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Measure Applications Partnership 2020 Considerations for Implementing Measures in Federal Programs: Hospitals

FINAL REPORT

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Guidance on Cross-Cutting Issues

Summary

- MAP emphasized that patients and consumers value patient safety measures in public accountability programs, and facilities can improve patient safety through quality improvement programs.
- MAP discussed the importance of a system-level measurement approach to identify priorities across settings, such as transfer of health information measures and electronic clinical quality measures (eCQMs).
- MAP expressed support for the CMS Meaningful Measures Initiative: MAP recommended priority gaps to consider and monitoring for the shift of services traditionally delivered in the hospital into ambulatory settings.

The Measure Applications Partnership (MAP) Hospital Workgroup reviewed six measures under consideration (MUC) for four hospital and setting-specific programs:

- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid EHR Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs)
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)

The following five programs did not have measures under consideration during this year's pre-rulemaking cycle:

- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Outpatient Quality Reporting (OQR)
- Hospital Value-Based Purchasing (VBP)

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

Overarching Themes

Patient Safety

MAP highlighted the importance of patient safety measures for each of the hospital and setting-specific program discussions. Patient safety-related events occur across healthcare settings and include healthcare-associated infections, medication errors, and other potentially avoidable events. The measures considered by MAP spanned a variety of patient safety topic areas, including preventable infection, preventable blood transfusion, reducing maternal morbidity, reducing hyperglycemia events,

and preventing harm through follow-up post-discharge. MAP emphasized that patients and consumers value patient safety measures in public accountability programs, and facilities can improve patient safety through quality improvement programs. Even for measures MAP considered this cycle but ultimately did not support, MAP members stressed the importance of each overall patient safety quality concept and the quality improvement activities that the measure would encourage.

MAP observed that although the healthcare industry has made major improvements in measuring and addressing patient harms, tens of thousands of patients still suffer preventable injuries each year, and many of these harms have dire consequences. Proactively addressing patient safety will protect patients from harm and lead to more affordable, effective, and equitable care. NQF has previously endorsed over 100 performance measures related to patient safety, and many of these measures are in use. However, MAP noted patient safety measurement gaps within each of the programs.

System View of Measurement Across Settings

MAP discussed using a system-level measurement approach to capture the patient episode of care, identify priorities in measurement across settings, and determine the appropriate accountable entity and setting. Measures specified for a single care setting that address system-level issues with shared accountability—such as follow-up visits and transitions of care—pose challenges in determining which entity that should be measured and how. MAP concluded that while it is necessary to review measures using a setting-specific approach, there is also a need to examine measures from a system-level perspective.

MAP noted that a system-level approach also requires the transfer of health information and use of electronic clinical quality measures (eCQMs). MAP supported CMS's efforts to drive towards eCQMs and cited eCQMs as one tool to assist in the reduction of measurement burden. MAP noted that a significant portion of measurement burden comes from reporting different versions of the same measure for different payers. MAP added that using similar data sources and standards framework such as the Fast Healthcare Interoperability Resources (FHIR) standard to establish consistency in data formats and elements would potentially alleviate this issue. MAP noted that a system-level approach would also align more closely with the patient's experience with the healthcare system.

Meaningful Measures Initiative Considerations for Hospitals

MAP provided feedback to CMS's proposed changes on the Meaningful Measures Initiative.

MAP reviewed 19 priority areas within the Meaningful Measures Initiative and encouraged CMS to further narrow focus to the nation's highest priority areas. MAP encouraged CMS to include in their considerations how and why they are prioritizing certain areas over others, as well as the rationale for why changes occur within Meaningful Measures. MAP recommended CMS consider several important priorities across programs and settings, including workforce availability, provider burnout, licensure expansions and standardization across states, staffing standards, and training. Specialty care was identified as a potential gap in the priority areas for Meaningful Measurement. Other gaps included changes in functional status measures, measures that improve the usability and safety of EHRs, behavioral health measures beyond concerns of opioids, and measures discouraging the provision of low-value care.

