



Measure Applications Partnership 2020-2021 Considerations for Implementing Measures in Federal Programs: Clinician, Hospital & PAC/LTC

FINAL REPORT

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Executive Summary

- MAP recognized the unique role that measurement plays in meeting the COVID-19 healthcare crisis through direct measurement of vaccination rates. While other quality measures will need flexibility to account for changes such as increased use of telehealth due to COVID-19, direct measurement of vaccination for patients and healthcare personnel is a key approach to addressing a national healthcare challenge.
- Services are increasingly moving from inpatient to ambulatory settings. This has implications for measures in both settings in how they are specified as well as approaches to performance improvement.
- Cost measures carry implicit concern associated with care stinting. The best thing clinically for a patient may result in higher episode-based costs even with long-term global cost savings. This also dictates a need for clear connections to upstream interventions that result in downstream cost savings.
- MAP underscored the need for mitigating measurement burden and recognized that the use of electronic clinical quality measures and other digital measures could reduce burden associated with data collection and reporting.
- MAP noted the importance of care coordination for all patients. Care coordination is vital to safe and effective care transitions. Coordination across and among all providers helps enable the most effective team-based care for patients.

The Measure Applications Partnership (MAP) provides multistakeholder pre-rulemaking input to the Centers for Medicare & Medicaid Services (CMS) on measures under consideration for payment and reporting programs. During the 2020-21 cycle, MAP reviewed 20 measures under consideration, with one measure considered for two programs and one measure considered for eight programs. The measures reviewed included five process measures (including three COVID-19 vaccination measures), five cost/resource use measures, five outcome measures, three composite measures, and two patient reported outcomes performance measures (PRO-PMs).

MAP's pre-rulemaking recommendations for measures in these programs reflect the MAP Measure Selection Criteria (MSC) and how well the measures address the goals of the program. These goals are determined either through statutory requirements or by CMS and are reflected in the measures brought forward to MAP for input. The MSC highlight characteristics of ideal program measures and complement program-specific federal statutory and regulatory requirements. The MSC focus on selecting high quality measures that address the three priority areas of better care, healthy people/communities, and affordable care; fill critical measure gaps; and increase alignment among programs. The selection criteria seek measures endorsed by the National Quality Forum (NQF) whenever possible; address a performance gap; encourage the appropriate mix of measure types; relate to person- and family-centered care and services; relate to disparities and cultural competency; avoid unintended consequences with benefits that outweigh burden and risk; and promote parsimony and alignment among public and private quality programs.

Clinician Programs

MAP considered a total of 11 measures under consideration for two clinician programs:

- Merit-Based Incentive Payment System (MIPS)
- Medicare Shared Savings Program (SSP)

There were no measures presented to MAP for review from the following program:

- Medicare Part C and D Star Ratings

Hospital Programs

MAP reviewed seven measures for seven hospital and setting-specific programs, with one measure considered for six programs and one measure considered for two:

- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Hospital Inpatient Quality Reporting (Hospital IQR) Program
- Hospital Outpatient Quality Reporting (Hospital OQR) Program
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)
- Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs)

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

- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing Program (VBP)

PAC/LTC Programs

MAP reviewed three measures for Post-Acute Care/Long-Term Care (PAC/LTC) programs, with one measure considered for three programs:

- Hospice Quality Reporting Program (HQRP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)

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

- Home Health Quality Reporting Program (HH QRP)
- Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

Overarching Discussion Themes

Measures to Address COVID-19 Vaccination Rates

MAP recognized the unique role that measurement plays in meeting the COVID-19 healthcare crisis through measurement of vaccination rates. While other quality measures will need flexibility to account

for changes such as increased use of telehealth due to COVID-19, measurement of vaccination for patients and healthcare personnel is a key approach to addressing a national healthcare challenge. With this emergent crisis, MAP encouraged CMS to finalize the specifications for the intended measures quickly. MAP recognized that many of the data collection methodologies mirror those already used for influenza measures, some of which are considered relatively burdensome by providers. Nonetheless, MAP noted that the nature of the COVID-19 pandemic is such that measures are necessary to help providers understand how they are performing at vaccinating their patients, and for patients to understand the extent to which providers are vaccinating their personnel.

