MEASURE APPLICATIONS PARTNERSHIP

Process and Approach for MAP Pre-Rulemaking Deliberations, 2015

FINAL REPORT

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NATIONAL QUALITY FORUM

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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 objectives for each program. 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 program 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. The workgroup recommendations were reviewed by the MAP Coordinating Committee in January. During its meeting, the Coordinating Committee reviewed the measure recommendations of the workgroups, as well as the public and member comments received on those recommendations. Following deliberations, the Coordinating Committee finalized MAP's recommendations for consideration by HHS. Please see attached spreadsheet for MAP's final recommendations.

MAP reviewed approximately 200 unique measures for potential inclusion in 20 federal health programs. Since several measures were considered for multiple programs, MAP made over 600 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.

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).

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.

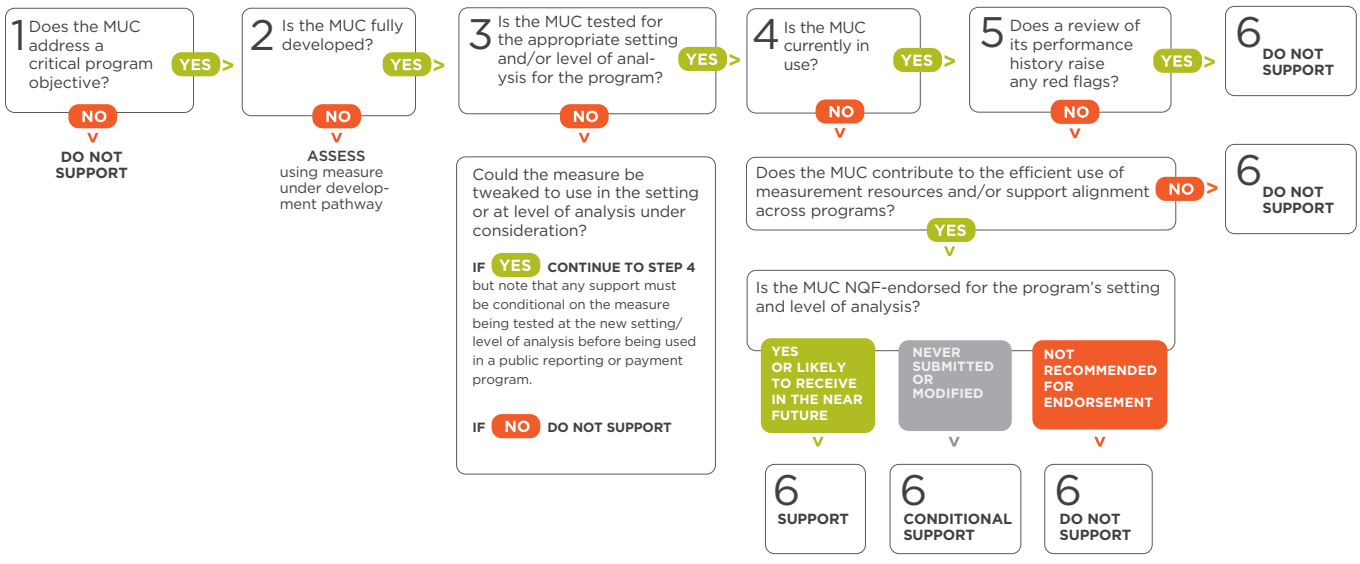
Preliminary Analysis

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 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?

For measures that are earlier in development, MAP may not have the information to answer all of the

FIGURE 1. MAP PRELIMINARY ANALYSIS ALGORITHM FOR FULLY DEVELOPED MEASURES



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?