MAP highlighted the shift of services traditionally delivered in the hospital into ambulatory settings, such as surgeries and other high-risk services. MAP encouraged CMS to consider if care is being appropriately moved and to standardize cost and quality measures across settings. MAP emphasized that the discussion of the measures should be considered as part of [measure sets and systems](#), with each measure considered in relation to the others and the context in which they are used. MAP also applauded the cascading of measure accountability and stressed considering the patient first to allow for comparison of quality for care providers.

MAP supported CMS's general move toward eQMs and encouraged CMS to engage with EHR vendors early in the measure development process. MAP also applauded CMS's efforts to standardize the measures deployed across payers and across quality programs. Finally, MAP was encouraged by CMS's effort to update public facing measurement websites like Hospital Compare with a more user-friendly interface and language that resonates with consumers and patients.

Considerations for Specific Programs

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

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

MAP considered one measure for ESRD QIP, MUC2019-64 Standardized Transfusion Ratio for Dialysis Facilities. The measure calculates a risk-adjusted standardized transfusion ration (STrR) for each dialysis facility specified for all adult dialysis patients. It is a ratio of the number of eligible red blood cell transfusion events observed in patients dialyzing at a facility, to the number of eligible transfusion events that would be expected under a national norm, after accounting for the patient characteristics within each facility.

This measure is based on an existing NQF endorsed measure currently in use within ESRD QIP. There are two significant differences between the current NQF-endorsed STrR specifications used on Dialysis Facility Compare and in QIP PY2021 and the proposed specifications submitted. First, for hospital inpatients, the current NQF endorsed STrR relies on a restricted transfusion identification algorithm. The measure utilizes only those reported transfusion events that include ICD procedure codes, ICD procedure codes with revenue center codes, or value codes. For the proposed revision to STrR, inpatient transfusion events are identified using on a broader definition that includes revenue center codes only, ICD10 procedure codes (alone or with revenue codes), or value codes alone or in combination. The measure developer pointed out that the proposed revision results in identification of a greater number of inpatient transfusion events compared to the currently implemented STrR.

Second, the current NQF-endorsed STrR includes all Medicare patients, including those with Medicare Advantage coverage, that meet inclusion criteria based on the presence of Medicare claims activity reflected as \$900 or greater in dialysis paid claims in a month or recent inpatient hospitalization. The proposed STrR revision uses similar criteria but excludes all Medicare Advantage patients from both the measure numerator and denominator. This proposed change aims to mitigate potential bias associated

with inclusion of Medicare Advantage patients. The bias derives from the absence of complete outpatient claims data for Medicare Advantage patients, severely limiting the identification of outpatient transfusion events for these individuals.

MAP conditionally supported MUC2019-64 for rulemaking, pending NQF endorsement of the revised measure specifications. MAP noted that the measure is based on an endorsed measure (NQF 2979) that was implemented in ESRD QIP, but with some modifications to the specifications. MAP considered the updates to the measure to be both appropriate and necessary. MAP noted that this measure is for reporting purposes only and is not used for payment.

MAP noted that this updated and re-specified claims-based outcome measure has been submitted for endorsement consideration to the NQF Renal Standing Committee for the fall 2019 review cycle. MAP noted that Medicare Advantage will include dialysis in 2021, which may impact which beneficiaries stay in their home to receive dialysis and which beneficiaries go to facilities.

The MAP Rural Health Workgroup noted that ESRD is a condition that afflicts many rural residents and this measure would be an important for them. Rural patients may be diagnosed late in the course of illness and thus be more likely to need dialysis.

In consideration of measure gaps, MAP noted that all of the ESRD patient experience measures are composites, and MAP suggested that In-Center Hemodialysis (ICH) CAHPS questions could be broken out and reported separately. MAP also called on CMS to consider how to include more specific patient safety measures beyond the generic question included in CAHPS as well as functional status and quality of life measures, especially given the slated changes in payment policy related to dialysis coverage through Medicare Advantage.

Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs)

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

MAP considered two measures for potential inclusion in IQR:

- MUC2019-26 Hospital Harm – Severe Hyperglycemia
- MUC2019-114 Maternal Morbidity

MAP Decision: Conditional Support for Rulemaking

MAP considered MUC2019-26 *Hospital Harm – Severe Hyperglycemia* for the Inpatient Quality Reporting Program. MUC2019-26 assesses the proportion of hospital days with a severe hyperglycemic event for hospitalized patients 18 or older who have a diagnosis of diabetes mellitus, have received at least one

administration of insulin or an anti-diabetic medication during the hospital admission, or have had an elevated blood glucose level (>200 mg/dL) during their hospital admission.

MAP offered conditional support for MUC2019-26 Hospital Harm – Severe Hyperglycemia, pending NQF endorsement of the measure. IQR currently does not include a measure that assesses severe hyperglycemia events that are largely avoidable through proper glycemic monitoring and intervention. MAP expressed concern and encouraged CMS to consider the unintended consequence that this measure may lead to increases in hypoglycemia, which was regarded as a more serious issue. The Rural Health Workgroup noted that diabetes rates are high in rural settings, and the measure addresses a preventable patient safety issue that is relevant for rural populations. The Rural Health Workgroup expressed concern that if glucose levels are derived from laboratory data (rather than at point of care), they may be more difficult to obtain and/or incorporate into EHR systems in rural hospitals. They also were concerned that EHR systems in rural hospitals may not be as robust or current, making it more difficult to compute the measure (e.g., using RxNORM). Finally, MAP generally agreed that the measure did not carry any significant implementation burden.

MAP noted that the measure has been submitted for NQF review for endorsement to the NQF Patient Safety Standing Committee in the Fall 2019 cycle as NQF 3533. MAP encouraged the NQF Standing Committee to consider the public comments related to feasibility, complexity of the numerator, and appropriateness to general inpatient population compared to at-risk ICU and surgical populations. MAP also noted that during the last MAP cycle, a hypoglycemia measure was discussed, during which time MAP suggested that there should be a balancing measure to address potential hyperglycemia. MAP offered supportive comments on how the two measures could potentially be paired to provide an appropriate balance. CMS expressed their intent to ultimately create an electronic composite measure of harm to include both hyperglycemia and hypoglycemia.

MAP also considered MUC2019-114 Maternal Morbidity for the Inpatient Quality Reporting Program. This measure is a structural measure to address severe maternal morbidity in the inpatient hospital setting. MUC2019-114 consists of one question attestation: “Does your hospital or health system participate in a Statewide and/or National Perinatal Quality Improvement Collaborative Program aimed at improving maternal outcomes during inpatient labor, delivery and post-partum care, and has implemented patient safety practices or bundles to address complications, including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis?”. The three response options are: yes; no; or N/A (our hospital does not provide inpatient labor and delivery care).

MAP conditionally supported MUC2019-114 Maternal Morbidity for rulemaking. The conditions identified by MAP include adjusting the language of the attestation question to clarify that the hospital is expected both to attest to participation in a quality improvement initiative as well as to implement patient safety practices or bundles to address complications. MAP included an additional condition that CMS allow multi-hospital quality improvement collaborative participation, in addition to Statewide or National collaboratives to account for programs sponsored by large health systems. Lastly, MAP added a condition that the Maternal Morbidity measure should go through the NQF endorsement process and receive endorsement. MAP underscored that maternal morbidity is increasing at an alarming rate in the U.S., nearly doubling in the last decade. With no quality measures that address maternal morbidity, MAP strongly supported CMS’s attempts to address this healthcare crisis through measurement.

Finally, the Rural Health Workgroup noted a concern that not all rural critical access hospitals would be able to participate in a state quality improvement (QI) collaborative. MAP noted that this is balanced by the universal availability of national-level QI programs.

