prior to its release.[20]

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. The Hospice Item Set will collect and report data on six NQF-endorsed® measures and one modified version of an NQF-endorsed measure that MAP supported in the previous pre-rulemaking cycles. Additionally, hospice providers are required to participate in the CAHPS Hospice Survey which will be implemented on January 1, 2015 for the FY 2017 annual payment update.

In previous pre-rulemaking cycles, MAP recommended the inclusion of measures in the program that addressed concepts such as goal attainment, patient engagement, care coordination, depression, caregiver roles, and timely referral to a hospice.[21] This year, MAP reiterated top priority measurement areas for this program including an appropriate outcome measure for pain and measures that address timeliness/responsiveness of care, access to the healthcare team on a 24-hour basis, and composite measures on communication, access, and care coordination. MAP also emphasized the need for inclusion of the family and caregivers in the hospice survey.

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NATIONAL QUALITY FORUM

MEASURE APPLICATIONS PARTNERSHIP

MAP 2015 Considerations for Implementing Measures in Federal Programs: Clinicians

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Summary

- **Noteworthy progress to high-value measures in federal programs is seen in a few areas but remains uneven or slow for many conditions. Incentives are needed to promote the development of meaningful and impactful measures, particularly those used for public reporting.**
- **Greater focus on parsimony and alignment of measures in programs is essential to reduce burden and improve participation in quality reporting, to avoid confusing audiences of public reports of performance, and to synergize quality improvements across providers and settings of care.**
- **Financial incentives are needed for more meaningful measures.**

BACKGROUND

Clinician quality reporting began in 2006 as the Physician Quality Reporting Initiative (PQRI) and became the Physician Quality Reporting System (PQRS) in 2007. PQRS is a voluntary reporting program for individual clinicians, practices, and groups. The PQRS measures will be publicly reported on CMS's website Physician Compare beginning in 2014 with large groups and increasing to all professionals in 2016. The PQRS measures will be also used in the quality component of the Physician Value-Based Payment Modifier beginning in 2015.

The other major quality reporting programs for clinicians are the Medicare and Medicaid EHR Incentive Programs, also known as "Meaningful Use." The EHR incentive programs encourage adoption and meaningful use of electronic health records. These voluntary quality reporting programs use payment incentives to encourage participation by "eligible professionals (EPs)," i.e., Medicare physicians, practitioners, and therapists allowed by law to participate in the quality programs.

In the past three years MAP has provided multistakeholder, pre-rulemaking input to CMS on measures for both PQRS and the EHR Incentive programs. MAP's Measure Selection Criteria to identify characteristics that are associated with ideal measure sets used for public reporting and payment programs. MAP's measure selection criteria complement program-specific statutory and regulatory requirements. The measure selection criteria focus on selecting high-quality measures that optimally address the National Quality Strategy's three aims; filling critical measure gaps; and increasing alignment among programs. Additionally, the selection criteria emphasize the use of NQF-endorsed® measures whenever possible; inclusion of a mix of measures types, i.e., outcome, composite, efficiency, patient reported outcomes, etc.; enabling measurement of person- and family-centered care and services; consideration of healthcare disparities and cultural competency; and promoting parsimony and alignment among public and private quality programs.

Overarching Themes

Include More High-Value Measures in Federal Programs

The multistakeholder MAP Clinician Workgroup has identified high-value measures as more meaningful and usable for various stakeholders and more likely to drive improvements in quality. High-value measures include outcome measures; patient-reported outcomes (PROs); composite measures; intermediate 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. Additional measures of value to patients and consumers for public reporting include patient experience and population health. Similarly, the MAP Dual Eligible Beneficiaries Workgroup emphasized that new and improved measures are needed to evaluate goal-directed, person-centered care planning and implementation; shared decisionmaking; systems to coordinate acute care, long-term services and supports, and nonmedical community resources; beneficiary sense of control/autonomy/self-determination; psychosocial needs; community integration/inclusion and participation; and optimal functioning (e.g., improving when possible, maintaining, managing decline).

MAP is concerned that progress to the high-value measures has been slow, particularly now that public reporting of performance measure results for PQRS is imminent. In past years, MAP noted that some condition/topic areas have more high-value measures and requested a "scorecard" to judge progress toward high-value measures. Table 1 presents a tally of the high-value measures by condition/topic area for the 2015 PQRS measures and the measures under consideration this year. Some topic areas have significantly more high-value measures for PQRS 2015 including cardiac care, eye care, renal disease, and surgery. MAP noted that clinicians who report on more high-value measures receive the same incentive payments even though they are reporting more challenging measures. Greater incentives for those who report on high-value measures might prompt faster development of high-value measures in other condition/topic areas.

