



Program-Specific Measure Needs and Priorities

2021 Measures Under Consideration List

*Centers for Medicare & Medicaid Services
Center for Clinical Standards and Quality*

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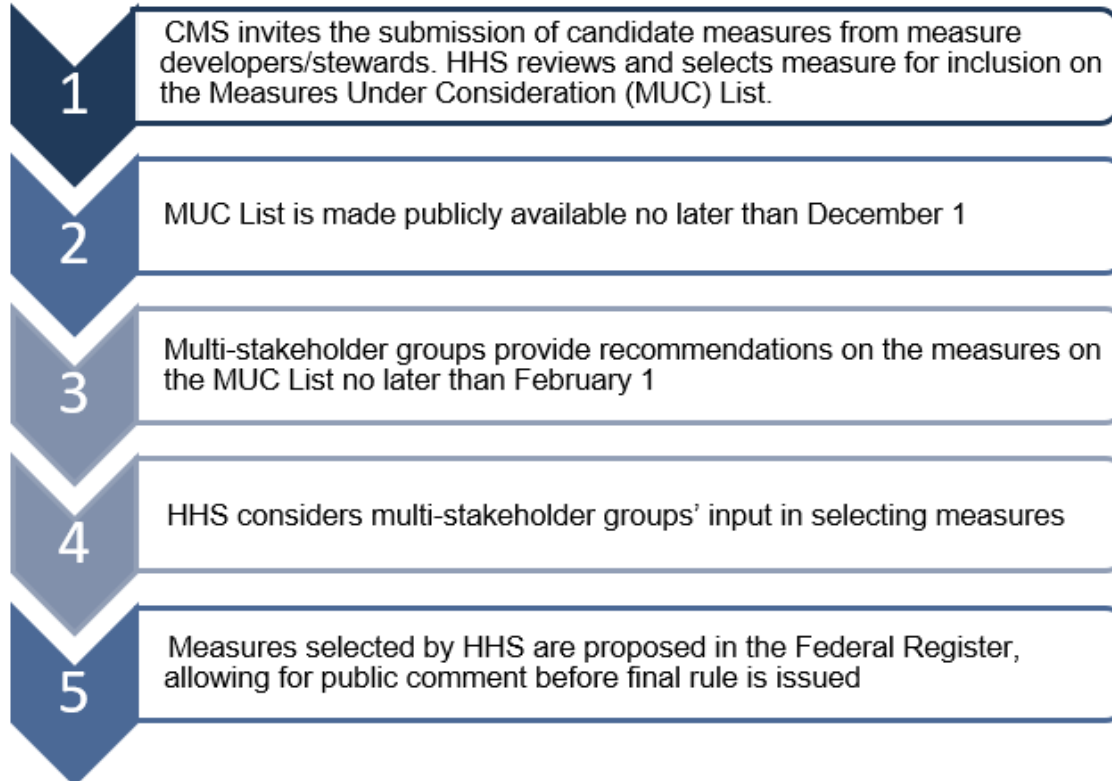
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Pre-Rulemaking Overview

Pre-Rulemaking Process



Relevant Legislation



Section 3014 of the Affordable Care Act of 2010 (ACA) (P.L. 111-148) created a new section 1890A of the Social Security Act (the Act), which requires that the U.S. Department of Health and Human Services (HHS) establish a federal pre-rulemaking process for the selection of quality and efficiency measures for use by HHS. The categories of measures are described in section 1890(b)(7)(B) of the Act.

CMS Priorities

The CMS Quality Measurement Action Plan (QMAP) identifies the activities of all agency components working together toward transformation of quality measurement and value-based programs, uniting strategic efforts to adopt measures that are the most critical to providing high quality care, reducing the burden of quality measure reporting, and driving better patient outcomes at lower costs.

Goals of the CMS QMAP

The QMAP delineates objectives supporting five interrelated goals:



Use Meaningful Measures Framework to Streamline Quality Measurement



Leverage Measures to Drive Outcome Improvement Through Public Reporting and Payment Programs



Improve Quality Measures Efficiency by a Transition to Digital Measures and Use of Advanced Data Analytics



Empower Consumers to Make Best Healthcare Choices through Patient-Directed Quality Measures and Public Transparency



Leverage Quality Measures to Promote Equity and Close Gaps in Care

Meaningful Measures 1.0 Accomplishments

- Since its inception in 2017, the Meaningful Measures Framework 1.0 has been utilized to review, reduce, and align measures.
- Meaningful Measures 1.0 highlighted 6 strategic domains and 17 strategic focus areas.
- This has resulted in a 15% reduction of the overall number of measures in the CMS Medicare FFS programs (from 534 to 460 measures).
- Overall, the measures portfolio has demonstrated a 25% increase in percentage of outcome measures; the percentage of process measures has dropped from 52% in 2017 to 37% in 2021.
- Streamlining measures has a projected savings of an estimated \$128M and a reduction of 3.3M burden hours through 2020.*

*Seema Verma's Speech at the 2020 CMS Quality Conference: <https://www.cms.gov/newsroom/press-releases/speech-remarks-cms-administrator-seema-verma-2020-cms-quality-conference>

Meaningful Measures 2.0

- Although the original Meaningful Measures initiative accomplished its initial goals, its scope and purpose have evolved to keep pace with a rapidly changing healthcare environment.
- With Meaningful Measures 2.0, CMS will not only continue to reduce the number of measures in its programs but will further shape the entire ecosystem of quality measures that drive value-based care.
- Meaningful Measures 2.0 will promote innovation and modernization of all aspects of quality, addressing a wide variety of settings, stakeholders, and measurement requirements.
- With Meaningful Measures 2.0, CMS plans to better address health care priorities and gaps, emphasize digital quality measurement, and promote patient perspectives.