MAP also encouraged CMS to require naming the specific QI program as well as attestation of participation. Further, MAP suggested that CMS review current participation rates to ensure the measure is not already topped out. MAP felt that the attestation alone would not be a good long-term solution, suggesting that the attestation itself was not especially meaningful. MAP supported CMS's statement within the submission that this measure will eventually be replaced by a more comprehensive maternal morbidity outcome measure but acknowledged that the data to support this outcome measure may not currently be sufficiently robust.

During the discussion around program measure gaps, MAP suggested the IQR program would benefit from additional care transitions measures as well as enhanced measures of preventable healthcare harm such as the *PSI 90* composite (NQF 0531). MAP encouraged the development of Medicare spending per beneficiary measures for conditions that align with CMS mortality and readmission measures. MAP also stressed that the program would benefit from additional patient safety measures as well as measures on engagement of patients and families and transfer of information across care settings.

Inpatient Psychiatric Facility Quality Reporting (IPFQR)

The Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) program is a pay for reporting program. The program's goal is to provide consumers with quality-of-care information to make informed decisions about healthcare options and to encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware of and reporting on best practices.

MAP considered a single measure for potential inclusion in the IPFQR program, MUC2019-22 Follow-Up After Psychiatric Hospitalization. This measure assesses the percentage of inpatient discharges with principal diagnoses of select mental illness or substance use disorders (SUD) for which the patient received a follow-up visit for treatment of mental illness or SUD. Two rates are reported, namely the percentage of discharges for which the patient received follow-up within 7 days of discharge—and the percentage of discharges for which the patient received follow-up within 30 days of discharge.

MAP conditionally supported MUC2019-22 for rulemaking pending NQF endorsement. MAP noted that this measure is an expansion of the existing NQF 0576 Inpatient Psychiatric Facility Quality Reporting Program Follow-Up After Hospitalization for Mental Illness measure, broadening the measure population to include patients hospitalized for drug and alcohol disorders as those patients also require follow-up care post-discharge. MAP noted the importance of robust care transitions for this expanded population but also identified several concerns with the proposed measure. MAP expressed concern that the numerator requires patients to pursue follow-up care and may not reflect whether follow-up care has been arranged by the hospital being measured; this was counterbalanced by other MAP members stating that hospitals can have an important role in ensuring patients keep their follow-up care appointments. MAP noted that the Stark Law may limit the ability for hospitals and care managers to ensure necessary SUD treatment follow-up after hospitalization, given the limited number of SUD providers. MAP members were also concerned that patients may not have access to appropriate SUD outpatient follow-up care. MAP was also concerned that the same evidence base for drug and alcohol

disorders as was provided for other behavioral health conditions may not be present. MAP members noted the importance of telehealth follow-up as a critical tool and the importance of including these visit types in the measure. CMS noted that telehealth is currently billable in a limited fashion, only if it is submitted with a GT modifier. Finally, several members noted that the evidence base for this measure needs to be specific to the conditions of interest and argued that the expanded SUD population should be measured separately from the patients with mental illness. By examining the two populations separately, CMS would acknowledge the two different provider groups that the hospital would be coordinating with and also help to illuminate potential workforce challenges limiting follow-up care for patients seeking SUD treatment. The MAP Rural Health Workgroup viewed this measure as appropriate, as SUD and mental health issues impact many rural residents, but the MAP Rural Workgroup expressed concern about access to care, recommending telehealth follow-up as a potential solution and harmonization with the NCQA HEDIS measure.

During the discussion on measure gaps, MAP suggested that CMS identify measurement priorities for patient populations within units for inpatient psychiatric facilities, specifically geriatric units.

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

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

MAP reviewed two measures for potential inclusion in PCHQR:

- MUC2019-18 National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure
- MUC2019-19 National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection Outcome Measure

MAP Decision: Support for Rulemaking

MAP considered MUC2019-18 National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure for the Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) program. The Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (UTI) will be calculated among patients in bedded inpatient care locations, except level II or level III neonatal intensive care units.

