

**2016 Measures under Consideration List**

**Program-Specific Measure Priorities and Needs**

**Centers for Medicare and Medicaid Services**

**Center for Clinical Standards and Quality**

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## Measure Selection Requirements for CMS Quality Initiatives

CMS quality initiative programs have identified requirements for selecting measures for future reporting years. In order for measures to be selected, all of the following requirements identified in Section 1 and 2 below, must be met, in addition to program-specific requirements identified in each program description.

### 1. Measure Information Requirements

- a. Title
- b. Numerator
- c. Denominator
- d. Exclusions
- e. Measure Steward
- f. Link to full specifications
- g. Established mechanism for data collection (e.g., CDC NHSN, AHRQ HCAHPS)

In addition to the aforementioned requirements, electronically specified clinical quality measures (eCQMs) require the following information:

- h. Electronic specifications for eCQMs
- i. Link to full electronic specifications for eCQMs

### 2. Measure Requirements

- a. Measure is responsive to specific program goals and statutory requirements.
- b. Measure addresses an important condition/topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure when implemented can lead to the desired outcomes and/or more affordable care (i.e., NQF's Importance criteria).
- c. Measure addresses one or more of the six National Quality Strategy (NQS) priorities.
- d. Measure selection promotes alignment with CMS program attributes and across HHS programs.
- e. Measure reporting is feasible and measures have been fully developed and tested. In essence, measures must be tested for reliability and validity.
- f. Measure results and performance should identify opportunities for improvement. CMS will not select measures in which evidence already identifies high levels of performance with little opportunity for improvement, e.g. measures that are "topped out."
- g. Potential use of the measure in a program does not result in negative unintended consequences (e.g., reduced lengths of stay, overuse or inappropriate use of care or treatment, limiting access to care).
- h. Measures should not duplicate other measures currently implemented in programs.
- i. Feasibility testing must be conducted for eCQMs.

## End-Stage Renal Disease Quality Incentive Program

### 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).

### Current Program Measure Information:

The following is a table detailing the number of ESRD QIP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed for the ESRD QIP.

NQS Primary Measure Domain	Number of Measures in ESRD QIP	
	Implemented/Finalized *	Proposed**
Effective Prevention and Treatment	12	TBD
Making Care Safer	2	TBD
Communication/Care Coordination	1	TBD
Best Practice of Healthy Living	0	TBD
Making Care Affordable	0	TBD
Patient and Family Engagement	1	TBD

*\*Implemented: Quality measures implemented for data collection.*

*\*\*Proposed: Quality measures proposed for data collection. The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.*

### **High Priority Domains for Future Measure Consideration:**

CMS identified the following 3 domains as high-priority for future measure consideration:

1. **Care Coordination:** ESRD patients constitute a vulnerable population that depends on a large quantity and variety medication and frequent utilization of multiple providers, suggesting medication reconciliation is a critical issue. Dialysis facilities also play a substantial role in preparing dialysis patients for kidney transplants, and coordination of dialysis-related services among transient patients has consequences for a non-trivial proportion of the ESRD dialysis population.
2. **Safety:** ESRD patients are frequently immune-compromised, and experience high rates of blood stream infections, vascular access-related infections, and mortality. Additionally, some medications provided to treat ESRD patients may cause harmful side effects such as heart disease and a dynamic bone disease. Recently, oral-only medications were excluded from the bundle payment, increasing need for quality measures that protect against overutilization of oral-only medications.
3. **Patient- and Caregiver-Centered Experience of Care:** Sustaining and recovering patient quality of life was among the original goals of the Medicare ESRD QIP. This includes such issues as physical function, independence, and cognition. Quality of Life measures should also consider the life goals of the particular patient where feasible, to the point of including Patient-Reported Outcomes.
4. **Access to Transplantation:** Obtaining a transplant is an extended process for dialysis patients, including education, referral, waitlisting, transplantation, and follow-up care. The care and information available from dialysis facilities are integral to the process. Complicating the issue of attribution are the role of transplant facilities in setting criteria and making decisions about transplant candidates and the limited availability of donor organs. Measures for the ESRD QIP must balance the role of the facility and other providers with the need to make transplants accessible to as many candidate recipients as possible.

### **Measure Requirements**

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

## **Inpatient Rehabilitation Facility Quality Reporting Program**

### **Program History and Structure:**

The Quality Reporting Program (QRP) for Inpatient Rehabilitation Facilities (IRFs) was established in accordance with section 1886(j) of the Social Security Act as amended by section 3004(b) of the Affordable Care Act. The IRF QRP applies to all IRF facilities that receive the IRF PPS (e.g., IRF hospitals, IRF units that are co-located with affiliated acute care facilities, and IRF units affiliated with critical access hospitals [CAHs]). Data sources for IRF QRP measures include Medicare FFS claims, the Center for Disease Control's National Health Safety Network (CDC NHSN) data submissions, and Inpatient Rehabilitation Facility - Patient Assessment instrument (IRF-PAI) records. The IRF QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2014, IRFs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable IRF Prospective Payment System (PPS) payment update. Plans for future public reporting of IRF QRP measures are under development.

Further, the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) to report standardized patient assessment data, data on quality measures including resource use measures. The development of standardized data stems from specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers.

The IMPACT Act requires CMS to develop and implement quality measures from five measure domains: functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; and the transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings. The IMPACT Act also delineates the implementation of resource use and other measures in at least these following domains: total estimated Medicare spending per beneficiary; discharge to the community; and all condition risk adjusted potentially preventable hospital readmission rates.