Consent Calendar

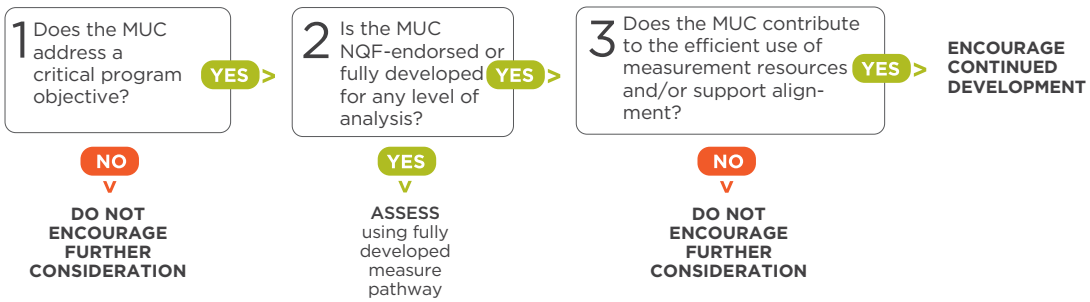
The measures were presented to the workgroups and Coordinating Committee in a consent calendar format that groups together similar measures. After being presented the set of measures, members could identify specific measures within these calendars that require further discussion. The goal was to allow 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 is reached when more than 60 percent of MAP 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 were 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.

FIGURE 2. MAP PRELIMINARY ANALYSIS ALGORITHM FOR EARLIER STAGE MEASURES



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

APPENDIX A:
Summary Information on Federal Health Programs

Medicare Shared Savings Program Summary (MSSP)

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

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

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

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

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

- Modifying the measure set (added 8 measures, retired/replaced 8) to be more outcome-oriented and reduce the reporting burden on ACOs;
- Modifying benchmarking approach for topped-out measures;
- Interest in aligning with physician programs (like Value-Based Payment Modifier and EHR incentive program);
- Finalized that CMS will award ACOs for quality improvement and that ACOs entering their second or subsequent agreement period will be assessed on the quality performance standard that would otherwise apply to an ACO if It were in the third performance year of the first agreement; and
- Sought input on (proposed rule):
  - Measures that might be used to assess the ACO's performance with respect to care coordination in post-acute care and other settings;
  - Specific caregiver experience of care measures that might be considered in future rulemaking;
  - Suggestions of new measures of the quality of care furnished to the frail elderly population; and
  - Measures/tools to assess changes in physical and mental health over time.

MAP's Suggested Critical Program Objectives
The following are proposed critical program objectives for MSSP:

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

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

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

MAP Clinician Federal Program Summaries

Physician Quality Reporting System (PQRS)

Program Type

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

Incentive Structure

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

Program Goals

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

Program Update

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

The most recent 2012 PQRS participation report reported:

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

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

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

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

  - Qualified Clinical Data Registries (QCDRs) must report at least 2 outcome measures or 1 outcome and 1 other (resource use, patient experience with care, efficiency/appropriate use or patient safety) measure; QCRDs may report up to 30 non-PQRS measures; QCRDs must public report measure results beginning in 2015 (except new measures that are not required to report in the first year)
  - Group practices of 100 or more EPs that report via PQRS must report CAHPS for PQRS GPRO

- Changes to the total number of PQRS measures:
  - Addition of 20 new individual measures and two measures groups to fill existing measure gaps;
  - Removal of 50 measures for a variety of reasons:
    - » Measure steward will no longer maintain the measure
    - » Performance rates consistently close to 100%, i.e., "topped out"
    - » Measure does not add clinical value to PQRS
    - » Measures a standard of care
    - » Evidence and guideline change
    - » Duplicative measures
  - The measures to be removed include 8 hypertension measures, 3 stroke measures, 4 back pain measures, , 4 inflammatory bowel disease measures, 3 emergency medicine measures

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

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

MAP's Suggested Critical Program Objectives

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

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

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

Program Type

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

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

Incentive Structure

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

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

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

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

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

Program Goals

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

Program Update

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

MAP's Suggested Critical Program Objectives

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

Physician Compare Initiative

Program Type

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

Incentive Structure

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

Program Goals

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

Program Update

The website was launched on December 30, 2010 providing information about Medicare physicians and other health care professionals including an indication of participation in Physician Quality Reporting System (PQRS). Public reporting of performance measure results is being employed via a phased approach. In February 2014, the first set of measure data were posted on Physician Compare. These data included a sub-set of the 2012 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) Diabetes Mellitus (DM) and Coronary Artery Disease (CAD) measures for the 66 group practices and 141 Accountable Care Organizations (ACOs) that successfully reported via the Web Interface. In late 2014, a similar subset of 2013 group-level measures will be reported. In 2015, the first individual eligible professional-level measures available for public reporting will be a sub-set of twenty 2014 PQRS measures and measures from the Cardiovascular Prevention measures group in support of the Million Hearts campaign.