MAP supported MUC2019-18 for rulemaking. A prior version of this measure is currently included in PCHQR and addresses the Meaningful Measure Area of healthcare-associated infections. The risk-adjustment model for this measure was updated, and the measure was submitted and re-endorsed by the NQF Patient Safety Standing Committee in the Spring 2019 cycle. The measure is otherwise identical to the existing measure in PCHQR. MAP also noted the importance of comparing cancer hospitals to like hospitals given the differences in the patient populations. The Rural Health Workgroup noted that the 11 PPS-exempt cancer hospitals in the program are in urban centers, but rural patients often use them, and expressed support of MUC2019-18. MAP supported the continued use of this measure in PCHQR with the updated specifications.

MAP encouraged the NQF Patient Safety Standing Committee to review the appropriateness of this measure for spinal cord injury patients, for whom continual use of a catheter may be warranted. Further, MAP expressed caution that the patient populations inside of cancer hospitals have a greater propensity to be immunocompromised, implying that comparisons between other types of hospitals with cancer hospitals would not be appropriate; rates in cancer hospitals were noted to trend higher.

MAP also considered MUC2019-19 National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection Outcome Measure for the PCHQR program. The measure reports the Standardized Infection Ratio (SIR) and Adjusted Ranking Metric (ARM) of healthcare-associated, central line-associated bloodstream infections (CLABSI) among patients in bedded inpatient care locations.

MAP supported MUC2019-19 for rulemaking. MAP noted that MUC2019-19 is an updated version of the existing measure in PCHQR (NQF 0139). The risk-adjustment model for this measure was updated, and the measure was submitted and re-endorsed by the NQF Patient Safety Standing Committee in the Spring 2019 cycle. MAP noted that this measure is also otherwise identical to the existing measure in PCHQR. MAP noted that CLABSIs are associated with significant morbidity, mortality, and costs. Patients in ICUs are at an increased risk for CLABSI because 48 percent of ICU patients have indwelling central venous catheters, accounting for 15 million central line days per year in U.S. MAP encouraged CMS and Centers for Disease Control and Prevention (CDC) to review if there are patient-specific traits that lead to higher rates of CLABSI within cancer hospitals. The Rural Health Workgroup also noted that the 11 cancer hospitals in the program are in urban centers, but rural patients often use them, and the Workgroup expressed support of MUC2019-19.

MAP noted a gap in measures within PCHQR regarding patient-reported outcomes for functional outcomes and quality of life, access to care, and survival. It was also noted that measures are needed to ensure smooth transitions between care settings, especially hospice. MAP also noted the need for measures that encourage the move from standardized approaches within cancer care to increased adoption of personalized medicine and pharmacogenomic testing. MAP encouraged CMS to continue partnerships with existing cancer registries to gather data for future measurement.

Ambulatory Surgical Center Quality Reporting (ASCQR)

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

MAP did not evaluate any measures for ASCQR during this MAP cycle, but they suggested infection-related measures, metrics that establish the quality and safety of procedures within ambulatory surgery centers previously done in hospital inpatient and outpatient settings, medication safety measures with an emphasis on opioid prescribing and stewardship, and measures of patient-reported outcomes with an emphasis on functional status.

Hospital-Acquired Condition (HAC) Reduction Program

The Hospital-Acquired Condition (HAC) Reduction Program is a pay for reporting and public reporting initiative. The incentive structure results in the worst performing 25 percent of hospitals in the program (as determined by the measures in the program) having their Medicare payments reduced by 1.0 percent. The goals of the program are to encourage hospitals to reduce HACs through penalties and to link Medicare payments to healthcare quality in the inpatient hospital setting.

There were no measures for consideration for the MAP during this cycle for the HAC program. MAP did not identify any specific measure gaps but included comments related to the risk adjustment model for HAC quality measure. Specifically, MAP noted concern that the risk adjustment model may unfairly penalize hospitals that have more reliable results by using the national average to impute the hospital score for those with smaller case volume. It was also mentioned that naloxone prescription is not always an indicator that there has been harm but may be appropriate prescribing.