UPDATED: Meaningful Measures 2.0

Building Value-Based Care

Goals of MM 2.0
Utilize only quality measures of highest value and impact focused on key quality domains
Align measures across value-based programs and across partners, including CMS, federal, and private entities
Prioritize outcome and patient reported measures
Transform measures to fully digital by 2025, and incorporate all-payer data
Develop and implement measures that reflect social and economic determinants



Measure Selection Requirements for CMS Quality Initiatives



In addition to program-specific requirements, *Measure Information Requirements* and *Measure Selection Requirements* on the following slides must be met



Measure submissions must be fully developed and tested for the appropriate provider level and adequate documentation of testing results must be submitted



Measure information **MUST** be submitted via [CMS MERIT](#) for consideration for inclusion on the MUC List

Measure Information Requirements

- Measure Information Requirements include:
 - Title
 - Numerator
 - Denominator
 - Exclusions
 - Measure steward
 - Established mechanism for data collection
 - Peer Reviewed Journal Article Requirement (Merit-based Incentive Payment System Program only)

Measure Information Requirements (Cont.)

- Electronic clinical quality measures (eCQMs), also require the following information:
 - Measure Authoring Tool (MAT) number
 - Bonnie test cases with 100% logic coverage
 - Attestation that value sets are published in the [Value Set Authority Center \(VSAC\)](#)
 - Feasibility scorecard
 - Attestation that the measure has a Health Quality Measures Format (HQMF) specification



Measure Selection Requirements

Selected measures must:

- Support the Quality Measurement Action Plan (QMAP), prioritizing outcome measures, patient reported outcome measures, and digital measures
- Respond to specific program goals and statutory requirements
- Address important condition topic with a performance gap and strong scientific evidence base to demonstrate measure can lead to desired outcomes and/or more affordable care
- Have written consent for any proprietary algorithms needed for measure production

Measure Selection Requirements (cont.)

- Promote alignment with CMS program attributes and across HHS and private payer programs
- Identify opportunities for improvement (e.g., not be “topped out”
- Not result in unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care
- Not duplicate other measures currently implemented in programs

Guidance for Candidate Measure Submission

- Measures must contain adequate specifications
- Measures on a published MUC List but not selected can be considered for future rulemaking cycles
 - Measures do not need to be resubmitted unless
 - There are substantial changes to specifications
 - A measure steward would like the measure to be considered for a different program
- Measures may be part of mandatory reporting programs or optional reporting programs
- MUC List measures must fulfill a measurement need and are assessed for alignment among CMS programs when applicable



Note: CMS is not required to adopt measures that are published on the MUC List

Program-Specific Needs and Priorities

Slides that follow provide background, current information on healthcare quality and efficiency measures, and future measure needs for each program covered by CMS Pre-Rulemaking.

Inpatient Rehabilitation Facility Quality Reporting Program

History and Structure

- The Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) was implemented with the fiscal year (FY) 2012 IRF Final Rule. Quality reporting requirements were mandated in section 3004(b) of the Patient Protection and Affordable Care Act (ACA) of 2010 which amended section 1886(j)(7) of the Social Security Act (SSA)
- The IRF QRP is a pay for reporting program where successfully meeting the requirements for each FY means IRFs must submit data on quality measures using the IRF-Patient Assessment Instrument (IRF PAI). IRFs must also submit standardized patient assessment data with regard to quality measures and Standardized Patient Assessment Data Elements (SPADEs)
- Failure to meet the IRF QRP requirements results in a two-percentage point (2%) reduction in IRFs Annual Increase Factor (AIF) for the corresponding, future FY payments
- Measures adopted in the IRF QRP are publicly reported on the Care Compare website

Current Measure Information

- There are 17 measures currently adopted for the IRF QRP. These are derived from the IRF-Patient Assessment Instrument (IRF PAI), the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) and Medicare Fee-For-Service claims
- For the FY 2022, the IRF QRP is proposing to adopt the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Outcome	11
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	6
Structure	0
Total	18

High Priorities for Future Measure Consideration

- Health Equity: Assess Disparities in Digital Access Among Inpatient Rehabilitation Facility patients – This measure is under consideration
- Patient Healthcare Associated Infections (HAIs) – This measure is currently being proposed to be adopted in other post-acute care settings. CMS plans to evaluate the appropriateness of adoption within IRFs.
- Patient-Reported Outcome-Based Performance Measure – This measure is under consideration

Measure Requirements

- For the IRF QRP, The IMPACT Act requires the development and reporting of quality measure addressing 5 domains in addition to resource use, hospitalization, and discharge to the community. These domains and categories are listed below:
 - **Quality Measure Domains:**
 - Skin integrity and changes in skin integrity
 - Functional status, cognitive function, and changes in function and cognitive function
 - Medication reconciliation
 - Incidence of major falls
 - Transfer of health information and care preferences when an individual transitions
 - **Resource Use and Other Measure Domains:**
 - Resource use measures, including total estimated Medicare spending per beneficiary
 - Discharge to community
 - All-condition risk-adjusted potentially preventable hospital readmissions rates.

Measure Requirements (cont.)

- Quality measures selected for the IRF QRP must be endorsed by the NQF unless they meet the statutory criteria for exception
- Measures address an important condition/topic with a performance gap and have a strong scientific evidence base to demonstrate that the measure can lead to the desired outcomes and/or more affordable care
- Reporting of measures is feasible to implement and measures have been fully developed and tested
- Results for and performance of measures should identify opportunities for improvement
- Potential use of a measure in a program does not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care)
- Measures adopted in the IRF QRP are publicly reported on Care Compare

Long-Term Care Hospital Quality Reporting Program

History and Structure

- The Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) was established in the Fiscal Year (FY) 2012 Inpatient Prospective Payment System (PPS)/LTCH PPS Final Rule, as authorized by Section 3004(a) of the Patient Protection and Affordable Care Act of 2010.
- The LTCH QRP is a pay for reporting program where successfully meeting the requirements for each fiscal year means LTCHs must meet or exceed two separate data completeness thresholds:
 - One threshold set at 80% for completion of quality measure data collected using the LTCH Continuity Assessment and Record of Evaluation (CARE) Data Set (LCDS)
 - The second set at 100% for quality measure data collected and submitted using the Centers for Disease Control (CDC) National Healthcare Surveillance Network (NHSN).
- Any LTCH who does not meet reporting requirements may be subject to a 2 percentage point (2%) reduction in their Annual Payment Update.