Evolving Trends in Service Setting

MAP emphasized that clinical services are increasingly moving from inpatient to the ambulatory setting. This has implications for measures in both settings relative to how they are specified as well as approaches to performance improvement. Specifically, MAP noted the increasing shift towards outpatient and ambulatory services may jeopardize certain minimum case thresholds over time, as the inpatient volume decreases. MAP reaffirmed the importance of measuring care services provided within the inpatient setting. However, MAP emphasized that CMS be sensitive to the changes in healthcare and the migration of services to the ambulatory setting. MAP further suggested that CMS explore the major groupings of the types of services and procedures offered in the outpatient setting to identify gaps for measure development.

Connections Between Cost Measures and Quality Measures

MAP recognized that CMS is required by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 to implement cost measures within the MIPS program. However, MAP expressed concerns related to explicit connections between cost and quality for measures that CMS is considering for MIPS. While the need to use appropriately correlated cost and quality measures together to assess health system efficiency is well established, there is currently no clear consensus among stakeholders or recognized state of the art on precisely how to do so. NQF has built much of its work around cost and resource use measurement on guidance established by prior work, including the Institute of Medicine's definition of efficiency and NQF's Patient Focused Episode of Care Model. In 2014, an NQF white paper explored various approaches to deploying cost and quality measures concurrently.

MAP noted that cost measures carry implicit concern associated with care stinting. MAP further asserted that the best initial clinical intervention for a patient may result in higher episode-based costs although long-term global cost savings may eventually be realized. This also dictates a need for clear connections to upstream interventions that result in downstream cost savings. MAP encouraged CMS to focus on cost measures that are fair to providers in appropriately connecting quality care and cost savings that demonstrate true value-based care. MAP suggested that there are opportunities to perform further analysis especially for episode-based cost measures that focus on chronic conditions to establish the impact measures have on quality of care.

Measure Burden and Digital Measures

CMS has emphasized as part of the CMS Quality Measurement Action Plan a focus on the transition to digital quality measures as a practical approach to reducing measurement burden. MAP noted that digital quality measures, especially electronic clinical quality measures (eCQMs), give opportunities for real-time feedback to providers. In addition, MAP noted the importance of digital quality measurement,

but suggested that many eCQMs are not entirely ready for use in accountability programs, and that electronic health record (EHR) vendors should be engaged throughout the process to ensure that such measures are ready for deployment. MAP also emphasized the need to ensure that digital quality measures are transparent to all entities, including health plans. MAP underscored the need for mitigating measurement burden and recognized that the use of eCQMs and other digital quality measures could reduce data collection and reporting burden.

MAP emphasized deeper alignment between public and private payors to have identical core measures as a potential means to decrease measurement costs and burden. MAP added that this needs to be balanced with pockets for measurement innovation to allow the quality measurement enterprise to move forward. With respect to PRO-PMs, MAP noted there is some resistance to PRO-PMs because they are more burdensome to collect. MAP encouraged CMS to provide support and infrastructure to ease the burden of data collection for PRO-PMs.

Composite Measures

MAP pointed out that composite measures serve as a consolidation of measures that may provide an important comprehensive view of how a given provider is performing on a series of important measures, which is especially useful for comparative purposes for public reporting. MAP also recognized that the importance of some components may be easier to understand by patients than others. MAP expressed concern related to the utility of such measures from a provider perspective if the individual measure rates are not presented to the provider and recognized that in such instances it is challenging for the provider to determine how to deploy quality improvement resources to improve performance. MAP also expressed concern about appropriate weighting of individual components of such measures and suggested that they should not always be equally weighted, depending on component relative importance. MAP further indicated that this is also true in instances when a composite measure may have an unequal distribution of patients represented through each component, recognizing that in such measures a heavier weighting for components with a larger number of events is appropriate.

Care Coordination

MAP noted the importance of care coordination for all patients. Care coordination is vital to safe and effective care transitions. Coordination across and among all providers helps enable the most effective team-based care for patients. Sharing information across care settings and throughout the entire care team promotes shared accountability for the quality of patient care and ensures that all clinicians on the care team have up-to-date and accurate information. This information is necessary to provide safe, high quality care. MAP urged CMS to consider topics such as communication and the transfer of information as components under the larger umbrella of coordination of care.