MAP noticed a definite shift toward more high-value measures in the current measures under consideration though it is uneven across conditions. MAP specifically praised the patient-reported, functional outcome measures and episode-based payment measures for hip and knee replacement that address both quality and cost. A few patient-reported outcomes (PROs) and appropriate use measures are included. Important gaps include measures for multiple chronic conditions and complex conditions, outcome measures for cancer patients, measures for palliative/end of life care, measures for specialist EPs with few or no measures and EHR measures that promote interoperability and health information exchange. MAP encourages moving from physician-centered measures to patient-centered measures with greater use of patient-reported data for patient experience, shared decisionmaking, care coordination, patient-reported outcomes, etc.

Table 1. Progress to High-Value Measures

	PQRS 2015							Measures Under Consideration for PQRS						
Condition/Topic Area	Total Measures	Outcomes	PROs	Composites	Intermediate Outcomes	Patient Experience	Efficiency/ Appropriate Use	Total Measures	Outcomes	PROs	Composites	Intermediate Outcomes	Patient Experience	Efficiency/ Appropriate Use
Asthma	3		1					1			1			
CAHPS/Patient Experience	2		2					0						
Cancer	23							0						
Cardiovascular Conditions	15	3		1	1			2			1			
Care Coordination	3	1						4						
CKD/ESRD	9				4			2						
COPD	2							0						
Cognitive Impairment/Dementia	9							2						
Diabetes	11			1	2			1						
Emergency Care	2							4						2
Ear, Nose, Throat/Head and Neck	7							0						
Eye Care	12	7			1	1		1						
Geriatric Care	2							0						
Gastrointestinal	6							2						
Genitourinary	1							11	3					
Hepatitis	7							1						
HIV/AIDS	7				1			0						
Hypertension	2	2						1				1		
Imaging	12						3	6	1					2
Interventional Radiology	0							3	2					
Medication Management	4							6						
Mental Health	10	1						2		1				
Multiple Chronic Conditions	1							0						
Musculoskeletal	22	5						3						
Neurologic Conditions	8							17		1				
Oral Health	2	1						0						
Pain Management	1							0						
Palliative care/End of Life	2		1					0						
Perinatal	5	1						2	2					
Population Health	20				2			10						2

	PQRS 2015							Measures Under Consideration for PQRS						
Condition/Topic Area	Total Measures	Outcomes	PROs	Composites	Intermediate Outcomes	Patient Experience	Efficiency/ Appropriate Use	Total Measures	Outcomes	PROs	Composites	Intermediate Outcomes	Patient Experience	Efficiency/ Appropriate Use
Respiratory Infections	3							0						
Skin conditions	5							2	1					
Sleep Apnea	4							0						
Stroke/TIA	3							2	2					
Substance Use	1							0						
Perioperative and Anesthesia	8	2						6	1					
Surgery – Cardiac	7	5						0						
Surgery – Colorectal	1	1						0						
Surgery – Orthopedic	4							2		2				
Surgery – Vascular	8	4			3			2	1					

Parsimony and Alignment Across Programs

MAP noted that continually adding measures to programs needs a counterbalancing effort toward assessment of overall value of the measures in the programs for public reporting and payment. The right measures should provide effective and comprehensive support for patients and be meaningful to EPs to promote quality improvement. MAP's priority on high-value measures focuses on measures that are most meaningful to patients and professionals. Greater focus on selecting composite measures, appropriate use measures and outcomes can promote greater parsimony and reduce the burden of measurement for professionals. Calls for alignment of the measures in federal programs recognize the benefits of reducing data collection and reporting burdens on clinicians and providers, avoiding confusion for audiences of the publicly reported information and promoting synergies among providers across settings.

MAP's Measure Selection Criteria and the critical program objectives for the clinician programs used to make recommendations on the measures under consideration emphasize the importance of alignment among the programs. The MAP Coordinating Committee continues to identify alignment of measures across federal programs and across public and private programs as a cross-cutting priority. The Coordinating Committee encouraged the three workgroups to consider alignment of similar measures under consideration from different settings or levels of analysis.

Clinicians must coordinate the reporting for overlapping programs sometimes with different implementation rules. In October 2014, the American Medical Association outlined the growing burden on clinicians and requested that CMS "synchronize and simplify" the requirements of the programs. The 2015 Physician Fee Schedule (PFS) final rule reflects a growing effort by CMS to align the federal quality programs for clinicians by using PQRS measures reported on by clinicians for public reporting on Physician Compare and for the quality component of the Physician Value-Based Payment Modifier. Additionally, EPs that satisfactorily report to PQRS using the EHR-based reporting option will also satisfy the Clinical Quality Measurement (CQM) component of the EHR Incentive program.

The growing use of registries suggests the possibility for greater interaction between measures for public reporting and payment and measures for quality improvement that can reinforce each other and reduce the burden of measurement.