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

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

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

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

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

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

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

MAP's Suggested Critical Program Objectives

- Focus on outcome measures and measures that are meaningful to consumers (i.e., have face validity) and purchasers.
- Focus on patient experience, patient-reported outcomes (e.g., functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care measures.
- Public reporting of PQRS measures for:
  - Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
  - Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
  - Therapists—physical therapist, occupational therapist, qualified speech-language therapist
  - Reporting of physicians in groups and ACOs is included.
- NQF-endorsed measures are preferred for public reporting programs over measures that are not endorsed or are in reserve status (i.e., topped out); measures that are not NQF-endorsed should be submitted for endorsement or removed.
- To generate a comprehensive picture of quality, measure results should be aggregated (e.g., composite measures), with drill-down capability for specific measure results.
- Alignment of measures in federal programs.

Medicare and Medicaid EHR Incentive Programs for Eligible Professionals

Program Type

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

Incentive Structure

The incentive structure varies by program:

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

Program Goals

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

Program Update

- The three main components of Meaningful Use:
  - The use of a certified EHR in a meaningful manner, such as e-prescribing;
  - The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and
  - The use of certified EHR technology to submit clinical quality and other measures.
- Meaningful Use Stage 2:
  - The earliest providers will demonstrate Stage 2 of meaningful use is 2014.
  - For Stage 2 (2014 and beyond): Eligible Professionals must report on 9 total clinical quality measures that cover 3 of the National Quality Strategy Domains (selected from a set of 64 clinical quality measures).
  - CMS is not requiring the submission of a core set of electronic CQMs (eCQMs). Instead, CMS has identified two recommended core sets of eCQMs—one for adults and one for children—that focus on high-priority health conditions and best-practices for care delivery.
- The program has several options that align with other programs:
  - Report individual eligible professionals' eCQMs through PQRS Portal
  - Report group's eCQMs through PQRS Portal
  - Report group's eCQMs through Pioneer ACO participation or Comprehensive Primary Care Initiative participation.
- Measures under consideration for the current pre-rulemaking cycle are for Meaningful Use Stage 3. CMS has determined that the measures under consideration (MUC) for the EHR Incentive Programs are appropriately specified as "electronic Clinical Quality Measures (eCQMs)" or "eMeasures". While some testing may have been done, the eMeasures under consideration are being revised to meeting the most recent standards and have not been used in the field. CMS agrees the eCQMs on the MUC list are "Measures Under Development".

MAP's Suggested Critical Program Objectives

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

MAP Hospital Federal Program Summaries

Ambulatory Surgical Centers Quality Reporting Program

Program Type

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

Incentive Structure

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

Program Goals

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

Program Update

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

MAP's Suggested Critical Program Objectives

- Include measures that have high impact and are meaningful to patients.
- Align measures with CMS' various quality reporting programs, particularly the Hospital Outpatient Quality Reporting program, to facilitate comparisons across care settings, and to reduce burden for facilities that participate in these programs.
- Priority measure gap areas for the ASCQR program include surgical care quality, infection rates, follow-up after procedures, complications including anesthesia related complications, cost, and patient and family engagement measures including an ASC-specific CAHPS module and patient-reported outcome measures.

Hospital-Acquired Condition (HAC) Reduction Program

Program Type

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

Incentive Structure

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

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

- FY 2017: CDC NHSN MRSA and C. difficile measures will be added to domain 2.

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

Program Goals

- Heighten awareness of HACs and eliminate the incidence of HACs that could be reasonably prevented by applying evidence-based clinical guidelines.
- Provide motivation to reduce the incidence of HACs, improve patient outcomes, and reduce the cost of care.
- Support a broader public health imperative by helping to raise awareness and action by prompting a national discussion on this important quality problem.
- Drive improvement for the care of Medicare beneficiaries, but also privately insured and Medicaid patients, through spill over benefits of improved care processes within hospitals.