Current Measure Information

- There are 17 measures currently adopted for the LTCH QRP, the majority of which are required by statute.
- These are derived from the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS), the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) and Medicare Fee-For-Service claims.

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Intermediate Outcome	0
Outcome	9
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	7
Structure	0
Total	17

High Priorities for Future Measure Consideration

- Health Equity: Assess Disparities in Digital Access Among Long Term Care Hospital Residents – This measure is under consideration
- Patient Healthcare Associated Infections (HAIs) – This measure is currently being proposed to be adopted in other post-acute care settings. CMS plans to evaluate the appropriateness of adoption within LTCHs.
- Patient-Reported Outcome-Based Performance Measure – This measure is under consideration

Measure Requirements

- The IMPACT Act requires CMS to develop and implement quality measures to satisfy at least 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 setting.
- The IMPACT Act also requires the implementation of resource use and other measures in satisfaction of 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.

Measure Requirements (cont.)

- The LTCH QRP measure development and selection activities take into account established national priorities and input from multi-stakeholder groups.
- 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.
- Measure reporting is feasible to implement, and measures have been fully developed and tested.
- Measure results and performance should identify opportunities for improvement.
- Potential use of the measure in a program does not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care).
- Measures adopted in the LTCH QRP are publicly reported on Care Compare.

Home Health Quality Reporting 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.
- HHAs that do not submit quality data to the Secretary are subject to a 2 percent reduction in the annual payment update (Section 1895(b) (3)(B)(v)(I))

Current Measure Information

- There are 20 current measures adopted into the HH QRP; derived from Outcome and Assessment Information Set (OASIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Medicare FFS claims.
- For CY 2022, the HH QRP will be proposing to implement the Potential Preventable Readmission (PPR) measure into the program. If adopted, the PPR measure will replace two claims-based outcome measures currently in the program.

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	12
Patient Reported Outcome-Based Performance Measure (PRO-PM)	1
Process	7
Structure	0
Total	20

High Priorities for Future Measure Consideration

HH QRP identified the following as high priorities for future measure consideration:

- Functional status and preventing functional decline are important priorities to assess for home health patients. Patients who receive home health care may have functional limitations, individual functional goals and may be at risk for further decline in function due to limited mobility and ambulation.

High Priorities for Future Measure Consideration (cont.)

- Patient Healthcare Associated Infections (HAIs) – This measure is currently being proposed to be adopted in other post-acute care settings. CMS plans to evaluate the appropriateness of adoption within HHAs
- COVID-19 Vaccination Coverage Among Healthcare Personnel – This measure is currently proposed for adoption in other PAC settings. CMS plans to evaluate the feasibility and appropriateness
- Health Equity: Assess Disparities in Digital Access Among Home Health Beneficiaries – This measure is under consideration.

Note: There are no proposals for the 2023 rules for NQF's consideration.

Measure Requirements

- For the HH QRP, The IMPACT Act requires the development and reporting of quality measure addressing 5 domains in addition to resource use, hospitalization, and discharge to the community. These domains and categories are listed below.
 - **Quality Measure Domains:**
 - Skin integrity and changes in skin integrity;
 - Functional status, cognitive function, and changes in function and cognitive function;
 - Medication reconciliation;
 - Incidence of major falls;
 - Transfer of health information and care preferences when an individual transitions;
 - **Resource Use and Other Measure Domains:**
 - Resource use measures, including total estimated Medicare spending per beneficiary;
 - Discharge to community; and
 - All-condition risk-adjusted potentially preventable hospital readmissions rates.

Measure Requirements (cont.)

- Measures implemented in the HH QRP are statutorily required to reflect consensus among stakeholders affected
- Measures adopted in the HH QRP may be available for public reporting on Care Compare
- Preference will be given to measures that are endorsed by the National Quality Forum (NQF)
- Measure performance should demonstrate variation amongst home health agencies and opportunities for improvement, exception for function maintenance measure

Measure Requirements (cont.)

- Measures must be fully developed, with completed testing results at the national level and ready for implementation at the time of submission (CMS' internal evaluation)
- No new measures adopted into the HH QRP will duplicate other measures currently/previously implemented into the program

Hospice Quality Reporting Program

History and Structure

- The Hospice Quality Reporting Program (HQRP) was established in accordance with Section 1814(i)(5) of the Social Security Act, as amended by section 3004(c) of the Affordable Care Act.
- The HQRP applies to all patients in Medicare-certified hospices, regardless of payer source.
- 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 are subject to a 2.0 percentage point reduction to their annual payment update that changes to 4.0 percentage point reduction beginning in FY 2024.

Current Measure Information

- For FY 2022, the HQRP anticipates two claims-based measures, Hospice care index (HCI) and Hospice Visits in the Last Days of Life (HVLDL) to become part of HQRP.

Measure Type	Number of Measures
Composite	1
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	1
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	8
Structure	0
Total	10

High Priorities for Future Measure Consideration

HQRP identified the following as high priorities for future measure consideration:

- The Hospice Outcome & Patient Evaluations (HOPE) tool
 - Pain and symptom impact outcome measures
- Claims/administrative data
 - Weekend visits process measures
- Hybrid measures
 - Wound care using claims and survey data
 - HOPE and claims data

Measure Requirements

- Measures implemented in the HQRP are statutorily required to reflect consensus among stakeholders affected
- Measures adopted in the HQRP are available for public reporting on Care Compare
- Measures must be fully developed, with completed testing results at the national level and ready for implementation at the time of submission (CMS' internal evaluation).
- Preference will be given to measures that are endorsed by the National Quality Forum (NQF)

Measure Requirements (cont.)