### Current Program Measure Information:

The following is a table detailing the number of IRF QRP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed in the program:

NQS Primary Measure Domain	Number of Measures in IRF QRP	
	Implemented/Finalized *	Proposed**
Effective Prevention and Treatment	2	***
Making Care Safer	6	***
Communication/Care Coordination	5	***
Best Practice of Healthy Living	0	***
Making Care Affordable	0	***
Patient and Family Engagement	0	***

\*Implemented/Finalized: Quality measures implemented/finalized for data collection.

\*\*Proposed: Quality measures proposed for data collection. NOTE: The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.

\*\*\*TBD as of March 9, 2016.

### High Priority Domains for Future Measure Consideration:

CMS identified the following four domains as high-priority for future measure consideration:

1. *Making Care Affordable*: An important consideration for the IRF QRP is to better assess medical costs based on PAC episodes of care. Therefore, CMS is considering developing efficiency-based measures such as a Medicare Spending per Beneficiary measure concept.
2. *Communication/Care Coordination*: Assessing resident care transitions and rehospitalizations are important. Therefore, CMS is considering developing measures that assesses discharge to the community and potentially preventable readmissions.
3. *Communication/Care Coordination*: Infrastructure and processes for care coordination are important for the IRF QRP. The World Health Organization regards implementing medication reconciliation as a standard operating protocol necessary to reduce the potential for ADEs that cause harm to patients. Preventing and responding to ADEs is of critical importance as ADEs account for significant increases in health services utilization and costs. Medication reconciliation conceptually highlights care transitions and resident follow-up. Therefore, a medication reconciliation quality measure for IRF patients is being considered for future quality measure development.
4. *Communication/Care Coordination*: Discharge to a community setting is an important health care outcome for patients in post-acute settings, offering a multi-dimensional view of preparation for community life, including the cognitive, physical, and psychosocial elements involved in a discharge to the community. Being discharged to the community is an important outcome for many patients for whom the overall goals of care include optimizing functional improvement, returning to a previous level of independence, and avoiding institutionalization. Therefore, a discharge to community measure for IRFs is being considered for the future use in the IRF QRP.

## Long-Term Care Hospital Quality Reporting Program

### Program History and Structure:

The Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) was established in accordance with section 1886(m) of the Social Security Act, as amended by Section 3004(a) of the Affordable Care Act. The LTCH QRP applies to all LTCHs facilities designated as an LTCH under the Medicare program. Data sources for LTCH QRP measures include Medicare FFS claims, the Center for Disease Control and Prevention’s National Health Safety Network (CDC’s NHSN) data submissions, and the LTCH Continuity Assessment Record and Evaluation Data Sets (LCDS). The LTCH QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2014, LTCHs that fail to submit data will be subject to a 2.0 percentage point reduction of the applicable Prospective Payment System (PPS) increase factor.

Further, the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) to report standardized patient assessment data, data on quality measures including resource use measures. The development of standardized data stems from specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers.

The IMPACT Act requires CMS to develop and implement quality measures from five measure domains: functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; and the transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings. The IMPACT Act also delineates the implementation of resource use and other measures in at least these following domains: total estimated Medicare spending per beneficiary; discharge to the community; and all condition risk adjusted potentially preventable hospital readmission rates.

### Current Program Measure Information (Includes Measures included in the FY 2015 NPRM):

The following is a table detailing the number of LTCH QRP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed in the program:

NQS Primary Measure Domain	Number of Measures in LTCH QRP	
	Implemented/Finalized*	Proposed**
Effective Prevention and Treatment	0	**
Making Care Safer	9	**
Communication/Care Coordination	2	**
Best Practice of Healthy Living	1	**
Making Care Affordable	0	**
Patient and Family Engagement	0	**

\*Implemented/Finalized: Quality measures implemented/finalized for data collection.

\*\*Proposed: Quality measures proposed for data collection.

### **High Priority Domains for Future Measure Consideration:**

CMS identified the following domains as high-priority for LTCH QRP future measure consideration:

1. *Effective Prevention and Treatment:* Having measures related to ventilator use, ventilator-associated event and ventilator weaning rate are a high priority for CMS as prolonged mechanical ventilator use is quite common in LTCHs and respiratory diagnosis with ventilator support for 96 or more hours is the most frequently occurring diagnosis.
2. *Effective Prevention and Treatment (Aim: Healthy People/Healthy Communities):* In discussions with LTCH providers, it was noted that mental health status is an important measure of care for LTCH patients. CMS is considering a Depression Assessment & Management quality measure.
3. *Patient and Family Engagement:* While rehabilitation and restoring functional status are not the primary goals of patient care in the LTCH setting, functional outcomes remain an important indicator of LTCH quality as well as key to LTCH care trajectories. Providers must be able to provide functional support to patients with impairments. Thus, metrics showing change in self-care and mobility function are under development.
4. *Patient and Family Engagement:* CMS would like to explore measures that will evaluate the patient's experiences of care as this is a high priority of providers. Therefore, the HCAHPS and Care Transition quality measure (CTM)-3 is being considered.
5. *Making Care Affordable:* An important consideration for the LTCH QRP is to better assess medical costs based on PAC episodes of care. Therefore, CMS is considering developing efficiency-based measures such as a Medicare Spending per Beneficiary measure concept.
6. *Communication/Care Coordination:* Assessing patient care transitions and rehospitalizations are important. Therefore, CMS is considering developing measures that assesses discharge to the community and potentially preventable readmissions.
7. *Communication/Care Coordination:* Infrastructure and processes for care coordination are important for the LTCH QRP. Therefore, a medication reconciliation quality measure for LTCH patients is being considered for future quality measure development. Medication reconciliation conceptually highlights care transitions and resident follow-up.