Hospital Readmissions Reduction Program (HRRP)

This program is a pay for performance and public reporting quality program. The incentive structure is such that the Medicare fee-for-service (FFS) base operating diagnosis-related group payment rates for hospitals with excess readmissions are reduced up to 3 percent per year. The stated program goals are to reduce excess readmissions in acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), which includes more than three-quarters of all hospitals, and to encourage hospitals to improve communication and care coordination efforts to better engage patients and caregivers, with respect to post-discharge planning.

The 2019 MUC list did not contain any potential HRRP measures for MAP to review. In the discussion of gaps for this measure set, MAP suggested evaluating seven-day readmission rates rather than 30-day rates. MAP suggested that there was an issue with attribution, namely that 30-day measures may not reflect just the performance of the hospital, but a combination of hospital and community care. MAP noted that some of the measures have been in the program a long time and may have topped out. They called on CMS to examine which measures may have outlived their usefulness. MAP also encouraged CMS to explore the potential interaction between mortality and readmissions, particularly for patients with heart failure.

Hospital Outpatient Quality Reporting (OQR)

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

There were no measures under consideration for OQR this cycle. MAP did not specify any measure gaps for the program during their discussion.

Hospital Value-Based Purchasing (VBP)

The Hospital Value-Based Purchasing Program is a pay for performance program. The incentive structure of the program is funded by reducing participating hospitals' base operating Medicare severity

diagnosis-related group payments by an estimated 2 percent. The sum total amount of those reductions is then redistributed to hospitals based on their total performance scores that they earn for the year based on their performance on quality and resource use measures. What hospitals earn depends on the range and distribution of all eligible hospitals' scores for a given year. It is possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that year. The program goals are to improve healthcare quality by realigning hospitals' financial incentives and to provide incentive payments to hospitals that meet or exceed performance standards.

Hospital VBP had no measures for consideration during this cycle. In MAP dialogue on measure gaps, it was noted that Hospital VBP is a subset of IQR measures. MAP suggested the IQR program would benefit from additional care transitions measures as well as enhanced measures of preventable healthcare harm such as the *PSI-90* composite (NQF 0531). MAP also emphasized making measures more actionable for Hospital VBP, such as by reporting CAHPS scores by unit, and by reporting Medicare spending per beneficiary for conditions that match CMS mortality and readmission measures.

Appendix A: Program Summaries

The material in this appendix was extracted from the [CMS Program Specific Measure Priorities and Needs document](#), which was released in April 2019, as well as the CMS website.

Ambulatory Surgical Center Quality Reporting (ASCQR)

Program History and Structure

The Ambulatory Surgical Center Quality Reporting Program (ASCQR) was established under the authority provided by Section 109(b) of the Medicare Improvements and Extension Act of 2006, Division B, Title I of the Tax Relief and Health Care Act (TRHCA) of 2006. The statute provides the authority for requiring ASCs paid under the ASC fee schedule (ASCFS) to report on process, structure, outcomes, patient experience of care, efficiency, and costs of care measures. ASCs receive a 2.0 percentage point payment penalty to their ASCFS annual payment update for not meeting program requirements. CMS implemented this program so that payment determinations were effective beginning with the Calendar Year (CY) 2014 payment update.

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

Program History and Structure

For more than 30 years, monitoring the quality of care provided to end-stage renal disease (ESRD) patients by dialysis facilities has been an important component of the Medicare ESRD payment system. The ESRD quality incentive program (QIP) is the most recent step in fostering improved patient outcomes by establishing incentives for dialysis facilities to meet or exceed performance standards established by CMS. The ESRD QIP is authorized by section 1881(h) of the Social Security Act, which was added by section 153(c) of Medicare Improvements for Patients and Providers (MIPPA) Act (the Act). CMS established the ESRD QIP for Payment Year (PY) 2012, the initial year of the program in which payment reductions were applied, in two rules published in the Federal Register on August 12, 2010, and January 5, 2011 (75 FR 49030 and 76 FR 628, respectively). Subsequently, CMS published rules in the Federal Register detailing the QIP requirements for PY 2013 through FY 2016. Most recently, CMS published a rule on November 6, 2014 in the Federal Register (79 FR 66119), providing the ESRD QIP requirements for PY2017 and PY 2018, with the intention of providing an additional year between finalization of the rule and implementation in future rules.