- Measure performance should demonstrate variation amongst Hospices and opportunities for improvement.
- Measures adopted into HQRP fill a gap or high priority area as determined by OIG, MedPAC, or other stakeholders.

Skilled Nursing Facility Quality Reporting Program

History and Structure

- The Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) was established in the Fiscal Year (FY) 2016 SNF Prospective Payment System (PPS) Final Rule, as authorized by the Improving Medicare Post-Acute Care Transformation Act of 2014.
- The SNF QRP is a pay for reporting program. SNFs must submit standardized patient assessment data with regard to quality measures and Standardized Patient Assessment Data Elements (SPADEs).
- Any SNF who does not meet reporting requirements may be subject to a two percentage point (2%) reduction in their Annual Payment Update. Measures adopted in the SNF QRP are publicly reported on the Care Compare website.

Current Measure Information

- There are 13 measures currently adopted for the SNF QRP, the majority of which are required by statute. These are derived from Minimum Data Set (MDS) and Medicare Fee-For-Service claims.
- For the FY 2022, the SNF QRP will be proposing to adopt the SNF Healthcare-Associated Infections Requiring Hospitalization measure (SNF HAI) and the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure.

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Outcome	8
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	4
Structure	0
Total	13

High Priorities for Future Measure Consideration

SNF QRP identified the following as high priorities for future measure consideration:

- Health Equity: Assess Disparities in Digital Access Among Skilled Nursing Facility Residents –This measure is under consideration
- Patient-Reported Outcome-Based Performance Measure: CoreQ: Short Stay Discharge Measure – This measure is under consideration

Measure Requirements

- For the SNF QRP, The IMPACT Act requires the development and reporting of quality measure addressing 5 domains in addition to resource use, hospitalization, and discharge to the community. These domains and categories are listed below.
 - **Quality Measure Domains:**
 - Skin integrity and changes in skin integrity;
 - Functional status, cognitive function, and changes in function and cognitive function;
 - Medication reconciliation;
 - Incidence of major falls;
 - Transfer of health information and care preferences when an individual transitions;
 - **Resource Use and Other Measure Domains:**
 - Resource use measures, including total estimated Medicare spending per beneficiary;
 - Discharge to community; and
 - All-condition risk-adjusted potentially preventable hospital readmissions rates.

Measure Requirements (cont.)

- Quality measures selected for the SNF QRP must be endorsed by the NQF unless they meet the statutory criteria for exception.
- 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.
- Measure reporting is feasible to implement, and measures have been fully developed and tested.
- Measure results and performance should identify opportunities for improvement.
- Potential use of the measure in a program does not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care).
- Measures adopted in the SNF QRP are publicly reported on Care Compare.

Merit-Based Incentive Payment System

History and Structure

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS, by law, to implement an incentive program for clinicians. This program, referred to as the Quality Payment Program, provides two participation pathways for clinicians:

- The Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)

History and Structure (cont.)

- MIPS combines three Medicare "legacy" programs – the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals – into a single program. Under MIPS, there are four connected performance categories that will affect a clinician's future Medicare payments.
- Each performance category is scored independently and has a specific weight, indicating its contribution towards the MIPS Final Score.
- The MIPS performance categories and their 2021 weights towards the final score are: Quality (40%); Promoting Interoperability (25%); Improvement Activities (15%); and Cost (20%). The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.

Current Measure Information

- MIPS quality measures by measure type:

Measure Type	Number of Measures
Patient Engagement/Experience	2
Efficiency	6
Intermediate Outcome	6
Outcome	35
Patient Reported Outcome-Based Performance Measure (PRO-PM)	17
Process	141
Structure	2
Total	209

High Priorities for Future Measure Consideration

The following specialties, clinical conditions, and topics have been identified as gaps within the MIPS quality performance category and are considered priority areas for future measure consideration.

Specialties:

- Pathology
- Nephrology
- Radiology
- Dentistry
- Anesthesiology
- Podiatry
- Nutrition/Dietician
- Plastic Surgery
- Speech Language Pathology
- Behavioral Health

Clinical Conditions:

- Stroke
- Arrhythmias
- Heart Failure
- Diabetes
- Human Immunodeficiency Virus (HIV)
- Chronic Obstructive Pulmonary Disease
- Hepatitis B
- Septicemia
- Respiratory Failure
- Asthma

Topics:

- Shared-decision Making
- Patient Voice
- Health equity
- Social Determinants of Health
- Opioid related

High Priorities for Future Measure Consideration (cont.)

MIPS has a priority focus on:

- Outcome measures – includes outcome, intermediate outcome and patient reported outcome (PRO).
 - Outcome measures show how a health care service or intervention influences the health status of patients.
- Person or family-reported experiences of being engaged as active members of the health care team and in collaborative partnerships with providers and provider organizations.
- Population Health - health behaviors and outcomes of a broad group of individuals, including the distribution of such outcomes affected by the contextual factors within the group.
- Measures that:
 - Provide new measure options within a topped-out specialty area;
 - Reduce reporting burden – includes digital quality measures (dQMs), administrative claims measures and measures that align across programs;
 - Capture relevant specialty clinicians;
 - Focus on patient-centered care and include the patient voice;
 - Reflect the quality of a group's overall health and wellbeing including access to care, coordination of care and community services, health behaviors, preventive care screening, and utilization of health care services;
 - Address behavioral health; and
 - Support health equity.