## Home Health Quality Reporting Program

### Program History and Structure:

The Home Health Quality Reporting Program (HH QRP) was established in accordance with section 1895 (b)(3)(B)(v)(II) of the Social Security Act. Home Health Agencies (HHAs) are required by the Act to submit quality data for use in evaluating quality for Home Health agencies. Section 1895(b) (3)(B)(v)(I) of the Act also requires that HHAs that do not submit quality data to the Secretary be subject to a 2 percent reduction in the annual payment update, effective in calendar year 2007 and every subsequent year. Data sources for the HH QRP include the Outcome and Assessment Information Set (OASIS) and Medicare FFS claims. Data is publically reported on the Home Health Compare website. The HH QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups.

Further, the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) to report standardized patient assessment data, data on quality measures including resource use measures. The development of standardized data stems from specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers.

The IMPACT Act requires CMS to develop and implement quality measures from five measure domains: functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; and the transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings. The IMPACT Act also delineates the implementation of resource use and other measures in at least these following domains: total estimated Medicare spending per beneficiary; discharge to the community; and all condition risk adjusted potentially preventable hospital readmission rates.

### Current Program Measure Information:

The following is a table detailing the number of HH QRP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed for the HH QRP.

NQS Primary Measure Domain	Number of Measures in HH QRP	
	Implemented/Finalized*	Proposed**
Effective Prevention and Treatment	47	TBD***
Making Care Safer	10	TBD***
Communication/Care Coordination	9	TBD***
Best Practice of Healthy Living	6	TBD***
Making Care Affordable	0	TBD***
Patient and Family Engagement	9	TBD***

\*Implemented/Finalized: Quality measures implemented/finalized for data collection.

\*\*Proposed: Quality measures proposed for data collection. NOTE: The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.

\*\*\*TBD as of March 9, 2016.

### **High Priority Domains for Future Measure Consideration:**

CMS identified the following domains as high-priority for future measure consideration:

1. *Patient and Family Engagement:* Functional status and functional decline are important to assess for residents in HH settings. Patients who receive care while in a HH may have functional limitations and may be at risk for further decline in function due to limited mobility and ambulation. Therefore, measures to assess functional status are in development.
2. *Making Care Safer:* Safety for individuals in a home-based setting is an important priority for the HH QRP as persons in home health settings are at risk for major injury due to falls, new or worsened pressure ulcers, pain, and functional decline. Therefore, these concepts will be considered for future measure development.
3. *Making Care Affordable:* An important consideration for the HH QRP is to better assess medical costs based on PAC episodes of care. Therefore, CMS is considering developing efficiency-based measures such as a Medicare Spending per Beneficiary measure concept.
4. *Communication/Care Coordination:* Assessing an individual's care transitions and rehospitalizations is important. Discharge to a community setting is an important health care outcome for patients in post-acute settings, offering a multi-dimensional view of preparation for community life, including the cognitive, physical, and psychosocial elements involved in a discharge to the community. Being discharged to the community is an important outcome for many individuals for whom the overall goals of care include optimizing functional improvement, returning to a previous level of independence, and avoiding institutionalization. Therefore, CMS is considering developing measures that assesses discharge to the community and potentially preventable readmissions.
5. *Communication/Care Coordination:* Infrastructure and processes for care coordination are important for the HH QRP. The World Health Organization regards implementing medication reconciliation as a standard operating protocol necessary to reduce the potential for ADEs that cause harm to patients. Preventing and responding to ADEs is of critical importance as ADEs account for significant increases in health services utilization and costs. Therefore, a medication reconciliation quality measure for individuals in a home health setting is being considered for future quality measure development. Medication reconciliation conceptually highlights care transitions and resident follow-up.

## Hospice Quality Reporting Program

### Program History and Structure:

The Hospice Quality Reporting Program (HQRP) was established in accordance with section 1814(i) of the Social Security Act, as amended by section 3004(c) of the Affordable Care Act. The HQRP applies to all hospices, regardless of setting. Proposed data sources for future HQRP measures include the Hospice Item Set and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. HQRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2014, Hospices that fail to submit quality data will be subject to a 2.0 percentage point reduction to their annual payment update.

### Current Program Measure Information:

The following is a table detailing the number of HQRP measures (prioritized under the National Quality Strategy (NQS) quality measure domains) that are currently implemented or proposed in the program:

NQS Primary Measure Domain	Number of Measures in HQRP	
	Implemented/Finalized *	Proposed**
Effective Prevention and Treatment	6	TBD***
Making Care Safer	0	TBD***
Communication/Care Coordination	0	TBD***
Best Practice of Healthy Living	0	TBD***
Making Care Affordable	0	TBD***
Patient and Family Engagement	1	TBD***

*\*Implemented/Finalized: Quality measures implemented/finalized for data collection.*

*\*\*Proposed: Quality measures proposed for data collection. NOTE: The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.*

*\*\*\*TBD as of April 22, 2016.*

### High Priority Domains for Future Measure Consideration:

CMS identified the following domains as high-priority for HQRP future measure consideration:

1. Overall goal HQRP: Symptom Management Outcome Measures. There is a lack of tested and endorsed outcome measures for hospice across domains of hospice care, including symptom management (e.g.; physical and other symptoms). Developing and implementing outcome measures for hospice is important for providers, patients and families, and other stakeholders because symptom management is a central aspect of hospice care.
2. Communication/Care Coordination and/or Patient and Family Engagement: Patient preference for care is difficult to measure at end of life when patients may or may not be able to state their preferences, and may have changes in their preferences. However, a central tenet of hospice care is responsiveness to patient and family care preferences; as much as possible, patient preferences should be incorporated into new measure development.
3. Patient and Family Engagement: Measurement of goal attainment is naturally linked to determining patient/family preferences. Quality care in hospice should address not only establishing what the patient/family desires but also providing care and services in line with those preferences.
4. Making Care Safer: Timeliness/responsiveness of care. While timeliness of referral to hospice is not within a hospices' control, hospice initiation of treatment once a patient has elected the hospice benefit is under the control of the hospice. Responsiveness of the hospice during time

of patient or family need is an important indicator about hospice services for consumers in particular.

5. Communication/Care Coordination: Measurement of care coordination is integral to the provision of quality care and should be aligned across care settings.

## Merit-Based Incentive Payment System

### Program History and Structure:

The Merit-Based Incentive Payment System (MIPS) is established by H.R. 2 Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repeals the Medicare sustainable growth rate (SGR) and improves Medicare payment for physician services. The MACRA consolidates the current programs of the Physician Quality Reporting System (PQRS), The Value-Based Modifier (VM), and the Electronic Health Records (EHR) Incentive Program into one program (MIPS) that streamlines and improves on the three distinct incentive programs. MIPS will apply to doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in 2019. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2021, provided there are viable performance metrics available. Positive and negative adjustments will be applied to items and services furnished beginning January 1, 2019 based on providers meeting a performance threshold for four performance categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology. Adjustments will be capped at 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and future years.

### Current Program Measure Information:

To implement the quality category of the MIPS, CMS anticipates using the measures in the existing quality programs (PQRS, VM and EHR).

The following is a table detailing the number of quality and cost measures prioritized under each domain that are currently implemented in the existing physician quality programs and that could be eligible for implementation in the MIPS program:

NQS Primary Measure Domain	Number of Measures in MIPS	
	Implemented/Finalized* (2016 Measure Set)	Proposed** (2015 MUC list)
Effective Clinical Care	145	TBD***
Patient Safety	43	TBD***
Communication/Care Coordination	42	TBD***
Community/Population Health	15	TBD***
Efficiency and Cost Reduction	23	TBD***
Person and Caregiver-Centered Experience and Outcomes	16	TBD***
<b>TOTAL</b>	<b>284</b>	<b>TBD***</b>

\*Implemented/Finalized: Quality measures implemented/finalized for data collection.

\*\*Proposed: The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.

\*\*\*To Be Determined as of April 2016.

### **High Priority Domains for Future Measure Consideration:**

CMS will not propose the implementation of measures that do not meet the MIPS criteria of performance and measure set gaps. MIPS has a priority focus on outcome measures and measures that are relevant for specialty providers. CMS identifies the following domains as high-priority for future measure consideration:

1. Person and caregiver-centered Experience and Outcomes
  - a. CMS wants to specifically focus on patient reported outcome measures (PROMs)
2. Communication and Care Coordination
  - a. Measures addressing coordination of care and treatment with other providers
3. Appropriate Use and Resource Use
4. Patient Safety

In addition, CMS identified the following measure types as high-priority for future measure consideration:

1. Outcome measures
2. Appropriate Use of Services measures
3. Patient Experience measures
4. Care Coordination measures

### **Measure Requirements:**

CMS applies criteria for measures that may be considered for potential inclusion in the MIPS. At a minimum, the following criteria and requirements must be met for selection in the MIPS: CMS is statutorily required to select measures that reflect consensus among affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities. To the extent practicable, quality measures selected for inclusion on the final list will address at least one of the following quality domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. In addition, before including a new measure in MIPS, CMS is required to submit for publication in an applicable specialty-appropriate, peer-reviewed journal the measure and the method for developing the measure, including clinical and other data supporting the measure.

- Measures implemented in MIPS may be available for public reporting on Physician Compare.
- Preference will be given to electronically specified measures (eQMs)
- eQMs must meet EHR system infrastructure requirements, as defined by the future MIPS regulation.
  - The data collection mechanisms must be able to transmit and receive requirements as identified in future MIPS regulation. For example, eQMs must meet QRDA standards.
- Measures must be fully developed and tested.
  - Reliability and validity testing must be conducted for measures.
  - Feasibility testing must be conducted for eQMs.
- Measures should not duplicate other measures currently in the MIPS. Duplicative measures are assessed to see which would be the better measure for the MIPS measure set.
- Measure performance and evidence should identify opportunities for improvement. CMS does not intend to implement measures in which evidence identifies high levels of performance with little variation or opportunity for improvement, e.g., measures that are “topped out.”

## Medicare Shared Savings Program

### Program History and Structure:

Section 3022 of the Affordable Care Act (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Shared Savings Program that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery. The Medicare Shared Savings Program (MSSP) was designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). If ACOs meet program requirements and the ACO quality performance standard, they are eligible to share in savings, if earned. There are three shared savings options: 1) one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year), 2) two-sided risk model (sharing of savings and losses for all three years), and 3) two-sided risk model (sharing of savings and losses for all three years) with prospective assignment

### Current Program Measure Information:

The Affordable Care Act specifies appropriate measures of clinical processes and outcomes; patient, and, wherever practicable, caregiver experience of care; and utilization (such as rates of hospital admission for ambulatory sensitive conditions) and that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
- Hospitals employing ACO professionals, and
- Other Medicare providers and suppliers as determined by the Secretary.