MAP continued to prioritize care coordination as a gap for all of the PAC/LTC programs, noting that the patients receiving care from PAC/LTC providers are clinically complex and patients may frequently transition between care settings. MAP reaffirmed the importance of measuring care coordination beyond facility stays, including referral to effective services after the stay. MAP noted that the ability to manage care and all the services after discharge has a direct impact on patient and caregiver burden and on patient readmissions.

Considerations for Specific Programs

Clinician Program Measures

Merit-Based Incentive Payment System (MIPS)

MIPS was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MIPS consolidated preexisting Medicare incentive and quality reporting programs for clinicians into a single program. MIPS makes positive and negative payment adjustments for Eligible Clinicians (ECs) based on performance in four categories:

- Quality
- Cost
- Promoting interoperability
- Improvement activities

To meet the quality component of the program, individual ECs or groups of ECs choose six measures to report to CMS. One of these measures must be an outcome measure or other high-priority measure. Clinicians can also choose to report a specialty measure set. In the 2020-2021 pre-rulemaking deliberations, MAP reviewed 10 measures for the MIPS program. The COVID-19 vaccination measure for MIPS is discussed under a separate section.

MIPS Cost Measures

- MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost
- MUC20-0016: Colon and Rectal Resection Episode-Based Cost
- MUC20-0017: Diabetes Episode-Based Cost
- MUC20-0018: Melanoma Resection Episode-Based Cost
- MUC20-0019: Sepsis Episode-Based Cost

MIPS Quality Measures

- MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System
- MUC20-0040: Intervention for Prediabetes
- MUC20-0042: Person-Centered Primary Care Measure Patient-Reported Outcome Performance
- MUC20-0043: Preventive Care and Wellness (Composite)

MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost

The Asthma/COPD cost measure evaluates a clinician's or clinician group's risk-adjusted cost to Medicare for patients receiving medical care to manage asthma or COPD. The measure score is a clinician's or clinician group's weighted average of risk-adjusted cost for each episode attributed to the clinician/clinician group, where each episode is weighted by the number of assigned days during the episode. This chronic measure includes services that are clinically related and under the reasonable influence of the attributed clinician/clinician group. Services are assigned during an Asthma/COPD episode, which is a portion of the overall time of a clinician's or clinician group's responsibility for managing a patient's asthma or COPD. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

MAP questioned the reliability of the data based on the number of cases. MAP also noted that while increases in the thresholds for the number of events resulted in improved reliability, there were remaining questions about the number of clinicians that would be included in the measure calculations. MAP encouraged CMS to ensure appropriate reliability thresholds are met. The importance of social risks factors for asthma and COPD was also noted.

MAP did not recommend the measure for rulemaking with potential for mitigation. Mitigation is contingent on further evaluation on impact points for actionability demonstrating the connection between upstream medical interventions and downstream costs, as well as NQF endorsement. MAP noted a tension between expenses associated with good care that may result in reductions in overall cost of care but raise condition-specific care. MAP urged CMS to balance these cost measures with appropriate quality measures and to demonstrate the connection between them. MAP further noted that cost measures associated with upstream preventions should result in lowered downstream costs and expressed concerns that this is not the case for the measure, impacting its overall actionability. The developer clarified that cost measures do not attempt to dictate clinician practice, as that would be beyond their scope; rather they aim to fairly capture costs related to that practice. The developer also noted that the literature and convened clinical experts identified this measure as an important area to assess costs in MIPS and one where clinicians could make care decisions that reduce the likelihood of high costs.

MUC20-0015 addresses the Patient-Focused Episode of Care goal of CMS's Meaningful Measures initiative, the MIPS high priority area of Efficiency/Cost Reduction and MACRA statutory requirements. MAP noted that this measure was devised to reduce costs to Medicare claimants who experienced episodes of asthma and COPD events. While there are suggestions that effective interventions for asthma and COPD that result in lowered overall cost of care for beneficiaries and better patient outcomes, MAP suggested that these should be explicitly connected with MIPS asthma and COPD measure prior to implementation. Some MAP members noted stakeholder concerns about the inclusion of Part D costs for all cost measures and expressed concerns over reliability rates below 0.7. Should testing data show that the measure appropriately measures episode-based cost and can be used alongside quality measures, this measure would be valuable to add to the program measure set.

The Rural Health Workgroup was supportive of the measure from a rural perspective.