Incentives for More Meaningful Measurement

Financial incentives for the quality measurement enterprise are often limited in scope and timeframe. There are no predictable financial supports to evolve measures from the "building blocks" to the meaningful measures desired by all. Measure developers need steady financial support and EPs must invest in infrastructure to support reporting data for measurement. CMS indicated a need for testing sites for eMeasures in development. MAP suggests that CMS could consider innovative incentives to further the enterprise such waving non-participation penalties in exchange for acting as a test site or participating in a registry. Primary care and emergency medicine physicians have not yet developed registries despite growing pressure to do so and are seeking a business case that would make a registry viable.

Considerations for Specific Programs

Physician Quality Reporting System (PQRS), Physician Compare, Physician Value-Based Payment Modifier

PQRS uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). Now in its eighth year PQRS has finalized 285 measures in the 2015 Physician Fee Schedule final rule. All PQRS measures will be used for public reporting on Physician Compare and for the quality component of the Value-Based Payment Modifier. As noted above, MAP encourages a focus on high-value measures that vary greatly by condition/topic (Table 1). CMS has identified 19 "cross-cutting measures" on the recommendation of MAP for a core set of measures that can be reported on by most EPs.

MAP's critical program objectives for PQRS:

- 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.
- To encourage widespread participation many measures are needed for the variety of EPs specialties and subspecialties.
- 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 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);
    - measure outcomes that are not already addressed by outcome measures included in the program; and
    - are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures.

More than half of the measures under consideration for PQRS are still in development. MAP encouraged the continued development of most measures with specific recommendations on developing high-value measures. MAP questioned the value of measures that are "building blocks" to more meaningful measures that require investments by EPs to comply with the measures – is this helpful in reducing burden if the measures will be replaced?

MAP identified many gaps in measurement including measures for end-of life and palliative care, geriatrics, COPD, and trauma care (increasingly important in the elderly population). Measures of diagnostic accuracy are critical because most quality measures are based on diagnosis codes. Current

measures for specific conditions are challenging for patients with multiple chronic conditions or overall frailty – focusing on improving outcomes in one condition may worsen outcomes in another.

Medicare and Medicaid EHR Incentive Programs

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. The programs promote widespread adoption of certified EHR technology by providers and incentivize "meaningful use" of EHRs to improve quality, safety, efficiency, and reduce health disparities; engage patients and family; improve care coordination, and population and public health; and maintain privacy and security of patient health information. As of September 2014, more than 414,000 healthcare providers received payment for participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The EHR Incentive Programs align with the PQRS program to allow individual EPs and groups to report electronic clinical quality measures or " eCQMs" through the PQRS portal. The programs also allow groups to report eCQMs through Pioneer ACO participation or Comprehensive Primary Care Initiative participation.

EHR measures under consideration for the current pre-rulemaking cycle are intended for Meaningful Use Stage 3. CMS has determined that the measures under consideration for the EHR Incentive Programs have been appropriately specified as eCQMs or "eMeasures" but all eCQMs are being revised to reflect recently revised standards. CMS indicates that the eCQMs under consideration for pre-rulemaking should be considered as measures under development. MAP noted that while most federal programs are focused on the Medicare population, the Medicaid EHR Incentive program also needs eMeasures applicable to children, young adults and pregnancy.

Critical program objectives for the EHR Incentive Programs include:

- Include endorsed measures that have eMeasure specifications available.
- Alignment with other federal programs, particularly PQRS.
- 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

MAP noted that the eMeasures under consideration tend to be limited by today's EHR environment reality rather than push to a system of greater interoperability and health information exchange in which measurement is readily performed without additional burden on the providers. MAP was interested in seeing more forward-thinking eMeasures for consideration.

Medicare Shared Savings Program (MSSP)

The MSSP is a pay for reporting and pay for performance for Accountable Care Organizations (ACOs) designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs. The 2015 Physician Fee Schedule reported that 53 of 204 organizations slowed spending enough to receive bonus payments. In 2013 over 125,000 eligible professionals who were ACO providers or suppliers also qualified for incentive payments from PQRS.

MAP identified the following critical program objectives for MSSP:

- Improve the overall health for a population of Medicare Fee-For-Service (FFS) beneficiaries
- 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 conditions, measures in all settings that patients receive care (including ambulatory, acute, and post-acute settings), and measures that span across settings.
- Promote alignment across other quality measurement reporting programs
- Include more high-value measures

MAP Clinician Workgroup considered 107 measures either in or under consideration for the PQRS program for suitability for the MSSP. MAP focused on broad measures applicable to the Medicare population and recommended that most condition specific measures be rolled up into composite measures to provide a broader view of the quality of care for specific conditions. MAP noted that measures that assess overuse are lacking and specifically recommended a composite measure of imaging overuse. Cross-cutting measures such as effectiveness of pain management would be appropriate for MSSP. The Clinician Workgroup noted other important gap areas, including outcome measures in general but specifically for cancer patients, measures of diagnostic accuracy, and measures of the quality/performance of screening methods (e.g., mammography, colonoscopy). MAP suggested that ACOs should report HEDIS health plan measures to align with Medicare Advantage and private health plans.