Domain	Number of Measures in MSSP	
	Implemented for 2016	Proposed for 2017*
Patient/Caregiver Experience	8	TBD
Care Coordination/Patient Safety	10	TBD
Preventive Health	9	TBD
Clinical Care for At Risk	7	TBD

*\*Proposed quality measure changes will be made public in the 2017 Physician Fee Schedule Proposed Rule, when available.*

The Shared Savings Program quality reporting requirements are aligned with the Merit-Based Incentive Payment System (MIPS). Quality measure data for the MSSP is collected via claims and administrative data, CG-CAHPS, and the CMS web interface.

**Measure Requirements:**

Specific measure requirements include:

1. Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients.
2. Measures that are targeted to the needs and gaps in care of Medicare fee-for-service patients and their caregivers.
3. Measures that align with CMS quality reporting initiatives, such as MIPS.
4. Measures that support improved individual and population health.
5. Measures that align with recommendations from the Core Quality Measures Collaborative.

## Hospital-Acquired Condition Reduction Program

### 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). Created 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%.

### Current Program Measure Information:

The following table details the number of quality measures finalized since the FY 2016 IPPS/LTCH PPS final rule. All measures in the HACRP address the NQS priority of “Making Care Safer.”

NQS Primary Measure Domain	Number of Measures in HACRP	
	Implemented/Finalized*	Proposed**
Effective Prevention and Treatment	0	TBD
Making Care Safer	6	TBD
Communication/Care Coordination	0	TBD
Best Practice of Healthy Living	0	TBD
Making Care Affordable	0	TBD
Patient and Family Engagement	0	TBD
Not Assignable	0	TBD

*\*Implemented/Finalized: Quality measures implemented/finalized for performance calculation and payment adjustment.*

*\*\*Proposed: Quality measures proposed for performance calculation and payment adjustment. The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.*

### High Priorities for Future Measure Consideration:

For FY 2017 federal rulemaking, CMS may propose the adoption, removal, and/or suspension of measures for fiscal years 2018 and beyond of the HACRP. CMS identified the following topics as areas within the NQS priority of “Making Care Safer” for future measure consideration:

## Making Care Safer:

- a. Adverse Drug Events
- b. Ventilator Associated Events
- c. Additional Surgical Site Infection Locations
- d. Outcome Risk-Adjusted Measures
- e. Diagnostic Errors
- f. All-Cause Harm

### **Measure Requirements:**

CMS applies criteria for measures that may be considered for potential adoption in the HACRP. At a minimum, the following requirements must be met for consideration in the HACRP:

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

## Hospital Readmissions Reduction Program

### 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.

### Current Program Measure Information:

The following table details the number of quality measures finalized in prior rulemaking. All measures in the HRRP program address the National Quality Strategy (NQS) priority of "Communication/Care Coordination".

NQS Primary Measure Domain	Number of Measures in HRRP	
	Implemented/Finalized*	Proposed**
Effective Prevention and Treatment	0	TBD
Making Care Safer	0	TBD
Communication/Care Coordination	6	TBD
Best Practice of Healthy Living	0	TBD
Making Care Affordable	0	TBD
Patient and Family Engagement	0	TBD

*\*Implemented/Finalized: Quality measures implemented/finalized for performance calculation and payment adjustment.*

*\*\*Proposed: Quality measures proposed for performance calculation and payment adjustment. The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.*

### High Priority Domains for Future Measure Consideration:

For FY 2017 federal rulemaking, CMS may propose the adoption, removal, refinement, and or suspension of measures for fiscal year 2018 and subsequent years of the HRRP. CMS continues to emphasize the importance of the NQS priority of "Communication/Care Coordination" for this program.

- Care Coordination
  - Measures that address high impact conditions identified by the Medicare Payment Advisory Commission or the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) reports.

**Measure Requirements:**

CMS applies criteria for measures that may be considered for potential adoption in the HRRP. At a minimum, the following criteria and requirements must be met for consideration in the HRRP:

- CMS is statutorily required to select measures for applicable conditions, which are defined as conditions or procedures selected by the Secretary in which readmissions are high volume or high expenditure.
- Measures selected must be endorsed by the consensus-based entity with a contract under Section 1890 of the Act. However, the Secretary can select measures which are feasible and practical in a specified area or medical topic determined to be appropriate by the Secretary, that have not been endorsed by the entity with a contract under Section 1890 of the Act, as long as endorsed measures have been given due consideration.
- Measure methodology must be consistent with other readmissions measures currently implemented or proposed in the HRRP.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

## Hospital Inpatient Quality Reporting Program and Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals

### Program History and Structure:

The Hospital Inpatient Quality Reporting (HIQR) 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.

### Current Program Measure Information:

The following table details the number of quality measures prioritized under each National Quality Strategy (NQS) Priority, which are currently implemented or proposed in each program as finalized to date.

NQS Priority	Number of Measures in HIQR Number of eCQMs reportable under both HIQR and EHR Incentive Programs are listed in parentheses ( )
	Finalized *
Effective Prevention and Treatment	21 (14)
Making Care Safer	19 (6)
Communication/Care Coordination	13 (2 <sup>^</sup> )
Best Practice of Healthy Living	1 (0)
Making Care Affordable	8 (2)
Patient and Family Engagement	4 (5)
Not Assignable	2 (0)

\* Finalized: Quality measures implemented/finalized for data collection.

