2020 Measures under Consideration List

Program-Specific Measure Needs and Priorities

Centers for Medicare and Medicaid Services

Center for Clinical Standards and Quality

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Contents

Overview

In preparation for the statutory requirement and to remain transparent and allow for additional stakeholder feedback, each spring CMS solicits public and private stakeholders to submit candidate quality and efficiency measures for consideration by the Agency as a part of the pre-rulemaking process.

The pre-rulemaking process is mandated by section 3014 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, enacted on March 23, 2010), which added Section 1890A to the Social Security Act (the Act), and which requires the Department of Health and Human Services (HHS) to establish a federal pre-rulemaking process for the selection of certain categories of quality and efficiency measures for use by HHS. These measures are described in section 1890(b)(7)(B) of the Act. The pre-rulemaking process requires that HHS make publicly available, not later than December 1 annually, a list of quality and efficiency measures HHS is considering adopting, through the federal rulemaking process, for use in the Medicare program. This list, referred to as the Measures under Consideration (MUC) List, is reviewed by a multi-stakeholder panel, the Measure Applications Partnership (MAP), convened by the National Quality Forum (NQF). The MAP provides recommendations on behalf of the public to HHS no later than February 1 annually. The following programs are included in the pre-rulemaking process. For additional information on the process and information from past years, please visit the Centers for Medicare & Medicaid Services (CMS) Pre-Rulemaking website.

Quality Programs:

1. Ambulatory Surgical Center Quality Reporting Program (ASCQR)
2. End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
3. Home Health Quality Reporting Program (HH QRP)
4. Hospice Quality Reporting Program (HQRP)
5. Hospital-Acquired Condition Reduction Program (HACRP)
6. Hospital Inpatient Quality Reporting Program (IQR)
7. Hospital Outpatient Quality Reporting Program (HOQR)
8. Hospital Readmissions Reduction Program (HRRP)
9. Hospital Value-Based Purchasing Program (HVBP)
10. Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
11. Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

12. Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
13. Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs)
14. Medicare Shared Savings Program (Shared Savings Program)
15. Merit-based Incentive Payment System (MIPS)
16. Part C and D Star Ratings
17. Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
18. Skilled Nursing Facility Quality Reporting Program (SNF QRP)
19. Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

Annually, CMS publishes the needs and priorities for each of the above identified programs based on the Meaningful Measures initiative, along with a list of the measures actively in the program by Meaningful Measure area. The Meaningful Measures initiative serves as a guide as CMS evaluates each measure for inclusion on the MUC List to ensure that the selection of measures pursues and aligns with the agency's priorities. Through setting each program's needs and priorities, CMS hopes stakeholders will take this into account when developing measures and submitting them to CMS for consideration on the MUC List.

CMS Priorities

The Meaningful Measures Initiative represents a new approach to quality measures, which will reduce the collection and reporting burden, while producing quality measurement focused on meaningful outcomes important to patients. In order to put patients first across all programs, CMS must empower patients to work with their physicians and make healthcare decisions that are best for them. This empowerment means giving patients meaningful information about quality and costs to be active healthcare consumers. It also includes supporting innovative approaches to improving quality, accessibility, and affordability, while finding the best ways to use innovative technology to support patient-centered care.

Empowering Patients: CMS puts patients at the center of our healthcare system by ensuring they have the resources they need to make the best decisions for themselves and their families.

Focusing on Results: CMS uses new flexibilities and incentives, working to make sure that patients receive the right care, at the right time, in the right place while protecting taxpayers by paying for care based on results.

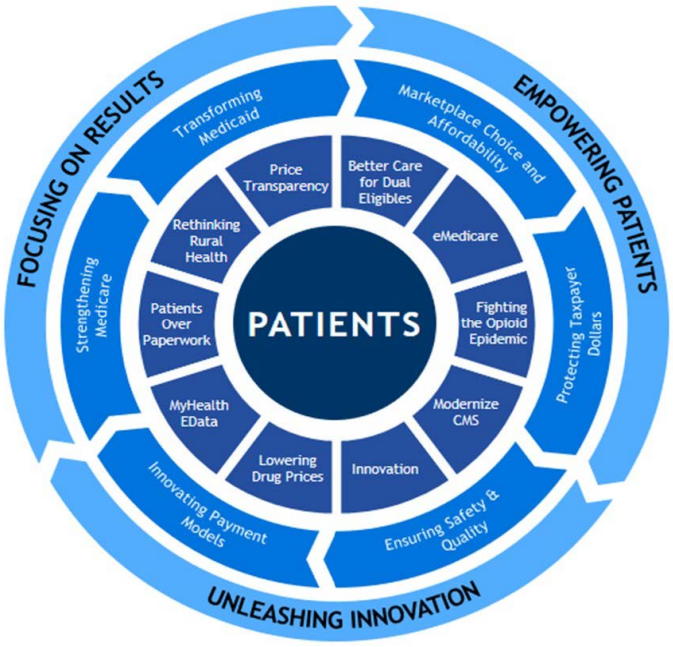

Figure 1: CMS Strategic Priorities

Unleashing Innovation: CMS continues to remove the barriers that too often limit innovation. Innovations are needed to make a healthcare system where providers and health plans compete to deliver better care at lower costs.

These goals are framed into a strategic wheel (Figure 1) reflecting the strategic initiatives across the agency.

By identifying the highest priorities for quality measurement and improvement, the Meaningful Measures Initiative provides a framework for core issues that are most vital to improving patient outcomes.

The objectives of the Meaningful Measures Framework include:

- Addressing high-impact measure areas that safeguard public health
- Focusing on areas that are patient-centered and meaningful to patients
- Developing measures that are outcome-based, where possible
- Fulfilling each program's statutory requirements
- Minimizing the level of burden for healthcare providers
- Identifying areas for significant opportunity for improvement
- Addressing measure needs for population-based payment through APMs
- Aligning across programs and/or with other payers.

To achieve these objectives and improve the health outcomes of beneficiaries, reduce regulatory burden, and improve quality, CMS is prioritizing the development of digital measures[1] and patient reported outcomes measures (PROMs). A focus on digital measures and leveraging digital data for advanced analytics will further interoperability, decrease reporting burden, enable more rapid feedback to clinicians, and help to identify trends, outliers, and predictive models for quality measurement. Additionally, CMS recognizes the importance of having the patient perspective driving quality measures. Their voice would change the paradigm of quality measurement to ensure CMS, and others, measure what is of highest importance to the patient, as well as evaluate performance from the patient perspective.

In order to ensure the measures in programs are focusing on priorities critical to patients and improvement of healthcare outcomes, CMS has identified 19 Meaningful Measures areas and mapped them to 6 overarching quality priorities as shown in the Meaningful Measures Framework (Figure 2). This framework, and the objectives and priorities listed above, are one piece of the measure evaluation selection criteria considered when evaluating measures to be included on the MUC List.

[1] A subset of digital measures are electronic quality measures (eCQMs), where information comes directly from electronic sources with no manual intervention required. Some examples of digital sources include electronic health records (EHRs), health information exchanges, clinical registries, case management systems, and claims.

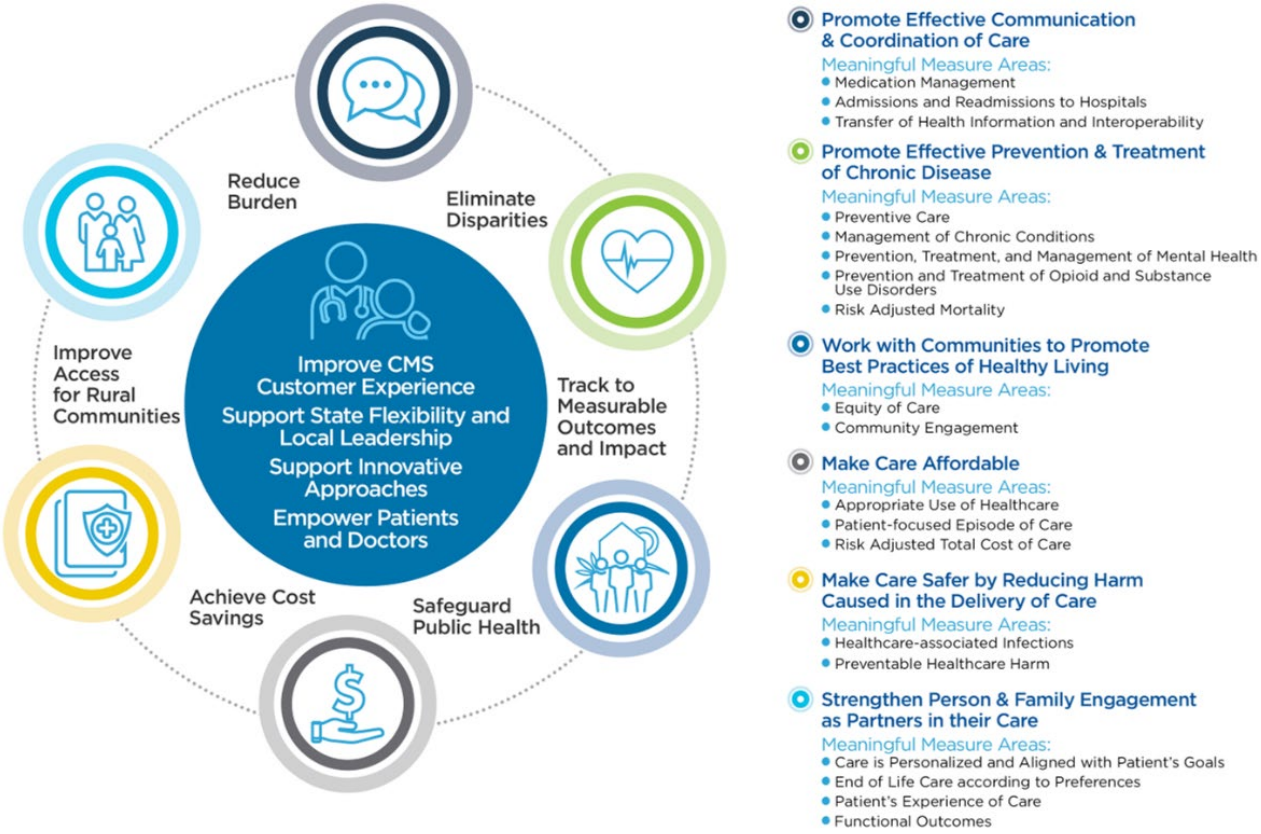

Figure 2: Meaningful Measures Framework

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. Measure submissions must be fully developed and tested for the appropriate provider level (e.g., tested for clinicians measurement if being submitted for consideration for the Merit Based Incentive Program), and adequate documentation to support testing results must be submitted. If insufficient information is submitted, CMS will be unable to further consider the measure for inclusion on a MUC List. Stakeholders can input quality and efficiency measure specifications for CMS review using Jira, an issues tracking system. Note: User credentials are required to access the Jira system. If you need access to Jira, refer to the latest CMS Measures under Consideration User Guide for Jira for assistance.