Section 1881(h) of the Act requires the Secretary to establish an ESRD QIP by (i) selecting measures; (ii) establishing the performance standards that apply to the individual measures; (iii) specifying a performance period with respect to a year; (iv) developing a methodology for assessing the total performance of each facility based on the performance standards with respect to the measures for a performance period; and (v) applying an appropriate payment reduction to facilities that do not meet or exceed the established Total Performance Score (TPS).

Hospital Acquired Condition Reduction Program (HACRP)

Program History and Structure

Section 3008 of the Patient Protection and Affordable Care Act of 2010 (ACA) established the Hospital-Acquired Condition Reduction Program (HACRP). Codified under Section 1886(p) of the Social Security Act (the Act), the HACRP provides an incentive for hospitals to reduce the number of HACs. Effective

Fiscal Year (FY) 2014 and beyond, the HACRP requires the Secretary to make payment adjustments to applicable hospitals that rank in the top quartile of all subsection (d) hospitals relative to a national average of HACs acquired during an applicable hospital stay. HACs include a condition identified in subsection 1886(d)(4)(D)(iv) of the Act and any other condition determined appropriate by the Secretary. Section 1886(p)(6)(C) of the Act requires the HAC information be posted on the Hospital Compare website.

CMS finalized in the FY 2014 IPPS/LTCH PPS final rule that hospitals will be scored using a Total HAC Score based on measures categorized into two (2) domains of care, each with a different set of measures. Domain 1 consists of Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI), and Domain 2 consists of Hospital Associated Infections (HAI) as collected by the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). Both domains of the HAC Reduction Program are categorized under the National Quality Strategy (NQS) priority of "Making Care Safer." The Total HAC Score is the sum of the two weighted domain scores, with Domain 1 weighted at 15% and Domain 2 weighted at 85%.

[Hospital Inpatient Quality Reporting \(IQR\) Program and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals \(CAHs\)](#)

Program History and Structure

The Hospital Inpatient Quality Reporting (IQR) Program was established by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and expanded by the Deficit Reduction Act of 2005. The program requires hospitals paid under the Inpatient Prospective Payment System (IPPS) to report on process, structure, outcomes, patient perspectives on care, efficiency, and costs of care measures. Hospitals that fail to meet the requirements of the HIQR will result in a reduction of one-fourth to their fiscal year IPPS annual payment update (the annual payment update includes inflation in costs of goods and services used by hospitals in treating Medicare patients). Hospitals that choose to not participate in the program receive a reduction by that same amount. Hospitals not included in the HIQR, such as critical access hospitals and hospitals located in Puerto Rico and the U.S. Territories, are permitted to participate in voluntary quality reporting. Performance of quality measures are publicly reported on the CMS Hospital Compare website.

The American Recovery and Reinvestment Act of 2009 amended Titles XVIII and XIX of the Social Security Act to authorize incentive payments to eligible hospitals (EHs) and critical access hospitals (CAHs) that participate in the EHR Incentive Program, to promote the adoption and meaningful use of certified electronic health record (EHR) technology (CEHRT). EHs and CAHs are required to report on electronically-specified clinical quality measures (eCQMs) using CEHRT in order to qualify for incentive payments under the Medicare and Medicaid EHR Incentive Programs. All EHR Incentive Program requirements related to eCQM reporting will be addressed in IPPS rulemaking including, but not limited to, new program requirements, reporting requirements, reporting and submission periods, reporting methods, alignment efforts between the HIQR and the Medicare EHR Incentive Program for EHs and CAHs, and information regarding the eCQMs.