<sup>^</sup> All EHR Incentive Program eCQMS, represented in parenthesis, are reportable in the HIQR program except ED-3--Median time from ED arrival to ED discharge for discharged patients.

### **High Priority Domains for Future Measure Consideration:**

CMS identified the following categories as high-priority for future measure consideration:

- 1. Patient and Family Engagement:**
  - a. Measures that foster the engagement of patients and families as partners in their care.
- 2. Best Practices of Healthy Living:**
  - a. Measures that promote best practices to enable healthy living.
- 3. Making Care Affordable:**
  - a. Measures that effectuate changes in efficiency and reward value over volume.

### **Measure Requirements:**

CMS applies criteria for measures that may be considered for potential adoption in the HIQR program. At a minimum, the following criteria will be considered in selecting measures for HIQR program implementation:

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

## Hospital Value-Based Purchasing Program

### Program History and Structure:

The Hospital Value-Based Purchasing (HVBP) 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 HVBP Program based on the statutory requirements, including specification under the Hospital Inpatient Quality Reporting (HIQR) Program and posting dates on the Hospital Compare website.

### Current Program Measure Information:

The following tables detail the number of quality measures prioritized under each National Quality Strategy (NQS) Priority, which are currently implemented or proposed in each program as finalized to date.

NQS Priority	HVBP Domain	Number of Measures in HVBP
		Finalized*
Effective Prevention and Treatment	Clinical Care	5
Making Care Safer	Safety	7
Patient and Family Engagement Communication/Care Coordination	Patient and Caregiver-Centered Experience of Care/Care Coordination	1
Making Care Affordable	Efficiency and Cost Reduction	1
Best Practice of Healthy Living	N/A	0

\* Finalized: Quality measures implemented/finalized for data collection.

### High Priority Domains for Future Measure Consideration:

CMS identified the following categories as high-priority for future measure consideration:

1. **Patient and Family Engagement:**
  - a. Measures that foster the engagement of patients and families as partners in their care.
2. **Making Care Affordable:**
  - a. Measures that effectuate changes in efficiency and reward value over volume.

### Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the HVBP Program. At a minimum, the following criteria will be considered in selecting measures for HVBP Program implementation:

1. Measure must adhere to CMS statutory requirements, including specification under the Hospital IQR Program and posting dates on the *Hospital Compare* website.

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

## Inpatient Psychiatric Facility Quality Reporting Program

### 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 (the 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.

### Current Program Measure Information:

The program seeks to adopt measures that reflect the priorities of the National Quality Strategy (NQS) and CMS Quality Strategy goals. The following is a table detailing the number of quality measures under each NQS Priority/CMS Quality Strategy Goal that are currently implemented in the program as finalized in the FY 2016 IPF PPS and prior rules.

NQS Priorities/CMS Quality Strategy Goals	Number of Measures in IPFQR	
	Implemented/Finalized*	Proposed**
Effective Prevention and Treatment	2	TBD
Making Care Safer	3	TBD
Communication/Care Coordination	5	TBD
Best Practice of Healthy Living	4	TBD
Making Care Affordable	0	TBD
Patient and Family Engagement	2	TBD

*\*Implemented/Finalized: Quality measures implemented/finalized for data collection.*

*\*\*Proposed: These measures were introduced in the FY2017 IPPS/LTCH Proposed Rule. The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.*

### High Priority Domains for Future Measure Consideration:

CMS identified the following categories as high-priority for future measure consideration:

- 1. Patient and Family Engagement**
  - a. Patient experience of care
- 2. Effective Prevention and Treatment**
  - a. Inpatient psychiatric treatment and quality of care of geriatric patients and other adults, adolescents, and children
  - b. Quality of prescribing for antipsychotics and antidepressants
- 3. Best Practices of Healthy Living**
  - a. Screening and treatment for non-psychiatric comorbid conditions for which patients with mental or substance use disorders are at higher risk
  - b. Access to care
- 4. Making Care Affordable**
  - a. Measures which effectuate changes in efficiency and that reward value over volume.

**Measure Requirements:**

CMS applies criteria for measures that may be considered for potential adoption in the IPFQR. At a minimum, the following criteria will be considered in selecting measures for IPFQR implementation:

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

## Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

### Program History and Structure:

Section 3005 of the Affordable Care Act added new subsections (a)(1)(W) and (k) to section 1866 of the Social Security Act (the Act). Section 1866(k) of the Act establishes a quality reporting program for hospitals described in section 1886(d)(1)(B)(v) of the Act (referred to as a “PPS-Exempt Cancer Hospital” or PCHQR). Section 1866(k)(1) of the Act states that, for FY 2014 and each subsequent fiscal year, a PCH shall submit data to the Secretary in accordance with section 1866(k)(2) of the Act with respect to such a fiscal year. In FY 2014 and each subsequent fiscal year, each hospital described in section 1886(d)(1)(B)(v) of the Act shall submit data to the Secretary on quality measures (QMs) specified under section 1866(k)(3) of the Act in a form and manner, and at a time, specified by the Secretary.

The program requires PCHs to submit data for selected QMs to CMS. PCHQR is a voluntary quality reporting program, in which data will be publicly reported on a CMS website. In the FY 2012 IPPS rule, five NQF endorsed measures were adopted and finalized for the FY 2014 reporting period, which was the first year of the PCHQR. In the FY 2013 IPPS rule, one additional measure was adopted. Twelve new measures were adopted in the FY 2014 IPPS rule and one measure was adopted in the FY 2015 IPPS rule. Data collection for the FY 2017 and FY 2018 reporting periods is underway.