Measure Requirements

CMS applies criteria for measures that may be considered for potential inclusion in MIPS. At a minimum, the following criteria and requirements must be met for selection in 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 MIPS quality domains: Communication and Care Coordination, Community/Population Health, Effective Clinical Care, Efficiency and Cost Reduction, Patient Safety, Person and Caregiver-Centered Experience and Outcomes.
- Candidate measures should align with the Meaningful Measures Initiative.
- Before including a new measure in MIPS, CMS is required to submit the measure for publication in an applicable specialty-appropriate, peer-reviewed journal and the method for developing the measure, including clinical and other data supporting the measure. The Peer-Review Journal template provided by CMS, must accompany each measure submission. Please see the template for additional information.

Measure Requirements (cont.)

At a minimum, the following criteria and requirements must be met for selection in MIPS: (cont.)

- Measures submitted should be linked to a Cost Measure, Improvement Activity, and/or an applicable MIPS Value Pathway (MVP).
- Measures implemented in MIPS may be available for public reporting on Care Compare.
- Measures must be fully developed, with completed testing results at the level of implementation and feasible at the time of submission (CMS' internal evaluation).
- Preference will be given to measures that are endorsed by the National Quality Forum (NQF).
- Measures should not duplicate other measures currently in 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."
- Electronic clinical quality measures (eCQMs) must meet electronic health record (EHR) system infrastructure requirements, as defined by MIPS regulation.

MIPS Value Pathways (MVPs)

Development Criteria

The following are the development criteria for MVPs:

- Use measures and improvement activities across all 4 performance categories, if feasible (quality, cost, improvement activities, and Promoting Interoperability).
- Have a clearly defined intent of measurement.
- Align with the Meaningful Measure Framework.
- Have measure and activity linkages within the MVP.
- Be clinically appropriate for the MVP under development.
- Be developed collaboratively across specialties in instances where the MVP is relevant to multiple specialties.
- Be understandable by clinicians, groups, and patients.
- To the extent feasible, include electronically specified quality measures.
- Incorporate the patient voice.
- Support health equity.

Medicare Shared Savings Program

History and Structure

- The Medicare Shared Savings Program (Shared Savings Program) 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.
- 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
 - Encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery

History and Structure (cont.)

- Eligible providers, hospitals, and suppliers voluntarily participate in the Shared Savings Program through an Accountable Care Organization (ACO).
- ACO share in savings by meeting the quality performance standard for the performance year.
- ACOs participating under a two-sided shared savings/losses model determines the amount earned or owed based on quality performance standard.
- For performance year 2021, ACOs will be required to report quality data via the Alternative Payment Model (APM) Performance Pathway (APP)
 - ACOs can choose to report either the 10 measures under the CMS Web Interface or the 3 eCQM/MIPS CQM measures.
 - ACOs will be required to field the CAHPS for MIPS survey
 - CMS will calculate 2 measures using administrative claims data

History and Structure (cont.)

- For performance year 2022 and subsequent performance years ACOs will be required to actively report:
 - 3 eCQM/MIPS CQM measures via the APP.
 - the CAHPS for MIPS survey
 - CMS will calculate two measures using administrative claims
- For performance years 2021 and 2022, ACOs who achieve a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores will meet the quality performance standard.
- For performance year 2023 and subsequent performance years, ACOs achieve a quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores.

Current Measure Information

- Shared Savings Program quality measures by measure type:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	2
Outcome	2
Patient Reported Outcome-Based Performance Measure (PRO-PM)	1
Process	8
Structure	0
Total	13

High Priorities for Future Measure Consideration

- The Shared Savings Program quality reporting requirements are aligned with the APP under the Quality Payment Program
 - The Shared Savings Program focuses on measures that improve the quality of care delivered to Medicare beneficiaries that result in better health outcomes.
 - Measures that result in reduced hospital admissions

Measure Requirements

- Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients.
- Measures that are targeted to the needs and gaps in care of Medicare fee-for-service patients and their caregivers.
- Measures that align with CMS quality reporting initiatives, such as the Quality Payment Program.
- Measures that support improved individual and population health.
- Measures addressing high-priority healthcare issues, such as opioid use.
- Measures that align with recommendations from the Core Quality Measures Collaborative.

Hospital-Acquired Condition Reduction Program

History and Structure

- 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) 2015 and beyond, the HACRP requires the Secretary to make payment adjustments to applicable hospitals that rank in the worst-performing 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 Care Compare website.

History and Structure (cont.)

- CMS finalized in the FY 2019 IPPS/LTCH PPS final rule a scoring methodology change that removed domains and assigns equal weighting to each measure for which a hospital has a measure beginning with the FY 2020 HACRP.
- The program uses the CMS Patient Safety Indicator 90 (CMS PSI 90) and five Healthcare-Associated Infections (HAI) as collected by the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN).
- The Total HAC Score is the sum of the equally weighted average of the hospital's measure scores.

Current Measure Information

- HACRP quality measures by measure type:

Measure Type	Number of Measures
Composite	1
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	5
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	0
Structure	0
Total	6

High Priorities for Future Measure Consideration

Making Care Safer:

- Measures that meet the Measure Requirements below that are electronic Clinical Quality Measures (eCQMs)
- Measures that address adverse drug events during the inpatient stay
- Measures that address ventilator-associated events
- Additional surgical site infection locations that are not already covered within an existing measure in the program

High Priorities for Future Measure Consideration (cont.)

Making Care Safer (Continued):

- Outcome risk-adjusted measures that capture outcomes from hospital-acquired conditions and are risk-adjusted to account for patient and/or facility differences (e.g., multiple comorbidities, patient care location)
- Measures that address diagnostic errors such as harm from receiving improper tests or treatment, harm from not receiving proper tests or treatment, harm from failure to diagnose, or harm from improper diagnosis
- Measure that address causes of hospital harm such as an all-cause harm measure or a measure that encompasses multiple harms
- Measures that demonstrate safety and/or high reliability practices and outcomes

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 program:
 - 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.
 - Measure steward must provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Readmissions Reduction Program

History and Structure

- The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program established under Section 1886(q) of the Social Security Act.
- Under HRRP, CMS reduces payments to subsection (d) hospitals with excess readmissions.
- The 21st Century Cures Act directs CMS to use a stratified methodology (beginning in FY 2019) to evaluate a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits.