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)
    h. Peer Reviewed Journal Article Requirement (Merit-based Incentive Payment System Program only).

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

    i. Electronic specifications for eCQMs
    j. Link to full electronic specifications for eCQMs
    k. Measure Authoring Tool (MAT) number.

2. **Measure Requirements**
    a. Measure supports the Meaningful Measure Initiative by addressing a Meaningful Measure area and prioritizing outcome measures, patient reported outcome measures (PROMs), and electronic measures when possible.
    b. Measure is responsive to specific program goals and statutory requirements.
    c. 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).

d. Certain measures may have a proprietary algorithm (i.e., owned by the measure steward and may not be willing to share it publicly) in order to produce the measure. Without the express written consent from the measure steward, measures may not be considered by CMS.
e. Measure selection promotes alignment with CMS program attributes and across HHS and private payer programs.
f. Measure reporting is feasible to implement and measures have been fully developed and tested. In essence, measures must be tested for reliability and validity.
g. 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."
h. 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).
i. Measures should not duplicate other measures currently implemented in programs.

Note: submissions that do not provide the required data will not be further considered.

3. Candidate Measure Submission Guidance

- In an effort to provide a more meaningful List of Measures under Consideration, CMS includes only measures that contain adequate specifications.
- Measures appearing on a published MUC List but that are not selected for use under the Medicare program for the current rulemaking cycle will remain on the MUC List for that year. They remain under consideration only for purposes of the particular program or other use for which CMS was considering them when they were placed on the MUC List. These measures can be selected for those previously considered purposes and programs/uses in future rulemaking cycles. For most programs, measures do not need to be resubmitted to the MUC List unless there were substantial changes to the measure specifications or unless the steward would like the measure to be considered under a different program.
- Some measures are part of a mandatory reporting program. However, a number of measures, if adopted, would be part of an optional reporting program. Under optional programs, providers or suppliers may choose whether to participate.
- The MUC List includes measures that CMS is currently considering for use in a Medicare program. Inclusion of a measure on this list does not require CMS to adopt the measure for the identified program.
- Measures on the MUC List had to fill a quality and efficiency measurement need and were assessed for alignment among CMS programs when applicable.

Program-Specific Measure Needs and Priorities

The following sections 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

Program History and Structure:
The Inpatient Rehabilitation Facilities Quality Reporting Program (IRF QRP) was established in accordance with section 1886(j) of the Social Security Act as amended by section 3004(b) of the Affordable Care Act. Inpatient Rehabilitation Facilities that receive the IRF Prospective Payment System (PPS) are required to participate in the IRF QRP (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 Healthcare Safety Network (CDC NHSN) data submissions, and Inpatient Rehabilitation Facility - Patient Assessment instrument (IRF-PAI) assessment data. 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 are subject to a 2.0 percentage point reduction of the applicable IRF PPS payment update. Public reporting of IRF QRP measures on IRF Compare (https://www.medicare.gov/inpatientrehabilitationfacilitycompare/) began in December 2016.

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, and data on quality measures including resource use measures. 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.

Current Program Measure Information:
The following is a table detailing the number of IRF QRP measures prioritized under the quality priorities and Meaningful Measure areas, which are currently implemented or proposed in the program. The IRF QRP currently has 17 previously finalized quality measures.

	Implemented/Finalized Measures in the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)	
CMIT ID	**Healthcare Priority Measure Title**	**Number of Measures Meaningful Measure Areas**
	Effective Prevention and Treatment	1
854	Influenza Vaccination Coverage Among Healthcare Personnel	Preventive Care
	Making Care Safer	4
1364	NHSN Catheter-Associated Urinary Tract Infection (CAUTI)	Healthcare Assoc. Infections
831	NHSN Clostridium difficile Infection	Healthcare Assoc. Infections
2586	Falls with Major Injury (Long-Stay)	Preventable Healthcare Harm
5740	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Preventable Healthcare Harm
	Communication/Care Coordination	5
2849	Drug Regimen Review Conducted	Medication Management
2886	30-Day Post-Discharge Readmission Measure	Admissions and Readmissions
2889	Within Stay Readmission Measure	Admissions and Readmissions
3499	Transfer of Health Information to Patient - Post-Acute Care	Transfer of Health Information and Interoperability
6087	Transfer of Health Information to Provider – Post-Acute Care	Transfer of Health Information and Interoperability
	Best Practices of Healthy Living	1
2848	Discharge to Community	Community Engagement
	Making Care Affordable	1
2871	Medicare Spending Per Beneficiary Inpatient Rehabilitation Facility	Patient Focused Episode
	Person and Family Engagement	5
2595	Admission and Discharge Functional Assessment	Functional Outcomes
1869	Change in Mobility Score for Medical Rehabilitation	Functional Outcomes
1870	Change in Self-Care Score	Functional Outcomes
2597	Discharge Mobility Score	Functional Outcomes
2596	Discharge Self-Care Score	Functional Outcomes

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domain as a high priority for future measure consideration:

Exchange of Electronic Health Information and Interoperability measure concept: CMS believes that IRF provider health information exchange supports the goals of high quality, personalized, and efficient healthcare, care coordination and person-centered care, and supports

real-time, data driven, clinical decision making. The interoperability of health information across health care systems is key to achieving safe, efficient, and high-quality health care. It is also necessary for IRF patients/residents to fully participate in their health care.

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 Healthcare Safety Network (CDC's NHSN) data submissions, and the LTCH Continuity Assessment Record and Evaluation Data Sets (LCDS) assessment data. 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) annual payment update. (APU). Public reporting of LTCH QRP measures on LTCH Compare (https://www.medicare.gov/longtermcarehospitalcompare) began in December 2016.

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 and data on quality measures including resource use measures. 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.

Current Program Measure Information:
The following is a table detailing the number of LTCH QRP measures prioritized under the quality priorities and Meaningful Measure areas currently implemented or proposed in the program. The LTCH QRP currently has 17 previously finalized quality measures.

	Implemented/Finalized Measures in the Long-Term Care Hospital Quality Reporting Program (LTCH QRP)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**3**
854	Influenza Vaccination Coverage Among Healthcare Personnel	Preventive Care
5738	Compliance with Spontaneous Breathing Trial(SBT)	Preventive Care
5739	Ventilator Liberation Rate	Preventive Care
	Making Care Safer	**5**
1364	NHSN Catheter-Associated Urinary Tract Infection (CAUTI)	Healthcare Assoc. Infections
1475	NHSN Central line-associated Bloodstream Infection (CLABSI)	Healthcare Assoc. Infections
831	NHSN Clostridium difficile Infection	Healthcare Assoc. Infections
5737	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Preventable Healthcare Harm
1299	Falls with Major Injury (Long Stay)	Preventable Healthcare Harm
	Communication/Care Coordination	**4**
2850	Drug Regimen Review Conducted	Medication Management
2887	Readmission Measure for Long-Term Care Hospital	Admissions and Readmissions
3501	Transfer of Health Information to Patient - Post-Acute Care	Transfer of Health Information and Interoperability
5650	Transfer of Health Information to Provider – Post-Acute Care	Transfer of Health Information and Interoperability
	Best Practices of Healthy Living	**1**
2847	Discharge to Community	Community Engagement
	Making Care Affordable	**1**
2869	Medicare Spending Per Beneficiary Long-Term Care Hospital	Patient Focused Episode
	Person and Family Engagement	**3**
1673	Admission and Discharge Functional Assessment	Functional Outcomes
2760	Admission and Discharge Functional Assessment (2631)	Functional Outcomes
1871	Change in Mobility Among Long-Term Care Hospital Patients	Functional Outcomes

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domain as a high priority for LTCH QRP future measure consideration:

Person and Family Engagement: Functional Outcomes. 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.

Exchange of Electronic Health Information and Interoperability measure concept: CMS believes that LTCH provider health information exchange supports the goals of high quality, personalized, and efficient healthcare, care coordination and person-centered care, and supports real-time, data driven, clinical decision making. The interoperability of health information across health care systems is key to achieving safe, efficient, and high-quality health care. It is also necessary for LTCH patients/residents to fully participate in their health care.

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), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Medicare FFS claims. Data is publicly 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, and data on quality measures including resource use measures. 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.

Current Program Measure Information:
The following is a table detailing the number of HH QRP measures prioritized under the quality priorities and Meaningful Measure areas currently implemented or proposed for the HH QRP. The HH QRP currently has 20 previously finalized quality measures.

	Implemented/Finalized Measures in the Home Health Quality Reporting Program (HH QRP)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**1**
212	Influenza Immunization Received for Current Flu Season	Preventive Care
	Making Care Safer	**2**
5852	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Preventable Healthcare Harm
3493	Falls with Major Injury (Long Stay)	Preventable Healthcare Harm
	Communication/Care Coordination	**9**
2946	Drug Regimen Review	Medication Management
2705	Drug Education on All Medications	Medication Management
189	Improvement in Management of Oral Medication	Medication Management
2945	Post-Discharge Readmission Measure	Admissions and Readmissions
180	Acute Care Hospitalization During Home Health	Admissions and Readmissions
182	Emergency Department Use During Home Health	Admissions and Readmissions
196	Timely Initiation Of Care	Transfer of Health Info.
3496	Transfer of Health Information to Patient - Post-Acute Care	Transfer of Health Information and Interoperability
5652	Transfer of Health Information to Provider – Post-Acute Care	Transfer of Health Information and Interoperability
	Best Practices of Healthy Living	**1**
2944	Discharge to Community-PAC HH QRP	Community Engagement
	Making Care Affordable	**1**
2943	Medicare Spending per Beneficiary Home Health	Patient Focused Episode
	Person and Family Engagement	**6**
5853	Admission and Discharge Functional Assessment (#2631)	Care is Personalized
2062	Experience with Care	Patient's Experience of Care
183	Improvement in Ambulation/Locomotion	Functional Outcomes
185	Improvement in Bathing	Functional Outcomes
1000	Improvement in Bed Transferring	Functional Outcomes
187	Improvement in Dyspnea	Functional Outcomes

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domains as high priority for future measure consideration:

Person and Family Engagement: Care is Personalized and Aligned with Patient's Goals:
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.

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 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.

Current Program Measure Information:
The following is a table detailing the number of HQRP measures (prioritized under the quality priorities and Meaningful Measure areas) that are currently implemented or proposed in the program. The Hospice QRP currently has 10 previously finalized quality measures.

	Implemented/Finalized Measures in the Hospice Quality Reporting Program (HQRP)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**0**
	Making Care Safer	**0**
	Communication/Care Coordination	**1**
1011	Patients Treated with an Opioid Given a Bowel Regimen	Medication Management
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**0**
	Person and Family Engagement	**9**
1009	Pain Screening	Care is Personalized
1010	Treatment Preferences	Care is Personalized
1668	Beliefs/Values Addressed	End of Life Care
2923	Comprehensive Assessment at Admission	End of Life Care
2921-2922	Hospice Visits When Death is Imminent 1 and 2	End of Life Care
5574-5581	CAHPS Hospice Survey	Patient's Experience of Care
1007	Dyspnea Screening	Functional Outcomes
1006	Dyspnea Treatment	Functional Outcomes
1008	Pain Assessment	Functional Outcomes

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domains as high priority for HQRP future measure consideration:

Patient-focused Episode of Care. We are developing a claims-based Care Composite Measure of hospice service utilization. This composite measure includes those utilization measures associated with positive Hospice Experience of Care and determines how they vary across hospices.