MUC20-0016: Colon and Rectal Resection Episode-Based Cost

The Colon and Rectal Resection cost measure evaluates clinician's or clinician group's risk-adjusted cost to Medicare for patients who receive colon or rectal resections for either benign or malignant indications. The measure score is a clinician's or clinician group's average risk-adjusted cost for the episode group across all attributed episodes. This inpatient procedural measure includes services that are clinically related and under the reasonable influence of the attributed clinician or clinician group during the 15 days prior to the clinical event that opens or "triggers" the episode through 90 days after. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

One MAP member suggested that CMS consider a 30-day window prior to the clinical event rather than a 15-day window. The developer responded that several options were considered and that the 15-day window was discussed and decided upon by a group of clinical experts.

MAP recommended conditional support for rulemaking contingent on NQF endorsement. MAP noted that MUC20-0016 addresses the Patient-Focused Episode of Care goal of CMS's Meaningful Measures initiative, the CMS high priority area of Efficiency/Cost Reduction, and MACRA statutory requirements. Currently, there are no measures that assess episode-based cost related to colectomy.

MAP noted that colorectal cancer represents 8.2 percent of all cancer diagnoses, impacting nearly 150,000 patients per year. Evidence suggests that surgical decision-making and treatment course related to colon and rectal resection can reduce length of hospital stay, risk of major post-operative complications, and cost. Should testing data show that the measure appropriately measures episode-based cost while maintaining quality, this measure would be valuable to add to the program measure set.

The Rural Health Workgroup was supportive of the measure from a rural perspective.

MUC20-0017: Diabetes Episode-Based Cost

This diabetes cost measure evaluates a clinician's or clinician group's risk adjusted cost to Medicare for patients receiving medical care to manage type 1 or type 2 diabetes. The measure score is a clinician's or clinician group's weighted average of risk-adjusted cost for each episode attributed to the clinician group, where each episode is weighted by the number of assigned days during the episode. This chronic measure includes services that are clinically related and under the reasonable influence of the attributed clinician group. Services are assigned during a diabetes episode, which is a portion of the overall time of a clinician's or clinician group's responsibility for managing a patient's diabetes. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

MAP questioned the reliability of the measure and asked for clarification related to exclusions and risk-adjustment. MAP expressed concern that the measure is significantly less reliable for individual physicians than for groups. MAP noted the importance of the correlation of cost measures with quality. Diabetes is very costly and there is substantial variation in performance. MAP suggested that there is a need to advance chronic care measures and to improve the opportunity for their testing.

MAP did not support the measure for rulemaking with potential for mitigation. Mitigation is contingent on further evaluation of impact points for actionability demonstrating the connection between upstream medical interventions and downstream costs, as well as NQF endorsement. MAP noted a tension between expenses associated with good care that may result in reductions in overall cost of care but raise condition-specific care costs. MAP urged CMS to balance these cost measures with appropriate quality measures that relate to lower costs. MAP further noted that upstream prevention should result in downstream costs and expressed concerns that this is not the case for the measure, impacting its overall actionability. MAP noted that this measure aims to improve care by optimizing resource use associated with diabetes management. While there are measures in MIPS related to individual treatments for diabetes, this measure would potentially focus care on the most cost-effective interventions, but these should be connected.

The developer clarified that cost measures do not attempt to dictate clinician practice, as that would be beyond their scope; rather they aim to fairly capture costs related to that practice. The developer also noted that the literature and convened clinical experts identified this measure as an important area to

assess costs in MIPS and one where clinicians could make care decisions that reduce the likelihood of high costs.

MUC20-0017 addresses the Patient-Focused Episode of Care goal of CMS's Meaningful Measures initiative, the MIPS high priority area of Efficiency/Cost Reduction and MACRA statutory requirements. This measure could improve Medicare costs of diabetes by incentivizing risk reduction treatments that are cost effective. Some MAP members noted stakeholder concerns about the inclusion of Part D costs for all cost measures and expressed concerns over reliability rates below 0.7. Should testing data show that the measure appropriately measures episode-based cost and can be used to improve value of care, this measure would be valuable to add to the program measure set.

The Rural Health Workgroup agreed that the measure was suitable for use with rural providers in MIPS.