History and Structure

The following steps are taken to calculate payment reductions under HRRP:

1. For each of the six conditions/procedures, CMS calculates an excess readmission ratio (ERR).
2. CMS stratifies hospitals into peer groups based on the dual proportion, and calculates median ERRs for each peer group.
3. CMS compares each hospital's performance relative to the peer group median ERR for each measure.
4. CMS calculates the hospital-specific payment reduction. The maximum payment reduction is 3 percent.

Current Measure Information

- HRRP currently includes six condition/procedure-specific claims-based readmission measures.

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	6
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	0
Structure	0
Total	6

High Priorities for Future Measure Consideration

- Improving scope by covering more clinical conditions
- Considering Agency priorities and possible application strategies on health equity

Hospital Inpatient Quality Reporting Program

History and Structure

- 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.
- Hospitals paid under the Inpatient Prospective Payment System (IPPS) are required to report on measures in the program.
- Failure to meet the requirements of the Hospital IQR Program will result in a reduction by 1/4 to a hospital's fiscal year IPPS annual payment update.
- Hospitals that choose to not participate in the program receive a reduction by that same amount.

History and Structure (cont.)

- Hospitals not included in the Hospital IQR Program, 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 *Care Compare* website.

Current Measure Information

- HIQR quality measures by measure type:

Measure Type	Number of Measures
Composite	1
Cost/Resource Use	4
Intermediate Outcome	0
Outcome	8
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	10
Structure	0
Total	23

High Priorities for Future Measure Consideration

- PRO-PM
- Care Coordination
- Radiology Safety
- Outcome eCQMs

*All Hospital Inpatient Quality Reporting Program eCQMs are reportable in the Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals.

Measure Requirements

- Measure must adhere to CMS statutory requirements. For more detail on statutory requirements, please refer to the CMS website.
- If feasible, 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 and must have successfully passed feasibility testing
- Measure must be fully developed, tested, and validated in the acute inpatient setting.
- Measure may not require reporting to a proprietary registry.

Measure Requirements (cont.)

- 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.
- Measure must address a Meaningful Measure area, with preference for measures addressing the high priority domains and/or measurement gaps for future measure consideration.
- Measure must promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

History and Structure

- Section 3005 of the Affordable Care Act added subsections (a)(1)(W) and (k) to section 1866 of the Social Security Act
- Section 1866(k) of the Social Security Act established a quality reporting program for hospitals described in section 1886(d)(1)(B)(v), referred to as a “PPS-Exempt Cancer Hospitals,” or: PCHs
 - These hospitals are excluded from payment under the inpatient prospective payment system (IPPS)

History and Structure (cont.)

- PCHQR is a voluntary quality reporting program, in which data will be publicly reported on the Provider Data Catalog website (PDC).
 - If a PCH participates in the program, the facility is required to submit data for selected quality measures to CMS.
 - There are no payment implications for PCHs related to the PCHQR program.

Current Measure Information

- PCHQR quality measures by measure type:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	2
Outcome	9
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	4
Structure	0
Total	15

High Priorities for Future Measure Consideration

- PRO-PM
- Care Coordination
- Behavioral Health

Measure Requirements

- Measure is responsive to specific program goals and statutory requirements
- Measure specifications must be publicly available
- Measure steward will provide CMS with technical assistance and clarification on the measure as needed
- Promote alignment with specific program attributes and across CMS and HHS programs
- Potential use of the measure in a program does not result in negative unintended consequences

Measure Requirements (cont.)

- Measures must be fully developed and tested, preferably in the PCH environment
- Measures must be feasible to implement across PCHs
- Measure addresses an important condition/topic with a performance gap and strong scientific evidence base to demonstrate that the measure when implemented can lead to the desired outcomes and/or more appropriate costs
- CMS has the resources to operationalize and maintain the measure

End-Stage Renal Disease Quality Incentive Program

History and Structure

- 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.

History and Structure (cont.)

- 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 Measure Information

- ESRD QIP quality measures by measure type:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	3
Outcome	2
Patient Reported Outcome-Based Performance Measure (PRO-PM)	1
Process	8
Structure	0
Total	14

High Priorities for Future Measure Consideration

- ***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.

High Priorities for Future Measure Consideration (cont.)

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. Home Dialysis also requires significant coordination of care.

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 EQRS data, alternative data sources will be considered dependent upon available infrastructure.

- Requirements 1-5 are mandated by statute

Hospital Value-Based Purchasing 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.

History and Structure (cont.)

- Measures are eligible for adoption in the HVBP Program based on the statutory requirements, including specification under the Hospital Inpatient Quality Reporting (IQR) Program and posting dates on the *Care Compare* website.
- The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. In addition, a cost efficiency measure, currently the Medicare Spending Per Beneficiary measure, must be included.

Current Measure Information

- HVBP quality measures by measure type

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Intermediate Outcome	0
Outcome	11
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	0
Structure	0
Total	12

High Priorities for Future Measure Consideration

- PRO-PM
- eCQMs

Measure Requirements

Measure requirements for the HVBP Program are similar to those of the HIQR Program. For more detail on statutory requirements, please refer to the CMS website.

- Measure must adhere to CMS statutory requirements, including specification under the Hospital IQR Program and posting dates on the *Care Compare* website.
- Measure may not require reporting to a proprietary registry.
- 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.

Measure Requirements (cont.)

- Measure must be fully developed, tested, and validated in the acute inpatient setting.
- Measure must address a Meaningful Measure area, with preference for measures addressing the high priority domains and/or measurement gaps for future measure consideration.
- Measure must promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Ambulatory Surgical Center Quality Reporting 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.