Care is Personalized and Aligned with Patient's Goals. We are also developing outcome and other quality measures based on the Hospice Outcomes & Patient Evaluations (HOPE) tool. These include pain, shortness of breath, caregiver well-being, and patient preferences. Other measure constructs emerging include: preventable hospitalization of persons with a do-not-hospitalize (DNH) order; falls, skin integrity, and addressing spiritual and religious beliefs.

Skilled Nursing Facility Quality Reporting Program

Program History and Structure:
The Skilled Nursing Facility Quality Reporting Program (SNF QRP) was established in accordance with the IMPACT Act of 2014, which amended 1888(e) of the SSA requiring data submission by SNFs. Skilled Nursing 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 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, and data on quality measures including resource use measures. 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.

Current Program Measure Information:
The following is a table detailing the number of SNF QRP measures prioritized under the quality priorities and Meaningful Measure areas currently implemented or proposed for the SNF QRP. The SNF QRP currently has 11 previously finalized quality measures.

	Implemented/Finalized Measures in the Skilled Nursing Facility Quality Reporting Program (SNF QRP)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**0**
	Making Care Safer	**2**
1299	Falls with Major Injury (Long Stay)	Preventable Healthcare Harm
5741	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	Preventable Healthcare Harm
	Communication/Care Coordination	**2**
2851	Drug Regimen Review Conducted	Medication Management
2888	Post-Discharge Readmission Measure	Admissions and Readmissions
	Best Practices of Healthy Living	**1**
2846	Discharge to Community	Community Engagement
	Making Care Affordable	**1**
2870	Medicare Spending per Beneficiary Skilled Nursing Facility	Patient Focused Episode
	Person and Family Engagement	**5**
2466	Admission and Discharge Functional Assessment	Care is Personalized
5742	Change in Self-Care Score (NQF #2633)	Functional Outcomes
5745	Discharge Mobility Score (NQF #2636)	Functional Outcomes
5744	Discharge Self-Care Score (NQF #2635)	Functional Outcomes
5743	Change in Mobility Score (NQF #2634)	Functional Outcomes

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domain as a high priority for future measure consideration:

1. *Making Care Safer: Healthcare Associated Infections:* Healthcare associated infections (HAIs) are an important public health and patient safety issue. These infections are one of the most common adverse events in health care delivery. HAIs are associated with longer length of stays, use of higher-intensity care (e.g., critical care services and hospital readmissions) and increased mortality (Office of Inspector General [OIG], 2014; Ouslander, Diaz, Hain, & Tappen, 2011; Zimlichman et al., 2013). Addressing HAIs and sepsis prevention activities in skilled nursing facilities (SNFs) is particularly important because several factors place SNF residents at high risk for infection, including increased age, cognitive and functional decline, use of indwelling devices, frequent care transitions, and close contact with other residents and health care workers (Office of Disease Prevention and Health Promotion [ODPHP], 2013; Montoya & Mody, 2011).

2. *Exchange of Electronic Health Information and Interoperability measure concept:* CMS believes that SNF provider health information exchange supports the goals of high quality, personalized, and efficient healthcare, care coordination and person-centered care, and supports real-time, data driven, clinical decision making. The interoperability of

health information across health care systems is key to achieving safe, efficient, and high-quality health care. It is also necessary for SNF patients/residents to fully participate in their health care.

Merit-Based Incentive Payment System

Program 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)

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 2020 weights towards the final score are: Quality (45%); Promoting Interoperability (25%); Improvement Activities (15%); and Cost (15%). The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.

Current Program Measure Information:
To implement new quality measures into the performance category of MIPS, CMS will use the Annual Call for Measures that lets clinicians and organizations including, but not limited to, those representing MIPS eligible clinicians (professional associations and medical societies) and other stakeholders (researchers and consumer groups) submit quality measures for consideration. The recommended list of new quality measures will be publicly available for comment through the rulemaking process before making a final selection of new quality measures. This list will not include Qualified Clinical Data Registry (QCDR) measures as those measures are self-nominated (submitted) and selected through a separate process.

The quality performance category focuses on measures in the following quality priorities and Meaningful Measure areas for future measure thought and selection. The following is a table detailing the number of quality measures in each Meaningful Measures area currently implemented in the MIPS program. See Appendix A for a complete listing of measures.

Implemented/Finalized Measures in the Merit-Based Incentive Payment System (MIPS)	
Healthcare Priority Meaningful Measure Area	**Number of Measures***
Effective Prevention and Treatment	**98**
Preventive Care	32
Management of Chronic Conditions	39
Prevention and Treatment of Opioid and Substance Use Disorders	10
Prevention, Treatment, and Management of Mental Health	16
Risk Adjusted Mortality	1
Making Care Safer	**22**
Healthcare Associated Infections	4
Preventable Healthcare Harm	18
Communication and Coordination of Care	**26**
Medication Management	5
Admissions and Readmissions to Hospitals	3
Transfer of Health Information and Interoperability	18
Best Practices of Healthy Living	**—**
Equity of Care	—
Community Engagement	—
Making Care Affordable	**38**
Appropriate Use of Healthcare	36
Patient-focused Episode of Care	2 (18)
Risk Adjusted Total Cost of Care	0 (2)
Person and Family Engagement	**34**
Care is Personalized and Aligned with Patient's Goals	4
End of Life Care According to Preferences	3
Patient's Experience of Care	1
Functional Outcomes	26

**Quality priority totals (bold rows) may be different from those previously established through formal rulemaking due to differences in categorizations.*

^ The parentheses above detail the number of Cost measures in the Meaningful Measure Areas that are currently implemented in the MIPS program. Example: 2 Patient-focused Episode of Care Clinical Quality measures (18 Cost measures).

High Priority Meaningful Measure Areas for Future Measure Consideration:

CMS will not propose the implementation of measures that do not meet the MIPS measure set gaps or criteria of performance. The gap areas include, but are not limited to: Dentistry, Hospitalist, Orthopedic Surgery (Hand Surgery), Pathology, Speech Language Pathology, Radiology, Chiropractic Medicine, Addiction Medicine/Substance use conditions, Palliative Care, and Emergency Medicine. MIPS has a priority focus on outcome measures, PROMs, measures that fill a topped out specialty area and measures that are relevant for specialty providers. CMS identified outcome and opioid-specific measures as high-priority for future measure consideration. Outcome measures show how a health care service or intervention influences the health status of patients. For example, the percentage of patients undergoing isolated CABG surgery who require postoperative intubation greater than 24 hours, the rate of surgical complications or the rate of hospital-acquired infections. CMS identifies the following as high-priority for future measure consideration:

1. *Person and Caregiver-centered Experience and Outcomes:* This means that the measure should address the experience of each person and their family; and the extent to which they are engaged as partners in their care.

    a. CMS wants to specifically focus on patient reported outcome measures (PROMs). 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.

2. *Communication and Care Coordination:* This means that the measure must address the promotion of effective communication and coordination of care; and coordination of care and treatment with other providers.

3. *Efficiency/Cost Reduction:* This means that the measure must address the affordability of health care including unnecessary health services, inefficiencies in health care delivery, high prices, or fraud. Measures should cause change in efficiency and reward value over volume.

4. *Patient Safety:* This means that the measure must address either an explicit structure or process intended to make care safer, or the outcome of the presence or absence of such a structure or process; and harm caused in the delivery of care. This means that the structure, process or outcome must occur as a part of or as a result of the delivery of care.

5. *Appropriate Use:* CMS wants to specifically focus on appropriate use measures. This means that the measure must address appropriate use of services, including measures of overuse.

6. *Opioid Related measures:* Opioid-related measures that measure opioid use, overuse, risks, monitoring, and education.

The identification of topped out measures may lead to potential measure gaps. A measure may be considered topped out if measure performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. Topped out process measures are those with a median performance rate of 95 percent or higher, while non-process measures are considered topped out if the truncated coefficient of variation is less than 0.10 and the 75th and 90th percentiles are within two standard errors. CMS continues to identify topped out measures through the benchmark file. The column labeled topped out in the benchmark file will indicate whether the measure is topped out with a designation of "Yes". Through the use of the topped out measure criteria and additional criteria that are only intended to phase in the topped out scoring policy, CMS has identified 86 quality measures that will activate the special topped out scoring policy, beginning with the 2020 performance period.

The 86 quality measures are:

Measure Titles for 2020 Topped Out Measures	Quality ID Number (Q#)	Collection Type
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	8	MIPS CQM
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	Medicare Part B Claims, MIPS CQM
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Medicare Part B Claims, MIPS CQM
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	MIPS CQM
Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second-Generation Cephalosporin	21	Medicare Part B Claims, MIPS CQM
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	23	Medicare Part B Claims, MIPS CQM
Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	24	Medicare Part B Claims
Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	44	MIPS CQM
Advance Care Plan	47	Medicare Part B Claims
Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	48	Medicare Part B Claims
Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	50	Medicare Part B Claims
Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy	52	Medicare Part B Claims MIPS CQM
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	65	MIPS CQM
Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections	76	Medicare Part B Claims MIPS CQM
Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use	93	Medicare Part B Claims MIPS CQM
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	102	MIPS CQM

Measure Titles for 2020 Topped Out Measures	Quality ID Number (Q#)	Collection Type
Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer	104	MIPS CQM
Diabetes: Eye Exam	117	Medicare Part B Claims MIPS CQM
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	128	Medicare Part B Claims
Documentation of Current Medications in the Medical Record	130	Medicare Part B Claims eCQM MIPS CQM
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	134	Medicare Part B Claims
Melanoma: Coordination of Care	138	MIPS CQM
Oncology: Medical and Radiation - Pain Intensity Quantified	143	eCQM MIPS CQM
Radiology: Exposure Dose Indices or Exposure Time and Number of Images Reported for Procedures Using Fluoroscopy	145	Medicare Part B Claims MIPS CQM
Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms	146	Medicare Part B Claims MIPS CQM
Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	147	Medicare Part B Claims MIPS CQM
Falls: Risk Assessment	154	Medicare Part B Claims MIPS CQM
Falls: Plan of Care	155	Medicare Part B Claims
Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure	167	MIPS CQM
Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration	168	MIPS CQM
Rheumatoid Arthritis (RA): Functional Status Assessment	178	MIPS CQM
Elder Maltreatment Screen and Follow-Up Plan	181	Medicare Part B Claims
Functional Outcome Assessment	182	Medicare Part B Claims
Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use	185	MIPS CQM
Stroke and Stroke Rehabilitation: Thrombolytic Therapy	187	MIPS CQM
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	191	MIPS CQM
Radiology: Stenosis Measurement in Carotid Imaging Reports	195	Medicare Part B Claims MIPS CQM
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Medicare Part B Claims
Use of High-Risk Medications in the Elderly	238	eCQM MIPS CQM
Barrett's Esophagus	249	Medicare Part B Claims MIPS CQM
Radical Prostatectomy Pathology Reporting	250	Medicare Part B Claims MIPS CQM
Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	254	MIPS CQM
Sentinel Lymph Node Biopsy for Invasive Breast Cancer	264	MIPS CQM