MUC20-0018: Melanoma Resection Episode-Based Cost

The Melanoma Resection cost measure evaluates clinician's or clinician group's risk-adjusted cost to Medicare for patients who undergo an excision procedure to remove a cutaneous melanoma. The measure score is a clinician's average risk-adjusted cost for the episode group across all episodes attributed to the clinician or clinician group. This procedural measure includes services that are clinically related and under the reasonable influence of the attributed clinician during the 30 days prior to the clinical event that opens or "triggers" the episode through 90 days after. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

MAP questioned the impact that the depth of a given melanoma may have on cost, especially with sentinel lymph node biopsies; the developer noted risk adjustment associated with assessment of disease severity. It was noted that reconstruction was also included in risk adjustment. MAP noted an attribution concern, which the developer addressed by noting that costs generally align with the clinicians performing the procedure. The developer noted that Part D costs are not included in this measure unlike some of the other cost measures brought before MAP this cycle.

MAP recommended conditional support for rulemaking contingent on NQF endorsement. MUC20-0018 addresses the Patient-Focused Episode of Care goal of CMS's Meaningful Measures initiative, the MIPS high priority area of Efficiency/Cost Reduction and MACRA statutory requirements. Currently, there are no measures that assess episode-based cost related to melanoma. Melanoma is of growing concern to the Medicare population. MAP noted that the total annual treatment cost for melanoma is estimated at \$3.3 billion, while melanoma resection is cited as curative in 85-90 percent of cases, with a 99 percent five-year survival rate. This measure aims to optimize resource use associated with melanoma resection. Clinician decision making is cited as being an important predictor of cost and an important pathway for risk reduction in melanoma care.

Melanoma represents 5.6 percent of all cancer diagnoses, impacting over 190,000 patients per year. This measure could reduce costs of melanoma treatment and incentivize reduction of treatments that are not cost effective. Should testing data show that the measure appropriately measures episode-based cost and can be used alongside quality measures, this measure would be valuable to add to the program measure set.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in MIPS.

MUC20-0019: Sepsis Episode-Based Cost

The sepsis cost measure evaluates clinician's or clinician group's risk adjusted cost to Medicare for patients who receive inpatient medical treatment for sepsis. The measure score is a clinician's or clinician group's average risk-adjusted cost for the episode group across all attributed episodes. This acute inpatient medical condition measure includes services that are clinically related and under the reasonable influence of the attributed clinician's role in managing care during each episode from the clinical event that opens or "triggers" the episode through 45 days after. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

MAP highlighted concerns about defining patients who have sepsis, including patients who are in very early stages of sepsis. The potential for miscoding with overdiagnoses to reflect lower costs is a continuing situation of concern. The developer noted that there are risk adjustment variables to assess the disease severity and to cover episodes that are not actually sepsis.

MAP did not support the measure with potential for mitigation, with the mitigation points being NQF endorsement, an analysis of the potential for gaming associated with overdiagnosis of sepsis, and further evaluation of the correlation with clinical quality measures.

MUC20-0019 addresses the Patient-Focused Episode of Care goal of CMS's Meaningful Measures initiative, the MIPS high priority area of Efficiency/Cost Reduction and MACRA statutory requirements. This measure was devised to reduce costs to Medicare septicemia-related events which represent a significant share of hospitalizations and Medicare cost. MAP noted that the annual number of Medicare beneficiaries with a sepsis hospitalization exceeds 1.1M, with over \$22B in costs. Some MAP members noted stakeholder concerns about the use of Part D costs for all cost measures and expressed concerns over reliability rates below 0.7. Should testing data show that the measure appropriately measures episode-based cost and can be used alongside quality measures, and a clear indication that there is not gaming of the measure through overdiagnosis, this measure would be valuable to add to the program measure set.

Public comment noted that there is a clear difference between patients who present with sepsis on admission and those who do not.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in MIPS.

MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-Based Incentive Payment System

This measure addresses annual risk-standardized rate of acute, unplanned cardiovascular-related admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with heart failure (HF) or cardiomyopathy.

MAP expressed concerns about the variation in staging of HF and the impact on clinicians who treat patients with more advanced conditions.

MAP did not recommend the measure for rulemaking with potential for mitigation. Mitigation points are NQF endorsement and an analysis of the appropriateness of the risk adjustment for clinicians with higher caseloads of patients with more complicated or severe heart failure. MAP noted that while the measure raises concerns that the risk adjustment may not adequately account for advanced heart

failure stages, the measure also centers on an important need. As MAP discussed, these points will be addressed by the NQF endorsement process. MUC20-0034 addresses MIPS high priority areas including patient outcomes, care coordination and cost reduction, as well as the Meaningful Measures areas of admissions and readmissions to hospitals and management of chronic conditions. If included in the measure set, MUC20-0034 would be the only outcome measure in MIPS related to heart failure.