### Current Program Measure Information:

The following is a table detailing the number of quality measures prioritized under each NQS Priority/CMS Quality Strategy Goal that are currently implemented in the program as finalized to date:

NQS Priorities/CMS Quality Strategy Goals	Number of Measures in PCHQR
	Implemented/Finalized *
Effective Prevention and Treatment	6
Making Care Safer	5
Communication/Care Coordination	2
Best Practice to Enable Healthy Living	1
Making Care Affordable	1
Person and Family Engagement	1
Not Assignable	0

*\*Implemented/Finalized: Quality measures implemented/finalized for data collection.*

### High Priority Domains for Future Measure Consideration:

CMS identified the following categories as high-priority for future measure consideration:

#### 1. Communication and Care Coordination

- Measures regarding care coordination with other facilities and outpatient settings, such as hospice care.
- Measures of the patient’s functional status, quality of life, and end of life.

#### 2. Making Care Affordable

- Measures related to efficiency, appropriateness, and utilization (over/under-utilization) of cancer treatment modalities such as chemotherapy, radiation therapy, and imaging treatments.

### 3. Person and Family Engagement

- Measures related to patient-centered care planning, shared decision-making, and quality of life outcomes.

#### **Measure Requirements:**

The following requirements will be considered by CMS when selecting measures for program implementation:

1. Measure is responsive to specific program goals and statutory requirements.
  - a. Measures are required to reflect consensus among stakeholders, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act; currently the National Quality Forum (NQF)
  - b. The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed, by the entity with a contract under Section 1890(a) of the Social Security Act, as long as endorsed measures have been given due consideration
2. Measure specifications must be publicly available.
3. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.
4. Promote alignment with specific program attributes and across CMS and HHS programs. Measure alignment should support the measurement across the patient's episode of care, demonstrated by assessment of the person's trajectory across providers and settings.
5. Potential use of the measure in a program does not result in negative unintended consequences (e.g., inappropriate reduced lengths of stay, overuse or inappropriate use of care or treatment, limiting access to care).
6. Measures must be fully developed and tested, preferably in the PCH environment.
7. Measures must be feasible to implement across PCHs, e.g., calculation, and reporting.
8. Measure addresses an important condition/topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure when implemented can lead to the desired outcomes and/or more appropriate costs.
9. CMS has the resources to operationalize and maintain the measure.

## Ambulatory Surgical Center Quality Reporting Program

### 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.

### Current Program Measure Information:

The following is a table detailing the number of quality measures prioritized under each National Quality Strategy (NQS) Priority and CMS Quality Strategy Goal currently implemented in the program as finalized in the CY 2016 OPPS and prior rules:

NQS Priorities / CMS Quality Strategy Goals	Number of Measures in ASCQR	
	Implemented/Finalized *	Proposed**
Effective Prevention and Treatment	1	TBD
Making Care Safer	7	TBD
Communication/Care Coordination	1	TBD
Best Practice of Healthy Living	1	TBD
Making Care Affordable	0	TBD
Patient and Family Engagement	1	TBD
Not Assignable	1	TBD

*\*Implemented/Finalized: Quality measures implemented/finalized for data collection.*

*\*\*Proposed: The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.*

### High Priority Domains for Future Measure Consideration:

CMS identified the following categories as high-priority for future measure consideration:

- 1. Making Care Safer**
  - a. Measures of infection rates
- 2. Person and Family Engagement**
  - a. Measures that improve experience of care for patients, caregivers, and families.
  - b. Measures to promote patient self-management.
- 3. Best Practice of Healthy Living**
  - a. Measures to increase appropriate use of screening and prevention services.
  - b. Measures which will improve the quality of care for patients with multiple chronic conditions.
  - c. Measures to improve behavioral health access and quality of care.
- 4. Effective Prevention and Treatment**
  - a. Surgical outcome measures
- 5. Communication/Care Coordination**
  - a. Measures to embed best practice to manage transitions across practice settings.
  - b. Measures to enable effective health care system navigation.
  - c. To reduce unexpected hospital/emergency visits and admissions.

**Measure Requirements:**

CMS applies criteria for measures that may be considered for potential adoption in the ASCQR. At a minimum, the following requirements will be considered in selecting measures for ASCQR implementation:

1. Measure must adhere to CMS statutory requirements.
  - a. Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act
  - b. The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed, by the entity with a contract under Section 1890(a) of the Social Security Act, as long as endorsed measures have been given due consideration
2. Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration.
3. Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization.
4. Measure must be field tested for the ASC clinical setting.
5. Measure that is clinically useful.
6. Reporting of measure limits data collection and submission burden since many ASCs are small facilities with limited staffing.
7. Measure must supply sufficient case numbers for differentiation of ASC performance.
8. Measure must promote alignment across HHS and CMS programs.
9. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

## Hospital Outpatient Quality Reporting Program

### Program History and Structure:

The Hospital Outpatient Quality Reporting (HOQR) Program was established by Section 109 of the Tax Relief and Health Care Act (TRHCA) of 2006. The program requires subsection (d) hospitals providing outpatient services paid under the Outpatient Prospective Payment System (OPPS) to report on process, structure, outcomes, efficiency, costs of care, and patient experience of care. Hospitals receive a 2.0 percentage point reduction of their annual payment update (APU) under the Outpatient Prospective Payment System (OPPS) for non-participation in the program. Performance on quality measures is publicly reported on the CMS *Hospital Compare* website.