Measure Titles for 2020 Topped Out Measures	Quality ID Number (Q#)	Collection Type
Biopsy Follow-Up	265	MIPS CQM
Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy	279	MIPS CQM
Dementia: Functional Status Assessment	282	MIPS CQM
Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management	283	MIPS CQM
Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	286	MIPS CQM
Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment for Patients with Parkinson's Disease	291	MIPS CQM
Parkinson's Disease: Rehabilitative Therapy Options	293	MIPS CQM
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	317	Medicare Part B Claims
Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	320	Medicare Part B Claims MIPS CQM
Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients	322	MIPS CQM
Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	323	MIPS CQM
Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients	324	MIPS CQM
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	326	Medicare Part B Claims MIPS CQM
Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)	332	MIPS CQM
Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse)	333	MIPS CQM
Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	350	MIPS CQM
Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	351	MIPS CQM
Anastomotic Leak Intervention	354	MIPS CQM
Unplanned Reoperation within the 30 Day Postoperative Period	355	MIPS CQM
Unplanned Hospital Readmission within 30 Days of Principal Procedure	356	MIPS CQM
Surgical Site Infection (SSI)	357	MIPS CQM
Patient-Centered Surgical Risk Assessment and Communication	358	MIPS CQM
Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies	360	MIPS CQM
Closing the Referral Loop: Receipt of Specialist Report	374	MIPS CQM

Measure Titles for 2020 Topped Out Measures	Quality ID Number (Q#)	Collection Type
Children Who Have Dental Decay or Cavities	378	eCQM
Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery	384	MIPS CQM
Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options	390	MIPS CQM
Lung Cancer Reporting (Biopsy/Cytology Specimens)	395	Medicare Part B Claims MIPS CQM
Lung Cancer Reporting (Resection Specimens)	396	MIPS CQM
Melanoma Reporting	397	Medicare Part B Claims MIPS CQM
Tobacco Use and Help with Quitting Among Adolescents	402	MIPS CQM
Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	406	Medicare Part B Claims MIPS CQM
Opioid Therapy Follow-up Evaluation	408	MIPS CQM
Documentation of Signed Opioid Treatment Agreement	412	MIPS CQM
Evaluation or Interview for Risk of Opioid Misuse	414	MIPS CQM
Perioperative Temperature Management	424	MIPS CQM
Prevention of Post-Operative Nausea and Vomiting (PONV) - Combination Therapy	430	MIPS CQM
Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	436	Medicare Part B Claims MIPS CQM
Skin Cancer: Biopsy Reporting Time - Pathologist to Clinician	440	MIPS CQM
Non-Recommended Cervical Cancer Screening in Adolescent Females	443	MIPS CQM
Medication Management for People with Asthma	444	MIPS CQM
Prevention of Post-Operative Vomiting (POV) - Combination Therapy (Pediatrics)	463	MIPS CQM
Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use	464	MIPS CQM

As topped out measures are removed from the program, CMS will monitor the impact of these removals on the quality measure specialty sets that are available for clinician reporting. CMS strongly encourages measure developers to review the benchmark file that identifies topped out measures, and develop measures that may replace those topped out measures for future program years. In addition, CMS also welcomes stakeholder suggestions to address these potential gaps within the measure sets.

* For reference purposes, the 2020 Quality Benchmarks (updated on 1/30/2020) file is posted online here:

https://qpp-cm-prod-content.s3.amazonaws.com/uploads/824/2020%20MIPS%20Quality%20Benchmarks.zip

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: Effective Prevention and Treatment, Making Care Safer, Communication and Coordination of Care, Best Practices of Healthy Living, Making Care Affordable or Person and Family Engagement. 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 submitted beginning with the 2020 Call for Measures should be linked to a Cost Measure and/or Improvement Activities if applicable.
- Measures implemented in MIPS may be available for public reporting on Physician Compare.
- Measures must be fully developed, with completed testing results at the clinician 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).
- 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."
- Section 101(c)(1) of the MACRA requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals prior to implementing in MIPS. The Peer-Review Journal template provided by CMS, must accompany each measures submission. Please see the template for additional information.
- eCQMs must meet EHR system infrastructure requirements, as defined by MIPS regulation. Beginning with calendar year 2019, eCQMs began using clinical quality

language (CQL) as the expression logic used in the Health Quality Measure Format (HQMF). CQL replaced the logic expressions defined in the Quality Data Model (QDM).

  - The data collection mechanisms must be able to transmit and receive requirements as identified in MIPS regulation. For example, eCQMs being submitted as Quality Reporting Data Architecture (QRDA) III must meet QRDA – III standards as defined in the CMS QRDA III Implementation Guide.

  - eCQMs must have HQMF output from the Measure Authoring Tool (MAT), using MAT v5.6, or more recent, with implementation of the clinical quality language logic. Additional information on the MAT can be found at https://www.emeasuretool.cms.gov/

  - Bonnie test cases must accompany each measure submission. Additional information on eCQM tools and resources can be found at https://www.emeasuretool.cms.gov/ .

  - Feasibility, reliability and validity testing must be conducted for eCQMs.

  - Testing data must accompany submission. For example, if a measure is being reported as CQM (registry) and eCQM, testing data for both versions must be submitted.

- eCQM readiness: How do I know if an eCQM is ready for implementation in MIPS?

Step 1: Assess and document eCQM characteristics

Characteristic	Testing	Documentation for CMS*
Is the eCQM feasible?	Feasibility test results	NQF's feasibility score card
Is the eCQM a valid measure of quality and/or are the data elements in the eCQM valid?	Correlation of data element or measure score with "gold-standard," or face validity results	Kappa agreement between EHR extracted data element and chart abstract and/or correlation between measure score and a related external measure of quality; information about data used for testing (e.g., number of practices, number of providers).
Is the eCQM reliable?	Provider level reliability testing for measure score in the setting which the measure is intended to be reported	Reliability coefficient using signal-to-noise or split half inter-rater reliability; information about data used for testing (e.g., number of practices, number of providers).

** Testing results must come from at least two different EHR installations*

Step 2: Assess and document eCQM specification readiness

Requirement	Tool	Documentation for CMS
Specify eCQM according to CMS and ONC standards	Measure Authoring Tool (MAT)	MAT output to include, at minimum, HQMF and human readable files
Create value sets that use current, standardized terminologies	The National Library of Medicine's Value Set Authority Center (VSAC)	Published value sets in the VSAC that have been validated against the most recent terminology expansion with 100% active codes
Test eCQM logic using a set of test cases that cover all branches of logic with 100% pass rate	Bonnie	Excel file of test patients showing testing results (Bonnie export)

References

Value Set Authority Center: https://vsac.nlm.nih.gov/

Bonnie: https://bonnie.healthit.gov/

eCQI Resource Center: https://ecqi.healthit.gov/

CMS Measures Management System Blueprint: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html

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 (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. Eligible providers, hospitals, and suppliers may voluntarily participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). Under the Shared Savings Program, ACOs may earn shared savings when they are able to lower growth in Medicare Parts A and B fee-for-service (FFS) costs while also meeting performance standards on quality of care. Before an ACO can share in any savings, it must demonstrate that it met the quality performance standard for that year. The quality performance standard determines an ACO's eligibility to share in savings, if earned, and the extent of an ACO's liability for sharing losses, if owed, for ACOs participating under a two-sided shared savings/losses model.

Current Program Measure Information:

CMS focuses ACO quality performance and improvement activity on four key domains, Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population to serve as the basis for assessing, benchmarking, rewarding, and improving ACO quality performance.

To determine an ACO's quality performance score, CMS weights each of the four measure domains equally, at 25 percent.

> The number of measures within the four key domains has changed over time to reflect changes in clinical practice, moving toward more outcome-based measures, and to align with other quality reporting programs and to reduce burden. Currently, there are 23 measures across the four domains and all measures are weighted equally within each domain.

The following is a table detailing the 23 measures in the Shared Savings Program measure set prioritized under the quality priorities and Meaningful Measure areas.

	Implemented/Finalized Measures in the Medicare Shared Savings Program (Shared Savings Program)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**9**
2508	Breast Cancer Screening	Preventive Care
451	Colorectal Cancer Screening	Preventive Care
439	Influenza Immunization	Preventive Care
1275	Tobacco Use: Screening and Cessation Intervention	Preventive Care
515	Screening for Clinical Depression and Follow-up Plan	Treatment of Mental Health
2572	Statin therapy for Cardiovascular Disease	Mgt. of Chronic Conditions
1404	Diabetes Mellitus: Hemoglobin A1c Poor Control	Mgt. of Chronic Conditions
1246	Hypertension (HTN): Controlling High Blood Pressure	Mgt. of Chronic Conditions
1741	Depression Remission at Twelve Months	Treatment of Mental Health
	Making Care Safer	**1**
1247	Falls: Screening for Future Fall Risk	Preventable Healthcare Harm
	Communication/Care Coordination	**3**
6040	Risk Standardized, All Condition Readmission	Admissions and Readmissions
1911	Ambulatory Sensitive Condition Acute Composite (PQI #91)	Admissions and Readmissions
2816	Unplanned Admissions for Multiple Chronic Conditions	Admissions and Readmissions
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**0**
	Person and Family Engagement	**10**
2804	Access to Specialists	Patient's Experience
5142	Care Coordination	Patient's Experience
5141	Courteous and Helpful Office Staff	Patient's Experience
2857	Health Promotion and Education	Patient's Experience
2858	Health Status/Functional Status	Patient's Experience
2861	How Well Your Providers Communicate	Patient's Experience
2878	Patients' Rating of Provider	Patient's Experience
2905	Shared Decision Making	Patient's Experience
2907	Stewardship of Patient Resources	Patient's Experience
2856	Timely Care, Appointments, and Information	Patient's Experience

The Shared Savings Program quality reporting requirements are aligned with the Quality Payment Program. The information used to determine ACO performance on these quality measures will be submitted by the ACO through the CMS Web Interface, calculated by CMS from administrative claims data, and collected via a patient experience of care survey referred to as the Consumer Assessment of Healthcare Provider and Systems (CAHPS) for ACOs Survey.

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 the Quality Payment Program.
4. Measures that support improved individual and population health.
5. Measures addressing high-priority healthcare issues, such as opioid use.
6. 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) 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 Hospital Compare website.

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 currently 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 measures in HACRP are categorized under the Meaningful Measure area of "Make Care Safer by Reducing Harm Caused in the Delivery of Care." The Total HAC Score is the sum of the equally weighted average of the hospital's measure scores.

