Legislative Mandates for Quality Measurement and Reporting

This document discusses the genesis of individual CMS quality reporting and incentive programs. Most CMS quality reporting and incentive programs are a result of legislation which, in turn, amends the Social Security Act (SSA). The Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA), Patient Protection and Affordable Care Act (ACA), and the American Recovery and Reinvestment Act of 2009 (ARRA), including the Health Information Technology for Economic and Clinical Health (HITECH) Act, have had the largest influence on CMS's quality measurement priorities. These legislative mandates led to broad payment reform and quality-based payment models.

1 Legislation Initiating CMS Quality Programs

Table 1 provides the legislation and SSA section for CMS quality programs for acute care. Table 2 provides the legislation and SSA section for CMS quality programs for ambulatory care. Table 3 provides the legislation and SSA section for CMS quality programs for post-acute care. Table 4 provides the legislation and SSA section for CMS quality programs across settings.[1]

Table 1. Legislation Initiating CMS Quality Programs for Acute Care

Quality Program	Legislation Initiating the Program
Ambulatory Surgical Center Quality Reporting (ASCQR)	Section 109(B) of the Tax Relief and Health Care Act of 2006 (p. 2985) amended Section 1833(i) of the SSA to authorize, but not require, the Secretary to implement the revised Ambulatory Surgical Center (ASC) payment system
Hospital Acquired Condition Reduction Program (HACRP)	Section 3008 of the ACA (pp. 376-378) established the program by adding Section 1886(p) of the SSA
Hospital Inpatient Quality Reporting (Hospital IQR)	Hospital IQR was mandated in Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (pp. 2289-2290)
Hospital Outpatient Quality Reporting (Hospital OQR)	Section 109 of the Tax Relief and Health Care Act of 2006 (p. 2984) added Section 1833(t)(17) to the SSA mandating hospital quality reporting
Hospital Readmissions Reduction Program (HRRP)	Section 3025 of the ACA (pp. 408-412), amended Section 1886(q) of the SSA to establish HRRP

[1]References in Tables 1-4 are external links, but we have forgone use of the external link icon for aesthetics.

Quality Program	Legislation Initiating the Program
Hospital Value-Based Purchasing (HVBP)	Section 3001(a) of the ACA authorized Inpatient HVBP (p. 353) and amended Section 1886(o) of the SSA to establish the program
Inpatient Psychiatric Facility Quality Reporting (IPFQR)	Section 3401(f) and Section 10322(a) of the ACA (pp. 483 and 952) and amended Section 1886(s)(4) of the SSA to establish the program
Promoting Interoperability (Formerly the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Eligible Hospitals and Critical Access Hospitals)	Title XIII (aka HITECH Act) of the ARRA of 2009 (pp. 226-279) amended Titles XVIII and XIX of the SSA, to establish the program
Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting	Mandated by Section 3005 of the ACA (pp. 371-372) and Section 1866(k) of the SSA

Table 2. Legislation Initiating CMS Quality Programs for Ambulatory Care

Quality Program	Legislation Initiating the Program
Medicaid Quality Reporting	Section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (pp. 72-82) added Section 1139A to the SSA requiring identification and publishing a core measure set of children's healthcare quality measures for voluntary use by Medicaid and CHIP programs Section 2701 of the ACA (pp. 317-318) added Section 1139B of the SSA, which requires identification and publishing core measure set of healthcare quality measures for adult Medicaid enrollees
Medicare Advantage Quality Improvement Program	Section 722 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (pp. 2347-2348) amended Section 1852(e) of SSA
Promoting Interoperability Programs (Formerly the Medicaid EHR Incentive Program for Eligible Professionals)	Title XIII (aka the HITECH Act) of the ARRA of 2009 (pp 226-279) amended Titles XVIII and XIX of the SSA
Medicare Part C Star Rating	Section 3201 of the ACA (pp. 567-568) established the star ratings as the basis of Quality Bonus Payments
Medicare Part D Star Rating	No legislative requirement Medicare Part D Star rating began in 2008
Merit-based Incentive Payment System (MIPS)	Section 101(c) of the MACRA of 2015 (p. 92) added Section 1848(q) of the SSA, thereby establishing the program
Quality Payment Program (QPP)	MACRA of 2015 established the program

Table 3. Legislation Initiating CMS Quality Programs for Post-acute Care

Quality Program	Legislation Initiating the Program
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (p. 2556) amended Section 1881(h) of the SSA to establish the program
Home Health Quality Reporting (HHQR)	Section 5201(c)(2) of the Deficit Reduction Act of 2005 (pp. 46-47) added Section 1895(b)(3)(B)(v)(II) of the SSA mandating the reporting of home health quality data
Hospice Quality Reporting (HQR)	Section 3004 of the ACA (p. 368) amended Section 1814(i)(5) of the SSA directing the Secretary to establish quality reporting requirements for hospice programs
Inpatient Rehabilitation Facility (IRF) Quality Reporting (QR)	Section 3004(b) of the ACA (pp. 369-340) amended Section 1886(j)(7) of the SSA directing the Secretary to establish quality reporting requirements for IRFs