Hospital Outpatient Quality Reporting (OQR)

Program History and Structure

The Hospital Outpatient Quality Reporting Program (OQR) is a pay for quality data reporting program implemented by CMS for outpatient hospital services. The OQR Program was mandated by the Tax Relief and Health Care Act of 2006, which requires subsection (d) hospitals to submit data on measures on the quality of care furnished by hospitals in outpatient settings. Measures of quality may be of various types, including those of process, structure, outcome, and efficiency.

Under the OQR Program, hospitals must meet administrative, data collection and submission, validation, and publication requirements, or receive a 2 percent reduction in payment for failing to meet these requirements, by applying a reporting factor of 0.980 to the Outpatient Prospective Payment System (OPPS) payments and copayments for all applicable services.

Hospital Readmissions Reduction Program (HRRP)

Program History and Structure

Section 3025 of the Patient Protection and Affordable Care Act of 2010 (ACA) established the Hospital Readmissions Reduction Program (HRRP). Codified under Section 1886(q) of the Social Security Act (the Act), the HRRP provides an incentive for hospitals to reduce the number of excess readmissions that occur in their settings. Effective Fiscal Year (FY) 2012 and beyond, the HRRP requires the Secretary to establish readmission measures for applicable conditions and to calculate an excess readmission ratio for each applicable condition, which will be used to determine a payment adjustment to those hospitals with excess readmissions. A readmission is defined as an admission to an acute care hospital within 30 days of a discharge from the same or another acute care hospital. A hospital's excess readmission ratio measures a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. Applicable conditions in the FY 2017 HRRP program currently include measures for acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, elective total knee and total hip arthroplasty, and coronary artery bypass graft surgery. Planned readmissions are excluded from the excess readmission calculation.

Hospital Value-Based Purchasing (VBP)

Program History and Structure

The Hospital Value-Based Purchasing (VBP) Program was established by Section 3001(a) of the Affordable Care Act, under which value-based incentive payments are made each fiscal year to hospitals meeting performance standards established for a performance period for such fiscal year. The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. In addition, measures of five conditions (acute myocardial infarction, pneumonia, heart failure, surgeries, and healthcare-associated infections), the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and efficiency measures must be included. Measures are eligible for adoption in the Hospital VBP Program based on the statutory requirements, including specification under the Hospital Inpatient Quality Reporting (HIQR) Program and posting dates on the Hospital Compare website.

Inpatient Psychiatric Facilities Quality Reporting (IPFQR)

Program History and Structure

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program was established by Section 1886(s)(4) of the Social Security Act, as added by sections 3401(f)(4) and 10322(a) of the Patient Protection and Affordable Care Act. Under current regulations, the program requires participating inpatient psychiatric facilities (IPFs) to report on 16 quality measures or face a 2.0 percentage point reduction to their annual update. Reporting on these measures apply to payment determinations for Fiscal Year (FY) 2017 and beyond.

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

Program History and Structure

The Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program was mandated by Section 3005 of the Patient Protection and Affordable Care Act. The PCHQR program is intended to equip consumers with quality-of-care information to make more informed decisions about healthcare options. It is also intended to encourage hospitals and clinicians to improve the quality of inpatient care provided to Medicare beneficiaries by ensuring that providers are aware of and reporting on best practices for their respective facilities and type of care.

To meet the PCHQR Program requirements, PPS-Exempt Cancer Hospitals (PCHs) are required to submit all quality measures to the Centers for Medicare & Medicaid Services (CMS), beginning with the Fiscal Year (FY) 2014 payment determination year. Participating facilities must comply with the program requirements set forth, including public reporting of the measure rates.

Appendix B: MAP Hospital Workgroup Roster and NQF Staff

WORKGROUP CHAIRS (VOTING)

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R. Sean Morrison, MD (Co-chair)

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