Current Program Measure Information:
The following is a table detailing the 6 HACRP measures prioritized under the quality priorities and Meaningful Measure areas, which are currently implemented or proposed for the HACRP.

	Implemented/Finalized Measures in the Hospital-Acquired Condition Reduction Program (HACRP)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**0**
	Making Care Safer	**6**
1364	Catheter-associated Urinary Tract Infection	Healthcare-Assoc. Infections
1475	Central line-associated Bloodstream Infection	Healthcare-Assoc. Infections
907	Hospital-Onset MRSA Bacteremia	Healthcare-Assoc. Infections
831	NHSN Clostridium difficile Infection	Healthcare-Assoc. Infections
2755	Procedure Specific Surgical Site Infection; Colon, Hysterectomy	Healthcare-Assoc. Infections
2920	Patient Safety and Adverse Events Composite (CMS PSI 90)	Preventable Healthcare Harm
	Communication/Care Coordination	**0**
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**0**
	Person and Family Engagement	**0**

High Priority Meaningful Measure Areas for Future Measure Consideration:
For FY 2020 federal rulemaking, CMS may propose the adoption, removal, and/or suspension of measures for fiscal years 2021 and beyond of the HACRP. CMS identified the following topics as areas within the domain of "Making Care Safer" for future measure consideration:

Making Care Safer:

a. Measures that meet the Measure Requirements below that are electronic Clinical Quality Measures (eCQMs)
b. Measures that address adverse drug events during the inpatient stay
c. Measures that address ventilator-associated events
d. Additional surgical site infection locations that are not already covered within an existing measure in the program
e. 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)
f. 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
g. Measure that address causes of hospital harm such as an all-cause harm measure or a measure that encompasses multiple harms
h. 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 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.
- Measure steward must 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 is a relative measures of a hospital's readmission performance compared to the average hospital that admitted similar patients with that applicable condition. Applicable conditions in the 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. In the (FY) 2018 IPPS final rule, CMS changed the methodology to calculate the payment adjustment factor in accordance with the 21st Century Cures Act to assess penalties based on a hospital's performance relative to other hospitals treating a similar proportion of Medicare patients who are also eligible for full Medicaid benefits (i.e. dual eligible) beginning with the (FY) 2019 program.

Current Program Measure Information:

The following is a table detailing the 6 HRRP measures prioritized under the quality priorities and Meaningful Measure areas, which are currently implemented or proposed for the HRRP.

	Implemented/Finalized Measures in the Hospital Readmissions Reduction Program (HRRP)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**0**
	Making Care Safer	**0**
	Communication/Care Coordination	**6**
80	Readmission Rate Following Acute Myocardial Infarction	Admissions and Readmissions
1455	Readmission Rate Following Chronic Obstructive Pulmonary Disease	Admissions and Readmissions
1426	Readmission Rate Following Coronary Artery Bypass Graft	Admissions and Readmissions
78	Readmission Rate Following Heart Failure	Admissions and Readmissions
899	Readmission Rate Following Hip and/or Knee Arthroplasty	Admissions and Readmissions
83	Readmission Rate Following Pneumonia	Admissions and Readmissions
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**0**
	Person and Family Engagement	**0**

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domains as high priority for future measure consideration:

- *Promote Effective Communication and Coordination of Care:*
    - Admissions and Readmissions to Hospitals

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 Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals

Program History and Structure:
The Hospital Inpatient Quality Reporting (IQR) Program was established by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and expanded by the Deficit Reduction Act of 2005. The program requires hospitals paid under the Inpatient Prospective Payment System (IPPS) to report on process, structure, outcome, patient experience of care, efficiency, and cost of care measures. Failure to meet the requirements of the Hospital IQR Program will result in a reduction by one-fourth to a hospital's 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 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 *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 Promoting Interoperability, 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 Promoting Interoperability Program. All Promoting Interoperability 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 Hospital IQR Program and the Medicare and Medicaid Promoting Interoperability Program for EHs and CAHs, and information regarding the eCQMs. Based on current alignment efforts, hospitals that successfully submit eCQM data to meet Hospital IQR Program requirements fulfill the Medicare and Medicaid Promoting Interoperability Program requirement for reporting of eCQMs with one submission.

Current Program Measure Information:
The following table details the 23 quality measures prioritized under the quality priorities and Meaningful Measure areas, which are currently implemented or proposed in each program as finalized to date.

	Implemented/Finalized Measures in the Hospital Inpatient Quality Reporting Program (IQR) and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**11**
2752	Elective Delivery (Chart-abstracted)	Preventive Care
5756	Exclusive Breast Milk Feeding (eCQM)	Preventive Care
5774	ICU Venous Thromboembolism Prophylaxis (eCQM)	Preventive Care
854	Influenza Vaccination Coverage Among Healthcare Personnel	Preventive Care
5773	Venous Thromboembolism Prophylaxis (eCQM)	Preventive Care
5752	Anticoagulation Therapy for Atrial Fibrillation/Flutter (eCQM)	Mgt. of Chronic Conditions
5754	Antithrombotic Therapy by End of Hospital Day 2 (eCQM)	Mgt. of Chronic Conditions
5751	Discharged on Antithrombotic Therapy (eCQM)	Mgt. of Chronic Conditions
5771	Discharged on Statin Medication (eCQM)	Mgt. of Chronic Conditions
1357	Death Among Surgical Inpatients	Risk Adjusted Mortality
86	Mortality rate following Acute Myocardial Infarction	Risk Adjusted Mortality
	Making Care Safer	**2**
844	Complication rate following hip and/or knee arthroplasty	Preventable Healthcare Harm
1017	Severe Sepsis and Septic Shock Management	Preventable Healthcare Harm
	Communication/Care Coordination	**5**
5770	Admit Decision Time to ED Departure Time for Admitted Patients (eCQM)	Admissions and Readmissions
2706	Excess days for Acute Myocardial Infarction	Admissions and Readmissions
2708	Excess days for Heart Failure	Admissions and Readmissions
2852	Excess days for pneumonia	Admissions and Readmissions
5746	Readmission Measure with Claims and Electronic Data	Admissions and Readmissions
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**4**
2594	Payment for Acute Myocardial Infarction (AMI)	Patient Focused Episode
2278	Payment for Heart Failure (HF)	Patient Focused Episode
2711	Payment for hip and/or knee arthroplasty	Patient Focused Episode
2277	Payment for pneumonia (PN)	Patient Focused Episode
	Person and Family Engagement	**1**
113	Consumer Assessment of Healthcare Providers	Patient's Experience

* All EHR Incentive Program eCQMs are reportable in the Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals.

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domains as high priority for future measure consideration:

1. *Strengthen Person & Family Engagement as Partners in their Care:*
    a. Functional Outcomes
    b. Care is Personalized and Aligned with Patient's Goals
2. *Promote Effective Communication and Coordination of Care:*
    a. Seamless Transfer of Health Information
        (i) Measures of EMR safety, such as patient matching and correct identification
3. *Promote Effective Prevention and Treatment of Chronic Disease:*
    a. Prevention and Treatment of Opioid and Substance Use Disorders
4. *Make Care Safer by Reducing Harm Caused in the Delivery of Care:*
    a. Preventable Healthcare Harm

Measure Requirements:
CMS applies criteria for measures that may be considered for potential adoption in the Hospital IQR Program. At a minimum, the following criteria will be considered in selecting measures for Hospital IQR 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. 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 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 Meaningful Measure area, 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.

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. Three new measures were adopted and six were removed in the FY 2016 IPPS rule. One measure was adopted in the FY 2017 IPPS rule. In the FY 2018 IPPS rule, four measures were adopted and three measures were removed. One measure was adopted and four measures were removed in the FY 2019 IPPS rule. In the FY 2020 IPPS rule, CMS finalized removal of the existing pain management questions from the HCAHPS Survey. Additionally, one measure was adopted and one measure was removed.

Current Program Measure Information:
The following is a table detailing the 15 quality measures prioritized under the quality priorities and Meaningful Measure areas that are currently implemented in the program as finalized to date:

	Implemented/Finalized Measures in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program (PCHQR)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**2**
2577	Influenza Vaccination Coverage Among Healthcare Personnel	Preventive Care
542	Oncology: Plan of Care for Pain	Mgt. of Chronic Conditions
	Making Care Safer	**6**
1364	Catheter-associated Urinary Tract Infection	Healthcare Assoc. Infections
1475	Central line-associated Bloodstream Infection	Healthcare Assoc. Infections
831	Clostridium Difficile Infection	Healthcare Assoc. Infections
907	Hospital-Onset MRSA Bacteremia	Healthcare Assoc. Infections
2755	Procedure Specific Surgical Site Infection; Colon, Hysterectomy	Healthcare Assoc. Infections
5921	Surgical Treatment Complications for Localized Prostate Cancer	Preventable Healthcare Harm
	Communication/Care Coordination	**2**
6030	30-day Unplanned Readmissions for Cancer Patients	Admissions and Readmissions
2806	Admissions and ED Visits for Chemotherapy Patients	Admissions and Readmissions
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**0**
	Person and Family Engagement	**5**
5736	Cancer Patient Death < 3 Days After Hospice	End of Life Care
5734	Cancer Patient Death with ICU in the Last 30 Days	End of Life Care
5735	Cancer Patient Death without Hospice Admission	End of Life Care
5733	Death with Chemotherapy in the Last 14 Days of Life	End of Life Care
113	Consumer Assessment of Healthcare Providers	Patient's Experience

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domains 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.
- Measures of the patient's end of life according to their preferences.

4. *Promote Effective Prevention & Treatment of Chronic Disease*
    - Measures related to appropriate opioid prescribing and pain management best practices for cancer patients

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.

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 13 ESRD QIP measures prioritized under the quality priorities and Meaningful Measure areas, which are currently implemented or proposed for the ESRD QIP.

	Implemented/Finalized Measures in the End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**7**
2713	Dialysis Adequacy	Mgt. of Chronic Conditions
5642	Hemodialysis Vascular Access: Long-term Catheter Rate	Mgt. of Chronic Conditions
5641	Hemodialysis Vascular Access: Standardized Fistula Rate	Mgt. of Chronic Conditions
1014	Proportion of Patients with Hypercalcemia	Mgt. of Chronic Conditions
1937	Standardized Transfusion Ratio	Mgt. of Chronic Conditions
2928	Ultrafiltration Reporting	Mgt. of Chronic Conditions
2326	Clinical Depression Screening and Follow-Up Reporting	Treatment of Mental Health
	Making Care Safer	**2**
1381	Bloodstream Infection in Hemodialysis Patients	Healthcare Assoc. Infections
2925	NHSN Event Reporting Measure	Healthcare Assoc. Infections
	Communication/Care Coordination	**3**
2926	Standardized Hospitalization Ratio	Admissions and Readmissions
1689	Standardized Readmission Ratio	Admissions and Readmissions
5673	Percentage of Prevalent Patients Waitlisted	N/A
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**0**
	Person and Family Engagement	**1**
2575	CAHPS In-Center Hemodialysis Survey	Patient's Experience

High Priority Domains for Future Measure Consideration:
CMS identified the following three 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 adynamic 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.