Program Update

- No new measures were added in the FY 2015 IPPS/LTCH PPS rule to allow hospitals time to gain experience with the measures that were finalized in the FY 2014 IPPS/LTCH PPS rule.
- PSI-90 is currently undergoing review by NQF. AHRQ is considering the addition of three additional measures for the composite, PSI #9 Perioperative Hemorrhage or Hematoma Rate, PSI #10 Postoperative Physiologic and Metabolic Derangement Rate, and PSI #11 Postoperative Respiratory Failure Rate. CMS believes this change to be significant and will propose the change in the rulemaking process prior to requiring reporting of the revised measure.
- The CDC NHSN CLABSI and CAUTI measures also recently underwent NQF review. These measures were recommended for continued endorsement.

MAP's Suggested Critical Program Objectives

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

Hospital Value-Based Purchasing Program

Program Type

Pay for Performance

Incentive Structure

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

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

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

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

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

Program Goals

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

Program Update

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

MAP's Suggested Critical Program Objectives

- Include measures where there is a need and opportunity for improvement.
- Emphasize areas of critical importance for high performance and quality improvement, and ideally, link clinical quality and cost measures to capture value.
- NQF-endorsed measures are strongly preferred.
- Keep the program measure set parsimonious to avoid diluting the payment incentives.
- MAP identified a number of gap areas that should be addressed within the VBP program measure set, including medication errors, mental and behavioral health, emergency department throughput, a hospital's culture of safety, and patient and family engagement.

Hospital Readmission Reduction Program

Program Type

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

Incentive Structure

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

Program Goals

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

Program Update

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

arthroplasty measures was updated.

MAP's Suggested Critical Program Objectives

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

Inpatient Psychiatric Facilities Quality Reporting Program

Program Type

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

Incentive Structure

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

Program Goals

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

Program Update

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

MAP's Suggested Critical Program Objectives

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

Inpatient Quality Reporting Program (IQR)

Program Type

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

Incentive Structure

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

Program Goals

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

Program Update

- For FY 2017, CMS has finalized a total of 63 measures for the program measure set.
  - 11 new measures were added for FY 2017.
    - » These measures address coronary artery bypass graft (CABG) surgery readmissions and mortality, pneumonia and heart failure episode of care payments, severe sepsis and septic shock management, newborn screening for hearing, exclusive breast feeding, child asthma home management plan of care, and healthy term newborns.
    - » Two measures were readopted as voluntary electronic clinical quality measures to support alignment with the Medicare EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals. These measures are NQF #0142 AMI-2 Aspirin Prescribed at Discharge and NQF #0639 AMI-10 Statin Prescribed at Discharge.
  - 19 measures were removed for FY 2017. These measures were removed because they were topped out. However, to continue aligning the IQR and Medicare EHR Incentive Program, 10 measures will be retained on a voluntary basis to allow hospitals an opportunity to test the accuracy of the electronic health record reporting systems.

MAP's Suggested Critical Program Objectives

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

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

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

Program Type

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

Incentive Structure

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

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

Program Goals

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

Program Update

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

MAP's Suggested Critical Program Objectives

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

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

Hospital Outpatient Quality Reporting Program

Program Type

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

Incentive Structure

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

Program Goals

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

Program Update

- For FY 2017, CMS proposed the following measure: OP-32 Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy
- CMS proposed criteria for determining when a measure is "topped-out". Two criteria were proposed: 1) statistically indistinguishable performance at the 75th and 90th percentiles and 2) a truncated coefficient of variation less than or equal to 0.10.
- CMS proposed removal of the following measures:
  - OP-4 Aspirin on arrival
  - OP-6 Timing to Prophylactic Antibiotics
  - OP-7 Prophylactic Antibiotic Selection for Surgical Patients

MAP's Suggested Critical Program Objectives

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

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

Program Type

Reporting: Information will be publicly reported beginning in 2014.

Incentive Structure

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

Program Goals

- Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program.
- Encourage hospitals and clinicians to improve the quality of their care, to share information,

and to learn from each other's experiences and best practices

Program Update

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

MAP's Suggested Critical Program Objectives

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

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

Nursing Home Quality Initiative

Program Type:

Public Reporting

Incentive Structure

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

Program Goals

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

Program Update

None

MAP's Suggested Critical Program Objectives

Statutory Requirements

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

- Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
- Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
- Applicable PAC programs are defined as: 1) HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
- Establishes a new "SNF Quality Reporting Program" at the start of FY 2019 and directs the Secretary to reduce by 2% the update to the market basket percentage for skilled nursing facilities which do not report assessment and quality data under this program.
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
  - » New quality measures will address, at a minimum, the following domains:
    - functional status and changes in function;
    - skin integrity and changes in skin integrity;
    - medication reconciliation;
    - incidence of major falls; and
    - accurately communicating health information and care preferences when a patient is transferred
  - » Resource use measures will address the following:
    - efficiency measures to include total Medicare spending per beneficiary;
    - discharge to community; and
    - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

- The Protecting Access to Medicare Act of 2014 (PAMA)[4]:
  - Directs the Secretary to establish a skilled nursing facility value-based purchasing (SNF VBP) program under which value-based incentive payments are made in a fiscal year to skilled nursing facilities, beginning in fiscal year 2019.
    1. Readmission measure - Not later than October 1, 2015, the Secretary shall specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such a measure).
    2. Resource use measure – Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities.
  - Directs the Secretary to: (1) provide confidential feedback reports to SNFs on their performance with respect to a measure specified for this program [under paragraph (1) or (2)], beginning October 1, 2016 and every quarter thereafter; and (2) establish procedures for making available to the public by posting on the Nursing Home

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

MAP Previous Recommendation

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

Home Health Quality Reporting Program

Program Type

Pay for Reporting, Public Reporting

Incentive Structure

Medicare-certified[8] home health agencies (HHAs) are required to collect and submit the Outcome and Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.[9] Home health agencies meet their quality data reporting requirements through the submission of OASIS assessments and Home Health CAHPS. HHAs that do not submit data will receive a 2 percentage point reduction in their annual HH market basket percentage increase.[10] 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.[11]

Program Goals

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

Program Update

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

MAP's Suggested Critical Program Objectives

Statutory Requirements

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

MAP Previous Recommendation

- MAP noted that the large measure set reflects the heterogeneity of home health population; however, the measure set could be more parsimonious.[17]

Future Direction of the Program

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

Inpatient Rehabilitation Facilities Quality Reporting Program

Program Type

Pay for Reporting, Public Reporting

Incentive Structure

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

Program Goals

Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.[20]

Program Update

- IRF Prospective Payment System for Federal Fiscal Year 2015 final rule:[21]
  - For the FY 2017 adjustments to the IRF PPS annual increase factor, in addition to retaining the previously finalized measures, CMS adopted two new quality measures:
    - » Measure NQF#1717 NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (supported by MAP in the 2014 pre-rulemaking report)
    - » Measure NQF #1716 NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (conditionally supported by MAP in the 2014 pre-rulemaking report)

MAP's Suggested Critical Program Objectives

Statutory Requirements

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

3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program

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

MAP Previous Recommendation

- Program measure set is too limited and could be enhanced by addressing core measure concepts not currently addressed in the set such as care coordination, functional status, and medication reconciliation and the safety issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and C. difficile.[24]

Long-Term Care Hospitals Quality Reporting Program

Program Type

Pay for Reporting, Public Reporting

Incentive Structure

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

Program Goals

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

Program Update

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

supported by MAP in the 2014 pre-rulemaking report)

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

MAP's Suggested Critical Program Objectives

Statutory Requirements

- Measures should align with the National Quality Strategy (NQS), promote enhanced quality with regard to the priorities most relevant to LTCHs (such as patient safety, better coordination of care, and person- and family-centered care).[29]
- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[30]:
  - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
  - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
  - Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
  - Applicable PAC programs are defined as: 1) HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
  - Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
    - » New quality measures will address, at a minimum, the following domains:
      - functional status and changes in function;
      - skin integrity and changes in skin integrity;
      - medication reconciliation;
      - incidence of major falls; and
      - accurately communicating health information and care preferences when a patient is transferred
    - » Resource use measures will address the following:
      - efficiency measures to include total Medicare spending per beneficiary;
      - discharge to community; and
      - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
  - Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

MAP Previous Recommendation

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

medication management (e.g., use of antipsychotic medications), and advance directives.[33]

End Stage Renal Disease Quality Incentive Program

Program Type

Pay for Performance, Public Reporting

Incentive Structure

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

Program Goals

Improve the quality of dialysis care and produce better outcomes for beneficiaries.[36]