History and Structure (cont.)

- 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 Measure Information

- ASCQR quality measures by measure type:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Intermediate Outcome	5
Outcome	4
Patient Reported Outcome-Based Performance Measure (PRO-PM)	2
Process	0
Structure	0
Total	12

High Priorities for Future Measure Consideration

- Person and Family Engagement
- Best Practices of Healthy Living
- Effective Prevention and Treatment
- Making Care Affordable
- Communication/Care Coordination

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:

- 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.

*CMS-wide priorities will be addressed in introductory materials

Measure Requirements (cont.)

- Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration.
- 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.
- Measure must be field tested for the ASC clinical setting.
- Measure that is clinically useful.

Measure Requirements (cont.)

- Reporting of measure limits data collection and submission burden since many ASCs are small facilities with limited staffing.
- Measure must supply sufficient case numbers for differentiation of ASC performance.
- Measure must promote alignment across HHS and CMS programs.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Hospital Outpatient Quality Reporting Program

History and Structure

- 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

History and Structure (cont.)

- Pay-for-Reporting Program
- Facilities receive a 2.0 percentage point reduction of their annual payment update (APU) under the OPPS for not meeting program requirements
- Data publicly reported on the CMS *Hospital Compare* website

Current Measure Information

- HOQR quality measures by measure type:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	3
Intermediate Outcome	0
Outcome	4
Patient Reported Outcome-Based Performance Measure (PRO-PM)	1
Process	6
Structure	0
Total	14

High Priorities for Future Measure Consideration

- Making Care Safer
- Person and Family Engagement
- Best Practices of Healthy Living
- Effective Prevention and Treatment
- Making Care Affordable
- Communication/Care Coordination

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:
 - Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration.
 - 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.
 - Measure must be fully developed, tested, and validated in the hospital outpatient setting.
 - Measure must promote alignment across HHS and CMS programs.

Measure Requirements (cont.)

- Feasibility of Implementation: An evaluation of feasibility is based on factors including, but not limited to
 - The level of burden associated with validating measure data, both for CMS and for the end user.
 - Whether the identified CMS system for data collection is prepared to accommodate the proposed measure(s) and timeline for collection.
 - The availability and practicability of measure specifications, e.g., measure specifications in the public domain.
 - The level of burden the data collection system or methodology poses for an end user.
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed.

Inpatient Psychiatric Facility Quality Reporting Program

History and Structure

- Sections 3401(f) and 10322(a) of the Affordable Care Act amended section 1886(s)(4) of the Social Security Act to require the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units
- Applies to all psychiatric hospitals and psychiatric units paid under Medicare's Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)
- IPFQR is a “pay-for-reporting” program
 - Non-compliance results in a 2 percentage point reduction to the market basket update
 - E.g., an IPF eligible for a 4% update increase would receive a 2% increase if it failed to comply with reporting requirements
 - Update reductions are noncumulative across payment years

History and Structure (cont.)

- Designed to provide patients, and their families and caregivers, with quality of care information to help make informed decisions about their health care options
- Intended to improve the quality of inpatient psychiatric care provided to beneficiaries by ensuring that providers are aware of and reporting on practices related to quality care
- FY 2014 was the first payment determination
- Payment reductions for non-participation or failure to submit quality measures are effective as of October 1 of each applicable fiscal year, i.e., for FY 2015, the payment reduction is effective for services provided starting on October 1, 2014

Current Measure Information

- 2021 Quality Measures by Measure Type

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	1
Outcome	2
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	11
Structure	0
Total	14

High Priorities for Future Measure Consideration

- Patient Experience of Care in an Inpatient Psychiatric Facility
- All-cause post-discharge mortality
- Depression focused patient-reported outcome performance measure (PRO-PM)

Skilled Nursing Facility Value-Based Purchasing Program

History and Structure

- The Protecting Access to Medicare Act (PAMA) of 2014 established the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program.
- The SNF VBP Program rewards incentive payments to SNFs per the quality of care provided to Medicare beneficiaries.
 - The SNF VBP Program measures quality of care with a single all-cause hospital readmission measure through FY 2024, as mandated by statute.
- CMS withholds 2 percent of SNF Medicare FFS payments to fund the Program, and 60 percent of these withheld funds are redistributed to SNFs in the form of incentive payments.
 - The SNF VBP Program began awarding incentive payments to SNFs on October 1, 2018.

SNF VBP Program Measure

- The SNF VBP Program measures quality of care with a single all-cause hospital readmission measure, the SNF 30-Day All-Cause Readmission Measure (SNFRM; NQF #2510).
 - Per the statute, the all-cause measure will be replaced as soon as practicable with a potentially preventable readmission measure.
- The SNFRM measures the rate of all-cause, unplanned hospital readmissions for SNF residents within 30 days of discharge from a prior hospital stay to a SNF.
- The SNFRM is a risk-standardized readmission rate (RSRR).
 - Risk adjustment accounts for patient-level risk factors, including clinical and demographic characteristics.
- The SNFRM is calculated for each SNF during a baseline and performance period for use in the SNF VBP Program.

Current Measure Information

- SNF VP quality measures by measure type

Measure Type	Number of Measures
Composite	
Cost/Resource Use	
Intermediate Outcome	
Outcome	1
Patient Reported Outcome-Based Performance Measure (PRO-PM)	
Process	
Structure	
Total	1

Expanded SNF VBP Program

- Consolidated Appropriations Act, 2021, authorizes the Secretary to, with respect to payments for services furnished on or after October 1, 2023, apply up to 10 additional measures determined appropriate by the Secretary, which may include measures of
 - functional status,
 - patient safety,
 - care coordination, or
 - patient experience.