Measure Requirements

Requirements 1-5 are statutorily mandated.

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.

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, a measure of Medicare Spending Per Beneficiary 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 (IQR) Program and posting dates on the Hospital Compare website.

Current Program Measure Information:
The following table details the 14 quality measures prioritized under the quality priorities and Meaningful Measure areas, which are currently implemented or proposed in the program as finalized to date.

	Implemented/Finalized Measures in the Hospital Value-Based Purchasing Program (HVBP)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**5**
86	Mortality rate following Acute Myocardial Infarction	Risk Adjusted Mortality
1930	Mortality rate following Chronic Obstructive Pulmonary Disease	Risk Adjusted Mortality
2264	Mortality rate following Coronary Artery Bypass Graft	Risk Adjusted Mortality
89	Mortality rate following heart failure	Risk Adjusted Mortality
92	Mortality rate following pneumonia	Risk Adjusted Mortality
	Making Care Safer	**7**
1364	Catheter-associated Urinary Tract Infection	Healthcare Assoc. Infections
1475	Central line-associated Bloodstream Infection	Healthcare Assoc. Infections
907	Hospital-Onset MRSA Bacteremia	Healthcare Assoc. Infections
831	NHSN Clostridium difficile Infection	Healthcare Assoc. Infections
2222	Procedure Specific Surgical Site Infection Outcome Measure	Healthcare Assoc. Infections
844	Complication rate following hip and/or knee arthroplasty	Preventable Healthcare Harm
104	Patient Safety for Selected Indicators (PSI 90)	Preventable Healthcare Harm
	Communication/Care Coordination	**0**
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**1**
2751	Medicare Spending Per Beneficiary	Patient Focused Episode
	Person and Family Engagement	**1**
113	Consumer Assessment of Healthcare Providers	Patient's Experience

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domains as high priority for future measure consideration:

1. *Strengthen Person & Family Engagement as Partners in their Care:*
    a. Functional Outcomes
2. *Promote Effective Prevention and Treatment of Chronic Disease:*
    a. Prevention and Treatment of Opioid and Substance Use Disorders
    b. Risk Adjusted Mortality

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 Meaningful Measure area, 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.

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 12 quality measures prioritized under the quality priorities and Meaningful Measure areas currently implemented in the program as finalized in the CY 2019 Outpatient Prospective Payment System (OPPS) and prior rules:

	Implemented/Finalized Measures in the Ambulatory Surgical Center Quality Reporting Program (ASCQR)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**1**
1061	Endoscopy/Poly Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (ASC-9)	Preventive Care
	Making Care Safer	**5**
2936	Normothermia Outcome (ASC-13)	Preventable Healthcare Harm
932	Patient Burn (ASC-1)	Preventable Healthcare Harm
933	Patient Fall (ASC-2)	Preventable Healthcare Harm
2937	Unplanned Anterior Vitrectomy (ASC-14)	Preventable Healthcare Harm
935	Wrong Site, Side, Patient, Procedure, Implant (ASC-3)	Preventable Healthcare Harm
	Communication/Care Coordination	**4**
931	All-Cause Hospital Transfer (ASC-4)	Admissions and Readmissions
5603	Hospital Visits after Orthopedic Procedures (ASC-17)	Admissions and Readmissions
5604	Hospital Visits after Urology Procedures (ASC-18)	Admissions and Readmissions
2086	Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (ASC-12)	Admissions and Readmissions
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**0**
	Person and Family Engagement	**2**
2938-2942	Outpatient CAHPS Facilities and Staff (ASC-15a-e)	Patient's Experience
1049	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (ASC-11)	Functional Outcomes

High Priority Meaningful Measure Areas for Future Measure Consideration:
Given the parsimonious measure set currently in use in ASCQR, CMS identified all of the following domains as high priority for future measure consideration:

1. *Making Care Safer*
2. *Person and Family Engagement*
3. *Best Practices of Healthy Living*
4. *Effective Prevention and Treatment*
5. *Making Care Affordable*
6. *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:

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 15 quality measures prioritized under the quality priorities and Meaningful Measure areas currently implemented in the program as finalized in the CY 2019 OPPS and prior rules.

	Implemented/Finalized Measures in the Hospital Outpatient Quality Reporting Program (HOQR)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**1**
1061	Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (OP-29)	Preventive Care
	Making Care Safer	**3**
2275	External Beam Radiotherapy for Bone Metastases (OP-33)	Preventable Healthcare Harm
128	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival (OP-02)	Preventable Healthcare Harm
918	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival (OP-23)	Preventable Healthcare Harm
	Communication/Care Coordination	**6**
2929	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (OP-35)	Admissions and Readmissions
2086	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (OP-32)	Admissions and Readmissions
930	Median Time from ED Arrival to ED Departure for Discharged ED Patients (OP-18)	Admissions and Readmissions
130	Median Time to Transfer to Another Facility for Acute Coronary Intervention (OP-03)	Admissions and Readmissions
922	Patient Left Without Being Seen (OP-22)	Admissions and Readmissions
2930	Hospital Visits after Hospital Outpatient Surgery (OP-36)	Admissions and Readmissions
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**3**
2599	Abdomen CT Use of Contrast Material (OP-10)	Appropriate Use of Healthcare
1367	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery (OP-13)	Appropriate Use of Healthcare
140	MRI Lumbar Spine for Low Back Pain (OP-08)	Appropriate Use of Healthcare
	Person and Family Engagement	**2**
2931-2935	Outpatient and Ambulatory Surgery CAHPS Facilities and Staff (OP-37a-e)	Patient's Experience
1049	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (OP-31)	Functional Outcomes

High Priority Meaningful Measure Areas for Future Measure Consideration:
Given the parsimonious measure set currently in use in HOQR, CMS identified all of the following domains as high priority for future measure consideration:

1. *Making Care Safer*
2. *Person and Family Engagement*
3. *Best Practices of Healthy Living*
4. *Effective Prevention and Treatment*
5. *Making Care Affordable*
6. *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:

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.

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 13 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) 2020 and beyond.

Current Program Measure Information:
The program seeks to adopt measures that reflect the priorities of the quality priorities and Meaningful Measure areas. The following is a table detailing the 13 quality measures under each of the quality priorities and Meaningful Measure areas that are currently implemented in the program as finalized in the FY 2019 IPF PPS and prior rules.

	Implemented/Finalized Measures in the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**7**
2759	Influenza Immunization	Preventive Care
2725	Screening for Metabolic Disorders	Preventive Care
5302	Alcohol Use Brief Intervention Provided or Offered	Prevention of Opioid Disorders
2813	Alcohol Use Treatment Provided or Offered at Discharge	Prevention of Opioid Disorders
2588	Tobacco Use Treatment Provided or Offered	Prevention of Opioid Disorders
5303	Tobacco Use Treatment Provided or Offered at Discharge	Prevention of Opioid Disorders
745	Follow-Up After Hospitalization for Mental Illness	Treatment of Mental Health
	Making Care Safer	**2**
1641	Hours of Physical Restraint Use	Preventable Healthcare Harm
2754	Hours of Seclusion Use	Preventable Healthcare Harm
	Communication/Care Coordination	**4**
1645	Patients Discharged on Antipsychotic Medications	Medication Management
2800	Thirty-Day All-Cause Unplanned Readmission	Admissions and Readmissions
2585	Timely Transmission of Transition Record	Transfer of Health Info.
2584	Transition Record with Specified Elements Received	Transfer of Health Info.
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**0**
	Person and Family Engagement	**0**

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domains as high priority for future measure consideration:

1. *Strengthen Person and Family Engagement as Partners in their Care*
   (1) Patient Experience and Functional Outcomes
      (a) Depression Measure
      (b) Patient's Experience of Care
   (2) Care is Personalized and Aligned with Patient's Goals
      (a) Caregiver Engagement Measure
2. *Make Care Safer by Reducing Harm Caused in the Delivery of Care*
   (1) Preventable Healthcare Harm
      (a) Aggregate Harm Measure

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 Meaningful Measure area, 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.

Skilled Nursing Facility Value-Based Purchasing Program

Program History and Structure:
The Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program was established by Section 215 (b) of the Protecting Access to Medicare Act of 2014. The facility adjusted Federal per diem rate will be reduced by 2% and an incentive payment will then be applied to facilities based upon readmission measure performance.

CMS has complied with the legislation mandates and has specified a SNF all-cause all-condition hospital readmission measure by October 1, 2015, and an all-condition risk-adjusted potentially preventable hospital readmission measure by October 1, 2016. We note that we intend to replace the all-cause measure with the potentially preventable measure as soon as practicable.

High Priority Future Measure Consideration:
CMS identified the following categories as high priority for future measure consideration:

1. CMS lacks the authority to implement additional measures beyond the two described in the statute.
2. CMS shall consider program transition to the potentially preventable readmission measure.

Measure Requirements:
CMS applies criteria for measures that may be considered for potential adoption in the SNF-VBP program. At a minimum, the following requirements must be met for selection in the SNF-VBP program:

- Must meet statutory requirements for all-condition potentially preventable hospital readmissions measure for SNFs.
- Must provide documentation sufficient to complete MUC list required data fields.
- Measures should be NQF endorsed, save where due consideration is given to endorsed measures of the same specified area or medical topic.
- May incorporate Medicare claims and/or alternative data sources will be considered dependent upon available infrastructure.

Part C and D Star Ratings

Program History and Structure:
The Part C & Part D Star Ratings program is based on sections 1851(d), 1852(e), 1853(o) and 1854(b)(3)(iii), (v), and (vi) of the Act and the general authority under section 1856(b) of the Act requiring the establishment of standards consistent with and to carry out Part C and Part D. We acted upon our authority to disseminate information to beneficiaries as the basis for developing and publicly posting the 5-star ratings system (sections 1851(d) and 1852(e) of the Act).

The Part C statute explicitly requires that information about plan quality and performance indicators be provided to beneficiaries to help them make informed plan choices. These data are to include disenrollment rates, enrollee satisfaction, health outcomes, and plan compliance with requirements. For Part C, the 5-star rating system is used in determining quality bonus payment (QBP) status and in determining rebate retention allowances. The Part D statute (at section 1860D–1(c)) imposes a parallel information dissemination requirement with respect to Part D plans, and refers specifically to comparative information on consumer satisfaction survey results as well as quality and plan performance indicators. Part D plans are also required by regulation (§ 423.156) to make Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data available to CMS and are required to submit pricing and prescription drug event data under statutes and regulations specific to those data. As of today, no Quality Bonus Payments (QBP) are associated with the ratings of Part D sponsors.

Initially, the Star Ratings Program measures were aligned with CMS' Quality Strategy objectives of optimizing health outcomes by improving quality and transforming the health care system. These objectives are consistent with the Meaningful Measures Framework's six quality categories of: 1) promoting effective communication and coordination of care, 2) strengthening person and family engagement in care, 2) promoting effective prevention and treatment of chronic disease, 4) working with communities to promote best practices of healthy living, 5) making care affordable, and 6) making care safer by reducing harm caused in the delivery of care.