Program Update

- Final rule for End-Stage Renal Disease (ESRD) prospective payment system (PPS) for calendar year (CY) 2015:[37]
  - Final measure set for the PY 2017 ESRD QIP
    - » Continue using measures finalized for the PY 2016 program measure set except one measure: the Hemoglobin Greater than 12 g/dl, which CMS has finalized to remove because it is topped out.
    - » Adopt the Standardized Readmission Ratio (SRR) clinical measure, which is currently under review by NQF (NQF#2496) and addresses care coordination. MAP had supported the direction of the measure concept in the 2013 pre-rulemaking.
  - Final measure set for the PY 2018 ESRD QIP
    - » Continue using measures finalized for the PY 2017 program measure set with the exception of the ICH CAHPS reporting measure, which will be converted to a clinical measure, 0258 In-center hemodialysis CAHPS Survey.
    - » Adopt three new measures which are based on NQF-Endorsed measures that MAP supported in 2014 (NQF #0420, NQF #0418, NQF #0431). CMS is finalizing to adopt the following measures as a reporting measure until such time that they can collect the baseline data needed to score it as a clinical measure:
      - ◦ Pain Assessment and Follow-Up, a reporting measure.
      - ◦ Depression Screening and Follow-Up, a reporting measure
      - ◦ NHSN Healthcare Personnel Influenza Vaccination, a reporting measure
    - » Adopt two additional new measures including: *Percentage of pediatric peritoneal dialysis patient-months with spKt/V greater than or equal to 1.8,* which was conditionally supported by MAP in 2014, and *Standard Transfusion Ratio* which MAP had supported the direction of in the 2013 pre-rulemaking.
- Dialysis Facility Compare Star Ratings[38]
  - CMS has finalized the methodology for its Dialysis Facility Compare (DFC) Star Rating Program and is providing all Medicare-participating dialysis facilities a 15 day review period to review their data and star rating before they are posted on Dialysis Facility Compare in January 2015.
  - The DFC Star Rating is based on the following nine measures, which will be grouped into three domains for evaluation purposes:

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

MAP'S Suggested Critical Program Objectives

Statutory Requirements

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

MAP Previous Recommendation

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

Future direction of the Program

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

Hospice Quality Reporting Program

Program Type

Pay for Reporting, Public Reporting

Incentive Structure

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

Program Goals

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

Program Update

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

MAP's Suggested Critical Program Objectives

Statutory Requirements

- As of July 1, 2014, all Medicare-certified hospices are required to submit an HIS-Admission record and HIS-Discharge record for each patient admission to their hospice.[46]
  - The HIS is a patient-level data collection tool developed as part of the HQRP, which can be used to collect data to calculate 6 National Quality Forum-endorsed (NQF) Measures and 1 modified NQF Measure: [47]
    1. NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
    2. NQF #1634 Pain Screening
    3. NQF #1637 Pain Assessment
    4. NQF #1638 Dyspnea Treatment
    5. NQF #1639 Dyspnea Screening
    6. NQF #1641 Treatment Preferences
    7. Modified NQF #1647 Beliefs/Values Addressed (if desired by the patient)

MAP Previous Recommendation

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

Future Direction of the Program

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

ENDNOTES

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APPENDIX B:
MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set. The MSC have evolved over time to reflect the input of a wide variety of stakeholders.

To determine whether a measure should be considered for a specified program, the MAP evaluates the measures under consideration against the MSC. MAP members are expected to familiarize themselves with the criteria and use them to indicate their support for a measure under consideration.

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures

Subcriterion 1.1	Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
Subcriterion 1.2	Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
Subcriterion 1.3	Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

Subcriterion 2.1	Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment
Subcriterion 2.2	Healthy people/healthy communities, demonstrated by prevention and well-being
Subcriterion 2.3	Affordable care

3. Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is "fit for purpose" for the particular program

Subcriterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)

Subcriterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Subcriterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

Subcriterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

Subcriterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

4. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program

Subcriterion 4.1 In general, preference should be given to measure types that address specific program needs

Subcriterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Subcriterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

Subcriterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Subcriterion 5.2 Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives

Subcriterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

6. Program measure set includes considerations for healthcare disparities and cultural competency

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Subcriterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Subcriterion 6.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Subcriterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

Subcriterion 7.2 Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

APPENDIX C:
Measure Applications Partnership (MAP) Rosters

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