High Priorities for Future Measure Consideration

- As Consolidated Appropriations Act, 2021 authorizes the Secretary to, with respect to payments for services furnished on or after October 1, 2023, apply up to 10 additional measures determined appropriate by the Secretary, which may include measures of
 - functional status, patient safety, care coordination, or patient experience
- In addition to the above measurement areas, and the aim to minimize burden, CMS may consider measures where SNFs and nursing homes are largely familiar with through the SNF Quality Reporting Program, 5-Star Rating Program, and/or the Nursing Home Quality Initiative.

Part C and D Star Ratings

History and Structure

- The Part C & D Star Ratings program is based on sections 1851(d), 1852(e), 1853(o) and the 1854(b)(3)(iii), (v), and (vi) of the Social Security Act.
- General authority under section 1856(b) of the Act: establishment of standards consistent with and to carry out Part C & D as basis for the 5-Star Ratings system.
- The methodology for the Part C & D Star Ratings program was codified in contract year (CY) 2019 Medicare Part C and D Final Rule.
- CMS must propose through rulemaking any changes to the methodology for calculating the Star Ratings, the addition of new measures, the removal of a measure within the Star Ratings, and substantive measure changes per §423.184 and §422.164.
- Non-substantive measure specification changes for the Star Ratings will be announced through the advance notice process per §423.184(d)(1) and §422.164(d)(1).

History and Structure (cont.)

- The Star Ratings Program is consistent with CMS's Quality Strategy of optimizing health outcomes by improving quality and transforming the health care system. The CMS Quality Strategy goals reflect the six priorities set out in the National Quality Strategy:
 - Safety, person and caregiver-centered experience and outcomes, care coordination, clinical care, population/community health, efficiency and cost reduction.
- CMS highlights contracts receiving an overall rating of 5 stars with the High Performing Icon (HPI) on the MPF:
 - Beneficiaries may enroll in a 5-Star PDP, MA-PD, or MA-only plan through a Special Election Period (SEP). 5-Star Plans may market year-round.
- Beneficiaries may not enroll online via the MPF in a Low Performing Icon (LPI) plan. Beneficiaries must contact the plan directly.
 - The LPI Icon is displayed for contracts rated less than 3 stars for at least the last 3 years in a row for their Part C or D summary rating.
 - Beneficiaries in LPI plans are eligible for a Special Enrollment Period (SEP) to move to a higher quality plan.

History and Structure (cont.)

- Per the Affordable Care Act, CMS makes Quality Bonus Payments (QBPs) to MA organizations that meet quality standards measured using a five-star quality rating.
- The QBP percentage for each Star Rating for 2020 payments:

Star Rating	QBP Percentage
3.5 stars or below	0%
4 stars or more	5%

- The MA rebate level for plans is tied to the contract's Star Rating.

Current Measure Information

- Part C & D Star Ratings quality measures by measure type:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	4
Outcome	4
Patient Reported Outcome-Based Performance Measure (PRO-PM)	10
Process	20
Structure	8
Total	46

High Priorities for Future Measure Consideration

The Medicare population includes a large number of individuals and older adults with high-risk multiple chronic conditions who often receive care from multiple providers and settings which can subsequently lead to fragmented care and adverse healthcare outcomes. Using evidence-based clinical practice guidelines, high priorities for the program include:

- Improving the coordination of care for Medicare beneficiaries, and
- Improving medication management for Medicare beneficiaries.

High Priorities for Future Measure Consideration for Part C

- ***Promote Effective Prevention and Treatment of Chronic Disease***
 - One primary goal is to focus attention on preventing and treating chronic disease.
 - **Physical Functioning Activities of Daily Living (PFADL)**
 - A longitudinal change measure from the Medicare Health Outcomes Survey (HOS).
 - At the contract-level, this measure tracks the change over two years in physical functioning of Medicare Advantage (MA) beneficiaries and complements the measurement of self-identified physical health status.
 - It is an assessment of a MA organization's ability to maintain or improve the physical functioning of its beneficiaries by identifying opportunities to provide needed assistance, prevent unsafe conditions, and improve quality of life.

High Priorities for Future Measure Consideration for Part D

- ***Promote Effective Communication and Coordination of Care***
 - A primary goal is to coordinate care for beneficiaries in the effort to provide quality care.
 - **Polypharmacy: Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)/Polypharmacy: Use of Multiple Central-Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)**
 - Monitor the use of multiple unique central-nervous system (CNS)-active medications or the use of multiple anticholinergic medications to prevent increased risk of cognitive decline or falls. Medicare population is at particular risk because of higher comorbidities, declining cognitive function and increased medication use.
- ***Promote Effective Prevention and Treatment of Chronic Disease***
 - Another primary goal is to focus attention on preventing and treating chronic disease.
 - **Concurrent Use of Opioids and Benzodiazepines (COB)**
 - Concurrent use of opioids and benzodiazepines significantly increases the risks associated with these medications, including respiratory depression, coma and death. Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing these serious risks.

Measure Requirements

- In addition to rulemaking, the following guiding principles are used in making enhancements and updates to the Part C and D Star Ratings program:
 - Ratings align with the current CMS Quality Strategy.
 - Measures developed by consensus-based organizations are used as much as possible.
 - Ratings are a true reflection of plan quality and enrollee experience; the methodology minimizes risk of misclassification.
 - Ratings are stable over time.
 - Ratings treat contracts fairly and equally.
 - Measures are selected to reflect the prevalence of conditions and the importance of health outcomes in the Medicare population.
 - Data are complete, accurate, and reliable.
 - Improvement on measures is under the control of the health or drug plan.
 - Utility of ratings is considered for a wide range of purposes and goals.
 - Accountability to the public.
 - Enrollment choice for beneficiaries.
 - Driving quality improvement for plans and providers.
 - Ratings minimize unintended consequences.
 - Process of developing methodology is transparent and allows for multi-stakeholder input.