Current Program Measure Information:
The following is a table detailing the number of the Parts C & D Star Ratings measures, prioritized under the quality priorities and Meaningful Measure areas, implemented in the program for measurement period starting on or after January 1, 2020. There are a total of 48 measures, 34 in Part C and 14 in Part D. Two of the measures share the same data source, so there are 46 unique measures in the Parts C & D Star Ratings. Both of these measures are included in the Part C and D measure lists:

- Complaints about the Health/Drug Plan
- Members Choosing to Leave the Health/Drug Plan

	Implemented/Finalized Measures in the Part C and D Star Ratings Program(s)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**21**
4000	Adult BMI Assessment	Preventive Care
4001	Annual Flu Vaccine	Preventive Care
4005	Breast Cancer Screening	Preventive Care
4008	Care for Older Adults – Functional Status Assessment	Preventive Care
4010	Care for Older Adults – Pain Assessment	Preventive Care
4013	Colorectal Cancer Screening	Preventive Care
4017	Controlling Blood Pressure	Management of Chronic Conditions
4019	Diabetes Care – Blood Sugar Controlled	Management of Chronic Conditions
4020	Diabetes Care – Eye Exam	Management of Chronic Conditions
4021	Diabetes Care – Kidney Disease Monitoring	Management of Chronic Conditions
4051	Improving or Maintaining Mental Health	Prevention, Treatment, and Management of Mental Health
4074	Medication Adherence for Cholesterol (Statins)	Management of Chronic Conditions
4075	Medication Adherence for Diabetes Medications	Management of Chronic Conditions
4076	Medication Adherence for Hypertension (RAS antagonists)	Management of Chronic Conditions
4080	Monitoring Physical Activity	Preventive Care
4082	Osteoporosis Management in Women who had a Fracture	Management of Chronic Conditions
4094	Rheumatoid Arthritis Management	Management of Chronic Conditions
4095	Special Needs Plan Care Management	Management of Chronic Conditions
6082	Statin Use in Persons with Diabetes	Management of Chronic Conditions
6083	Statin Therapy for Patients with Cardiovascular Disease	Management of Chronic Conditions
6084	Improving Bladder Control	Management of Chronic Conditions
	Making Care Safer	**1**
4092	Reducing the Risk of Falling	Preventable Healthcare Harm
	Communication/Care Coordination	**6**
311	Medication Reconciliation Post-Discharge	Medication Management
4007	Care Coordination	Transfer of Health Information and Interoperability
4009	Care for Older Adults – Medication Review	Medication Management
4077	MTM Program Completion Rate for CMR	Medication Management
4081	MPF Price Accuracy	Transfer of Health Information and Interoperability
4087	Plan All-Cause Readmissions	Admissions and Readmissions to Hospitals
	Best Practices of Healthy Living	**0**

	Implemented/Finalized Measures in the Part C and D Star Ratings Program(s)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Making Care Affordable	**6**
4002	Appeals Auto - Forward	Appropriate Use of Healthcare
4003	Appeals Upheld	Appropriate Use of Healthcare
4023	Drug Plan Quality Improvement	Patient Focused Episode of Care
4049	Health Plan Quality Improvement	Patient Focused Episode of Care
4088	Plan Makes Timely Decisions about Appeals	Appropriate Use of Healthcare
4093	Reviewing Appeals Decisions	Appropriate Use of Healthcare
	Person and Family Engagement	**14**
Not 4006	Call Center – Foreign Language Interpreter and TT Availability – Part D	Patient's Experience of Care
4006	Call Center – Foreign Language Interpreter and TT Availability – Part C	Patient's Experience of Care
4015	Complaints about the Drug Plan	Patient's Experience of Care
4015	Complaints about the Health Plan	Patient's Experience of Care
4018	Customer Service	Patient's Experience of Care
4025	Getting Appointments and Care Quickly	Patient's Experience of Care
4028	Getting Needed Care	Patient's Experience of Care
4029	Getting Needed Prescription Drugs	Patient's Experience of Care
4052	Improving or Maintaining Physical Health	Patient's Reported Functional Outcomes
4078	Members Choosing to Leave the Health Plan	Patient's Experience of Care
4078	Members Choosing to Leave the Drug Plan	Patient's Experience of Care
4089	Rating of Drug Plan	Patient's Experience of Care
4090	Rating of Health Care Quality	Patient's Experience of Care
4091	Rating of Health Plan	Patient's Experience of Care

High Priority Meaningful Measure Areas for Future Measure Consideration:
CMS identified the following domains as high priority for future measure consideration:

Promote Effective Communication and Coordination of Care. A primary goal of the Medicare Advantage Program is to coordinate care for beneficiaries in the effort to provide quality care. The Medicare population includes a large number of individuals and older adults with high-risk multiple chronic conditions (MCC) who often receive care from multiple providers and settings and, as a result, are more likely to experience fragmented care and adverse healthcare outcomes. Additionally, our priority is to improve medication management in older adults through evidence-based clinical practice guidelines to prevent harm and ensure patient safety. For older adults, it is important to 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. This population is at particular risk because of higher comorbidities, declining cognitive function and increased medication use.

Promote Effective Prevention and Treatment of Chronic Disease. The Medicare population includes a large number of individuals and older adults with high-risk multiple chronic conditions (MCC). Medicare beneficiaries with multiple high-risk chronic conditions are at increased risk for fragmented care and poor health outcomes so attention to effectively preventing and treating chronic disease is of utmost importance for the Medicare population. In addition, given that many Medicare beneficiaries with MCC are at great risk of experiencing daily pain, and the current opioid epidemic, it is important to monitor opioid prescribing practices for this population. 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:
CMS codified the methodology for the Part C and D Star Ratings program in the Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program Final Rule (CMS-4182-F) published in April 2018. The CY 2019 Final Rule includes the methodology for the 2021 Star Ratings. Any changes to the methodology for calculating the ratings, the addition of new measures, and substantive measure changes will be proposed and finalized through rulemaking.

The following guiding principles have been used historically in making enhancements and updates to the MA and Part D Star Ratings:

- 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.

Appendix A: List of MIPS Measures by Priority and Meaningful Measure Area

	Merit-Based Incentive Payment System (MIPS)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
	Effective Prevention and Treatment	**98**
1404	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Management of Chronic Conditions
226	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Management of Chronic Conditions
230	Coronary Artery Disease (CAD): Antiplatelet Therapy	Management of Chronic Conditions
233	Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Management of Chronic Conditions
235	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Management of Chronic Conditions
243	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	Management of Chronic Conditions
246	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	Management of Chronic Conditions
323	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Management of Chronic Conditions
328	Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy	Management of Chronic Conditions
358	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	Management of Chronic Conditions
364	Hematology: Multiple Myeloma: Treatment with Bisphosphonates	Management of Chronic Conditions
367	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	Management of Chronic Conditions
1926	Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer	Management of Chronic Conditions
461	Diabetes: Eye Exam	Management of Chronic Conditions
464	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Management of Chronic Conditions

	Merit-Based Incentive Payment System (MIPS)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
1406	Diabetes: Medical Attention for Nephropathy	Management of Chronic Conditions
533	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	Management of Chronic Conditions
539	Oncology: Medical and Radiation – Pain Intensity Quantified	Management of Chronic Conditions
625	Rheumatoid Arthritis (RA): Tuberculosis Screening	Management of Chronic Conditions
628	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	Management of Chronic Conditions
635	Rheumatoid Arthritis (RA): Glucocorticoid Management	Management of Chronic Conditions
662	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Management of Chronic Conditions
693	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis	Management of Chronic Conditions
1246	Controlling High Blood Pressure	Management of Chronic Conditions
2351	Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy	Management of Chronic Conditions
1168	Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy	Management of Chronic Conditions
1138	Sleep Apnea: Severity Assessment at Initial Diagnosis	Management of Chronic Conditions
1144	Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy	Management of Chronic Conditions
1501	Parkinson's Disease: Rehabilitative Therapy Options	Management of Chronic Conditions
1765	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Management of Chronic Conditions
2039	HIV Viral Load Suppression	Management of Chronic Conditions
2046	HIV Medical Visit Frequency	Management of Chronic Conditions
2390	Optimal Asthma Control	Management of Chronic Conditions
2543	Clinical Outcome Post Endovascular Stroke Treatment	Management of Chronic Conditions
2544	Psoriasis: Clinical Response to Systemic Medications	Management of Chronic Conditions

	Merit-Based Incentive Payment System (MIPS)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
2552	Osteoporosis Management in Women Who Had a Fracture	Management of Chronic Conditions
2572	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Management of Chronic Conditions
2864	Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)	Management of Chronic Conditions
5632	Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy	Management of Chronic Conditions
1275	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Prevention and Treatment of Opioid and Substance Use Disorders
2511	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Prevention and Treatment of Opioid and Substance Use Disorders
2274	Tobacco Use and Help with Quitting Among Adolescents	Prevention and Treatment of Opioid and Substance Use Disorders
2538	Anesthesiology Smoking Abstinence	Prevention and Treatment of Opioid and Substance Use Disorders
2542	Opioid Therapy Follow-up Evaluation	Prevention and Treatment of Opioid and Substance Use Disorders
2546	Documentation of Signed Opioid Treatment Agreement	Prevention and Treatment of Opioid and Substance Use Disorders
2548	Evaluation or Interview for Risk of Opioid Misuse	Prevention and Treatment of Opioid and Substance Use Disorders
2565	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Prevention and Treatment of Opioid and Substance Use Disorders
5881	Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)	Prevention and Treatment of Opioid and Substance Use Disorders
6043	Multimodal Pain Management	Prevention and Treatment of Opioid and Substance Use Disorders
432	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Prevention, Treatment, and Management of Mental Health
1077	Dementia: Cognitive Assessment	Prevention, Treatment, and Management of Mental Health

	Merit-Based Incentive Payment System (MIPS)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
1080	Dementia: Functional Status Assessment	Prevention, Treatment, and Management of Mental Health
1083	Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management	Prevention, Treatment, and Management of Mental Health
1092	Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	Prevention, Treatment, and Management of Mental Health
1098	Dementia: Education and Support of Caregivers for Patients with Dementia	Prevention, Treatment, and Management of Mental Health
1492	Parkinson's Disease: Psychiatric Symptoms Assessment for Patients with Parkinson's Disease	Prevention, Treatment, and Management of Mental Health
1495	Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment for Patients with Parkinson's Disease	Prevention, Treatment, and Management of Mental Health
1958	Maternity Care: Postpartum Follow-up and Care Coordination	Prevention, Treatment, and Management of Mental Health
2519	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Prevention, Treatment, and Management of Mental Health
1741	Depression Remission at Twelve Months	Prevention, Treatment, and Management of Mental Health
2535	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Prevention, Treatment, and Management of Mental Health
515	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Prevention, Treatment, and Management of Mental Health
1635	Adherence to Antipsychotic Medications For Individuals with Schizophrenia	Prevention, Treatment, and Management of Mental Health
745	Follow-Up After Hospitalization for Mental Illness (FUH)	Prevention, Treatment, and Management of Mental Health
2503	Anti-Depressant Medication Management	Prevention, Treatment, and Management of Mental Health
264	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	Preventive Care
291	Screening for Osteoporosis for Women Aged 65-85 Years of Age	Preventive Care
317	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	Preventive Care
439	Preventive Care and Screening: Influenza Immunization	Preventive Care
443	Pneumococcal Vaccination Status for Older Adults	Preventive Care
2508	Breast Cancer Screening	Preventive Care
451	Colorectal Cancer Screening	Preventive Care