### Current Program Measure Information:

The following is a table detailing the number of quality measures prioritized under each National Quality Strategy (NQS) Priority and CMS Quality Strategy Goal currently implemented in the program as finalized in the CY 2016 OPPS and prior rules.

NQS Priorities / CMS Quality Strategy Goals	Number of Measures in HOQR	
	Implemented/Finalized *	Proposed**
Effective Prevention and Treatment	6	TBD
Making Care Safer	2	TBD
Communication/Care Coordination	7	TBD
Best Practice of Healthy Living	1	TBD
Making Care Affordable	6	TBD
Patient and Family Engagement	1	TBD
Not Assignable	3	TBD

*\*Implemented/Finalized: Quality measures implemented/finalized for data collection.*

*\*\*Proposed: The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.*

### High Priority Domains for Future Measure Consideration:

CMS identified the following categories as high-priority for future measure consideration:

- 1. Making Care Safer:**
  - a. Measures that address processes and outcomes designed to reduce risk in the delivery of health care, e.g., emergency department overcrowding and wait times.
- 2. Best Practices of Healthy Living:**
  - a. Measures that focus on primary prevention of disease or general screening for early detection of disease unrelated to a current or prior condition.
- 3. Patient and Family Engagement:**
  - a. Measures that address engaging both the person and their family in their care.
  - b. Measures that address cultural sensitivity, patient decision-making support or care that reflects patient preferences.
- 4. Communication/Care Coordination:**
  - a. Measures to embed best practices to manage transitions across practice settings.
  - b. Measures to enable effective health care system navigation.
  - c. Measures to reduce unexpected hospital/emergency visits and admissions.

**Measure Requirements:**

CMS applies criteria for measures that may be considered for potential adoption in the HOQR. At a minimum, the following criteria will be considered in selecting measures for HOQR implementation:

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

## Skilled Nursing Facility Quality Reporting Program

### Program History and Structure:

The Improving Medicare Post-Acute Care Transitions Act of 2014 (The IMPACT Act) added Section 1899B to the Social Security Act establishing the Skilled Nursing Facility Quality Reporting Program (SNF QRP). Facilities that submit data under the SNF PPS are required to participate in the SNF QRP, excluding units that are affiliated with critical access hospitals (CAHs). Data sources for SNF QRP measures include Medicare FFS claims as well as Minimum Data Set (MDS) assessment data. The SNF QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups. Beginning in FY 2018, providers that fail to submit required quality data to CMS will have their annual updates reduced by 2.0 percentage points.

Further, the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) amends title XVIII (Medicare) of the Social Security Act (the Act) to direct the Secretary of the Department of Health and Human Services (HHS) to require Long-term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs) to report standardized patient assessment data, data on quality measures including resource use measures. The development of standardized data stems from specified assessment domains via the assessment instruments that are used to submit assessment data to CMS by these post-acute care (PAC) providers.

The IMPACT Act requires CMS to develop and implement quality measures from five measure domains: functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; and the transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another settings. The IMPACT Act also delineates the implementation of resource use and other measures in at least these following domains: total estimated Medicare spending per beneficiary; discharge to the community; and all condition risk adjusted potentially preventable hospital readmission rates.

### Current Program Measure Information:

The following is a table detailing the number of SNF QRP measures prioritized under the National Quality Strategy (NQS) quality measure domains, which are currently implemented or proposed for the SNF QRP.

NQS Primary Measure Domain	Number of Measures in SNF QRP	
	Implemented/Finalized*	Proposed**
Effective Prevention and Treatment	0	***
Making Care Safer	2	***
Communication/Care Coordination	1	***
Best Practice of Healthy Living	0	***
Making Care Affordable	0	***
Patient and Family Engagement	0	***

\*Implemented/Finalized: Quality measures implemented/finalized for data collection.

\*\*Proposed: Quality measures proposed for data collection. NOTE: The NPRM has not yet been released that would include proposed measures from the 2015 MUC list.

\*\*\*TBD as of March 9, 2016.

### **High Priority Domains for Future Measure Consideration:**

CMS identified the following domains as high-priority for future measure consideration:

1. *Making Care Affordable:* An important consideration for the SNF QRP is to better assess medical costs based on PAC episodes of care. Therefore, CMS is considering developing efficiency-based measures such as a Medicare Spending per Beneficiary measure concept.
2. *Communication/Care Coordination:* Assessing resident care transitions and rehospitalizations are important. Therefore, CMS is considering developing measures that assesses discharge to the community and potentially preventable readmissions.
3. *Communication/Care Coordination:* Infrastructure and processes for care coordination are important for the SNF QRP. The World Health Organization regards implementing medication reconciliation as a standard operating protocol necessary to reduce the potential for ADEs that cause harm to patients. Preventing and responding to ADEs is of critical importance as ADEs account for significant increases in health services utilization and costs. Therefore, a medication reconciliation quality measure for SNF residents is being considered for future quality measure development.
4. *Communication/Care Coordination:* Discharge to a community setting is an important health care outcome for patients in post-acute settings, offering a multi-dimensional view of preparation for community life, including the cognitive, physical, and psychosocial elements involved in a discharge to the community. Being discharged to the community is an important outcome for many residents for whom the overall goals of care include optimizing functional improvement, returning to a previous level of independence, and avoiding institutionalization. Therefore, a discharge to community measure for SNFs is being considered for the future use in the SNF QRP.

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