Quality Program	Legislation Initiating the Program
Long-Term Care Hospital Quality Reporting (LTCH QR)	Section 3004(a) of the ACA (pp. 368-369) amended Section 1886(m)(5) of the SSA directing the Secretary to establish quality reporting requirements for long-term care hospitals
Nursing Home Quality Initiative	No legislative requirement Pilot and program initiation in 2002
Post-Acute Care Quality Initiatives	Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act)
Program of All-Inclusive Care for the Elderly (PACE)	Section 4801 of the Balanced Budget Act of 1997 (BBA) (pp. 528-538) added Section 1894 to the SSA, which established the PACE program Section 4802 of the Balanced Budget Act of 1997 (BBA) (pp. 538-549) added Section 1934 to the SSA, which established PACE as a state option
Skilled Nursing Facility Quality Reporting Program (SNF QRP)	Improving Medicare Post-Acute Care Transformation Act of 2014 amended Section 1899B of the SSA to establish the SNF QRP and require submission of quality data (the IMPACT Act)
Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)	Section 215 of the Protecting Access to Medicare Act of 2014 (pp. 1048-1053) added Sections 1888(g) and (h) to SSA, thereby establishing the program

Table 4. Legislation Initiating CMS Quality Programs Across Settings

Quality Program	Legislation Initiating the Program	Setting Type
Medicare *Shared Savings Program*	Section 3022 of the ACA (p. 395) amended Section 1899 of SSA, thereby establishing the program	Acute care; ambulatory care; post-acute care
Health Insurance Exchange Quality Rating System (QRS)	Section 1311(c)(3) of the ACA (p.175)	Health Insurance Exchange

2 Additional Information About Legislation Influencing CMS Quality Programs

ARRA was an economic stimulus package that affected many sectors (e.g., federal tax relief, expansion of unemployment benefits, education, infrastructure, and healthcare). Title XIII of ARRA is the HITECH Act, which initiated the EHR Incentive Programs, now called Promoting Interoperability Programs. The primary goal of the HITECH Act was to promote and expand the meaningful use of health IT, but it also included funding for things such as workforce education and health information exchanges. Promoting Interoperability Programs provide payments to eligible professionals and eligible hospitals if they demonstrate meaningful use of certified electronic health record technology (CEHRT) and penalize those who do not. The belief is that EHR use will improve the quality, safety, and efficiency of healthcare. MIPS incorporated the Medicare EHR Incentive Program for Eligible Professionals.

The Improving Medicare Post-Acute Care Transformation Act of 2014, commonly referred to as the IMPACT Act, required the submission of standardized data by LTCHs, SNFs, home health agencies (HHAs), and IRFs, in addition to initiating the SNF Quality Reporting Program. The IMPACT Act required nesting of specified clinical assessment domains using standardized (uniform) data elements within the assessment instruments currently required for submission by LTCH, IRF, SNF, and HHA providers. The Act further required that CMS develop and implement quality measures from five quality measure domains using standardized assessment data. Also required was the development and reporting of measures pertaining to resource use, hospitalization, and discharge to the community. Through the

use of standardized quality measures and standardized data, the goal is to enable interoperability and access to longitudinal information for such providers to facilitate coordinated care, improved outcomes, and overall quality comparisons. The *CMS Data Element Library* (DEL) is an output of the IMPACT Act and is the centralized resource for CMS assessment instrument data elements (e.g., questions and responses) and their associated health information technology standards.

MACRA of 2015 (P.L. 114-10) defined five quality domains, including: (i) clinical care; (ii) safety; (iii) care coordination; (iv) patient and caregiver experience; and (v) population health and prevention. In response to this Act and the laws it amends, CMS conducts measure priorities planning across these domains and emphasizes (a) outcome measures, including patient-reported outcome measures (PROMs) and functional status measures; (b) patient experience measures; (c) care coordination measures; and (d) measures of appropriate use of services, including measures of overuse.

With MACRA (P.L. 114-10) in 2015, Congress mandated that several quality reporting and incentive programs phase out in 2018, while MIPS would continue well beyond 2019. Under MACRA, CMS has developed performance assessment methods using composite scoring for the determination of MIPS adjustment factors for all MIPS-eligible clinicians. This effort is supported by the funding provided under the ACA for the creation of a wide array of quality measures, including outcome measures and measures for settings that are new to quality reporting such as IRFs, hospices, LTCHs, inpatient psychiatric facilities, and PPS-exempt cancer hospitals. In addition, under MACRA and ACA, Medicaid and other Health and Human Services programs will continue to develop and implement quality measures. MACRA also supports the gains made under ARRA. ARRA launched a period of significant funding for the development of standards for EHRs and the widespread adoption of CEHRT across providers. MACRA continues this support with a mandate for widespread interoperability among these systems with requirements for CMS to develop metrics for successful interoperability. Further, MACRA requires incentives and payment penalties to encourage rapid achievement of that goal.

Enacted in 2016, The 21st Century Cures Act (Public Law [P.L.] 114-255) (Cures Act), aligns with many of CMS's quality measurement priorities. The Cures Act serves largely to increase choice, access, and quality of care for patients. The Cures Act mandates efforts to reduce administrative burden on healthcare providers and calls for the alignment and simplification of quality measures across federal programs and other payers. The Cures Act specifically mandates the reduction of regulatory or administrative burden related to the use of EHRs and calls for the identification of priority uses for the data arising from the implementation of value-based payment programs. The Cures Act aims to increase data-sharing and interoperability via the expanded use of health IT and the creation of partnerships between health information exchange organizations and healthcare providers. The increase in data-sharing is also meant to increase patient access to EHRs and thus improve patient care.

3 KEY POINTS

CMS quality reporting and incentive programs for healthcare delivered in acute care, ambulatory care, post-acute care, and across healthcare settings, are primarily the result of legislation which amended the SSA. MACRA, ACA, and ARRA have had the largest influence on CMS's quality measurement priorities and have led to broad payment reform and quality-based payment models. Other legislation that significantly influenced CMS Quality Programs includes the IMPACT Act, which mandated the use of standardized quality measures and standardized data in several post-acute care settings, and the Cures Act, which mandated efforts to reduce administrative burden on healthcare providers, improve electronic interoperability, and align and simplify quality measures.

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