	Merit-Based Incentive Payment System (MIPS)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
496	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Preventive Care
499	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	Preventive Care
502	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Preventive Care
522	Melanoma: Continuity of Care – Recall System	Preventive Care
638	Elder Maltreatment Screen and Follow-Up Plan	Preventive Care
1272	Radiology: Reminder System for Screening Mammograms	Preventive Care
2509	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Preventive Care
1296	Childhood Immunization Status	Preventive Care
1070	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	Preventive Care
1114	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	Preventive Care
2512	Cervical Cancer Screening	Preventive Care
2513	Chlamydia Screening for Women	Preventive Care
1572	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Preventive Care
2003	Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier	Preventive Care
1844	Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	Preventive Care
2531	Children Who Have Dental Decay or Cavities	Preventive Care
2532	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Preventive Care
2383	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	Preventive Care
1605	Immunizations for Adolescents	Preventive Care
2387	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	Preventive Care
2392	Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis	Preventive Care
2563	Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy	Preventive Care
2564	Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy	Preventive Care
5644	Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)	Preventive Care

	Merit-Based Incentive Payment System (MIPS)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
5730	HIV Screening	Preventive Care
2904	Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft (CABG)	Risk Adjusted Mortality
	Making Care Safer	**22**
258	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin	Healthcare Associated Infections
375	Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections	Healthcare Associated Infections
2431	Falls: Risk Assessment	Preventable Healthcare Harm
2430	Falls: Plan of Care	Preventable Healthcare Harm
2438	Coronary Artery Bypass Graft (CABG): Prolonged Intubation	Preventable Healthcare Harm
602	Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure	Preventable Healthcare Harm
605	Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration	Preventable Healthcare Harm
673	Radiology: Stenosis Measurement in Carotid Imaging Reports	Preventable Healthcare Harm
1247	Falls: Screening for Future Fall Risk	Preventable Healthcare Harm
1979	Implantable Cardioverter-Defibrillator (ICD) Complications Rate	Preventable Healthcare Harm
1962	Anastomotic Leak Intervention	Preventable Healthcare Harm
2378	Surgical Site Infection (SSI)	Healthcare Associated Infections
2537	Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery	Preventable Healthcare Harm
2388	Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Preventable Healthcare Harm
2389	Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	Healthcare Associated Infections
2555	Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal	Preventable Healthcare Harm
2556	Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury	Preventable Healthcare Harm
2558	Perioperative Temperature Management	Preventable Healthcare Harm
2566	Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair	Preventable Healthcare Harm
2567	Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair	Preventable Healthcare Harm

	Merit-Based Incentive Payment System (MIPS)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
2568	Proportion of Patients Sustaining a Ureter Injury at the Time of Pelvic Organ Prolapse Repair	Preventable Healthcare Harm
2571	Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure	Preventable Healthcare Harm
	Communication and Coordination of Care	**26**
1966	Unplanned Reoperation within the 30 Day Postoperative Period	Admissions and Readmissions to Hospitals
1969	Unplanned Hospital Readmission within 30 Days of Principal Procedure	Admissions and Readmissions to Hospitals
2701	All-cause Hospital Readmission	Admissions and Readmissions to Hospitals
303	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	Medication Management
506	Documentation of Current Medications in the Medical Record	Medication Management
656	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	Medication Management
816	Use of High-Risk Medications in the Elderly	Medication Management
2872	Medication Management for People with Asthma	Medication Management
254	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Transfer of Health Information and Interoperability
267	Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	Transfer of Health Information and Interoperability
525	Melanoma: Coordination of Care	Transfer of Health Information and Interoperability
546	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms	Transfer of Health Information and Interoperability
549	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	Transfer of Health Information and Interoperability
1101	Barrett's Esophagus	Transfer of Health Information and Interoperability
1104	Radical Prostatectomy Pathology Reporting	Transfer of Health Information and Interoperability
1147	Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness	Transfer of Health Information and Interoperability
1180	Biopsy Follow-Up	Transfer of Health Information and Interoperability

	Merit-Based Incentive Payment System (MIPS)	
CMIT ID	**Healthcare Priority** Measure Title	**Number of Measures** Meaningful Measure Areas
2286	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies	Transfer of Health Information and Interoperability
2295	Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	Transfer of Health Information and Interoperability
2527	Closing the Referral Loop: Receipt of Specialist Report	Transfer of Health Information and Interoperability
2395	Lung Cancer Reporting (Biopsy/Cytology Specimens)	Transfer of Health Information and Interoperability
2396	Lung Cancer Reporting (Resection Specimens)	Transfer of Health Information and Interoperability
2397	Melanoma Reporting	Transfer of Health Information and Interoperability
2559	Photodocumentation of Cecal Intubation	Transfer of Health Information and Interoperability
2875	Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician	Transfer of Health Information and Interoperability
5651	Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries	Transfer of Health Information and Interoperability
	Best Practices of Healthy Living	**0**
	Making Care Affordable	**38**
1719	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Appropriate Use of Healthcare
356	Appropriate Testing for Children with Pharyngitis	Appropriate Use of Healthcare
411	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	Appropriate Use of Healthcare
2343	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Appropriate Use of Healthcare
543	Radiology: Exposure Dose Indices or Exposure Time and Number of Images Reported for Procedures Using Fluoroscopy	Appropriate Use of Healthcare
650	Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	Appropriate Use of Healthcare
1126	Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7)	Appropriate Use of Healthcare

	Merit-Based Incentive Payment System (MIPS)	
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1129	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Operative Day #2)	Appropriate Use of Healthcare
1132	Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2)	Appropriate Use of Healthcare
1177	Sentinel Lymph Node Biopsy for Invasive Breast Cancer	Appropriate Use of Healthcare
1061	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Appropriate Use of Healthcare
1988	Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)	Appropriate Use of Healthcare
2573	Age Appropriate Screening Colonoscopy	Appropriate Use of Healthcare
2908	Trastuzumab Received By Patients With AJCC Stage I (T1c) – III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy	Appropriate Use of Healthcare
2865	RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy	Appropriate Use of Healthcare
2880	Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies	Appropriate Use of Healthcare
5616	Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use	Appropriate Use of Healthcare
5720	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture	Appropriate Use of Healthcare
460	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Appropriate Use of Healthcare
1850	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients	Appropriate Use of Healthcare
1853	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	Appropriate Use of Healthcare

	Merit-Based Incentive Payment System (MIPS)	
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1856	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients	Appropriate Use of Healthcare
1826	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	Appropriate Use of Healthcare
1829	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)	Appropriate Use of Healthcare
1832	Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse)	Appropriate Use of Healthcare
1955	Maternity Care: Elective Delivery or Early Induction Without Medical Indication at < 39 Weeks (Overuse)	Appropriate Use of Healthcare
2539	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	Appropriate Use of Healthcare
2540	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	Appropriate Use of Healthcare
2549	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	Appropriate Use of Healthcare
2550	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years	Appropriate Use of Healthcare
2553	Overuse of Imaging for the Evaluation of Primary Headache	Appropriate Use of Healthcare
2570	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Appropriate Use of Healthcare
2876	Non-Recommended Cervical Cancer Screening in Adolescent Females	Appropriate Use of Healthcare
2825	Appropriate Workup Prior to Endometrial Ablation	Appropriate Use of Healthcare
2896	Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score – better)	Appropriate Use of Healthcare
2893	Percentage of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life (lower score – better)	Appropriate Use of Healthcare
542	Oncology: Medical and Radiation - Plan of Care for Pain	Patient Focused Episode of Care
2547	Door to Puncture Time for Endovascular Stroke Treatment	Patient Focused Episode of Care

	Merit-Based Incentive Payment System (MIPS)	
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	Person and Family Engagement	**34**
313	Advance Care Plan	Care is Personalized and Aligned with Patient's Goals
2000	Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	Care is Personalized and Aligned with Patient's Goals
1985	Patient-Centered Surgical Risk Assessment and Communication	Care is Personalized and Aligned with Patient's Goals
2386	Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options	Care is Personalized and Aligned with Patient's Goals
1975	Pain Brought Under Control Within 48 Hours	End of Life Care According to Preferences
2382	Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences	End of Life Care According to Preferences
2948	Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (lower score – better)	End of Life Care According to Preferences
641	Functional Outcome Assessment	Functional Outcomes
1248	Functional Status Change for Patients with Knee Impairments	Functional Outcomes
1251	Functional Status Change for Patients with Hip Impairments	Functional Outcomes
1254	Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments	Functional Outcomes
1257	Functional Status Change for Patients with Low Back Impairments	Functional Outcomes
1260	Functional Status Change for Patients with Shoulder Impairments	Functional Outcomes
1263	Functional Status Change for Patients with Elbow, Wrist or Hand Impairments	Functional Outcomes
1049	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Functional Outcomes
1052	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	Functional Outcomes
2517	CAHPS for MIPs Clinician/Group Survey	Functional Outcomes
2528	Functional Status Assessment for Total Knee Replacement	Functional Outcomes
2529	Functional Status Assessment for Total Hip Replacement	Functional Outcomes
2530	Functional Status Assessments for Congestive Heart Failure	Functional Outcomes

	Merit-Based Incentive Payment System (MIPS)	
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2381	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery	Functional Outcomes
2385	Cataract Surgery: Difference Between Planned and Final Refraction	Functional Outcomes
2554	Varicose Vein Treatment with Saphenous Ablation: Outcome Survey	Functional Outcomes
2569	Quality of Life Assessment For Patients With Primary Headache Disorders	Functional Outcomes
5597	Back Pain After Lumbar Discectomy/Laminectomy	Functional Outcomes
5598	Back Pain After Lumbar Fusion	Functional Outcomes
5599	Leg Pain After Lumbar Discectomy/Laminectomy	Functional Outcomes
5877	Functional Status After Lumbar Fusion	Functional Outcomes
5876	Functional Status After Primary Total Knee Replacement	Functional Outcomes
5878	Functional Status After Lumbar Discectomy/Laminectomy	Functional Outcomes
5875	Leg Pain After Lumbar Fusion	Functional Outcomes
5874	International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	Functional Outcomes
6045	Functional Status Change for Patients with Neck Impairments	Functional Outcomes
629	Rheumatoid Arthritis (RA): Functional Status Assessment	Patient's Experience of Care

For more information, email the Measure Management Support Team at MMSSupport@Battelle.org.