MAP noted that 6.5M Americans are living with heart failure, and a fifth of patients hospitalized with heart failure are readmitted to the hospital within 30 days. Hospitalization is costly and accounts for 79 percent of lifetime costs associated with heart failure. However, a 20-30 percent reduction in hospitalization rates can be achieved for heart failure patients through high quality care with patient support programs. MUC20-0034 encourages clinicians to reduce readmissions through high quality ambulatory care.

Public comment noted a lack of ability for ICD-10 codes to keep up with the staging of HF and cautioned against using the ICD-10 set alone.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in MIPS.

MUC20-0040: Intervention for Prediabetes

This measure is the percentage of patients aged 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period who were provided an intervention.

MAP noted that the measure was not supported for NQF endorsement by the Primary Care and Chronic Illness Committee during their spring 2020 measure evaluation cycle and agreed that the set of interventions did not reflect the range of interventions that are available to clinicians to address prediabetes. The measure developer asserted that the measure is reflective of current evidence-based interventions and that expanding beyond them may make the available interventions to meet the numerator less evidence based. MAP noted that there are other evidence-based approaches recommended by the U.S. Preventive Services Task Force that the developer may consider, among others. MAP further suggested that “patients with abnormal glucose levels” is more appropriate terminology than prediabetes. It was also noted that the measure considers nonpharmacological interventions (lifestyle changes such as diet and exercise) on par with pharmacological interventions. The measure could be a burden given that referrals and lab results are not always easily obtained.

MAP did not recommend the measure for rulemaking with potential for mitigation. Mitigation points include re-specifying the measure to include an adequate range of interventions for prediabetes available to the clinician beyond prescription of metformin or referring the patient to an external service. The measure should also receive NQF endorsement. MUC20-0040 addresses the Meaningful Measure area of Preventive Care. Clinicians who identify patients with prediabetes can reduce risk of diabetes onset through clinical and lifestyle interventions. Prevention measures are of high value to MIPS and there are currently no prediabetes measures in MIPS.

MAP acknowledged that prediabetes and diabetes are important conditions within the Medicare population resulting in high mortality, morbidity, and cost of care. Diabetes has preventable risk factors and can be addressed through intervention. Medical Nutrition Therapy has been shown to be successful in deterring the progression of prediabetes to type 2 diabetes. Current evidence supports a role for

metformin in diabetes prevention when coupled with lifestyle interventions in people with prediabetes. However, the measure was noted by the NQF Primary Care and Chronic Illness Committee to offer too few options for intervention.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in MIPS.

MUC20-0042: Person-Centered Primary Care Measure Patient-Reported Outcome Performance

The Person-Centered Primary Care Measure Patient-Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM PROM (a comprehensive and parsimonious set of 11 patient-reported items) to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the provider or practice. Patients identify the PCPCM PROM as meaningful and able to communicate the quality of their care to their clinicians and/or care team. The items within the PCPCM PROM are based on extensive stakeholder engagement and comprehensive reviews of the literature.

MAP expressed that the measure offers a valuable additional prospective PRO-PM to the MIPS measure set. MAP reviewed the differences between this measure and the Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) measure. The developer noted that there is little overlap between the CG-CAHPS questions and this performance measure. The focus of CG-CAHPS is consumer experiences with questions concerning items such as friendliness, openness, environment, and communication. This measure concerns primary care and includes items such as access and behavioral health.

MAP offered conditional support for rulemaking contingent on NQF endorsement. MAP noted that MUC20-0042 addresses the Meaningful Measurement area of Care is Personalized and Aligned with Patient's Goals, and the MIPS high priority measurement area of Person and Caregiver-Centered Experience and Outcomes. MAP considers appropriate PRO-PMs an important consideration for MIPS. Capturing the voice of the patient is an important component of delivering high value primary care. There are a limited number of patient experience measures within the MIPS program measure set.

MAP noted a body of evidence that demonstrates a strong connection between patient experience of care and traditional healthcare outcomes, such as improved intermediate outcomes, greater adherence to recommended treatment, and reduced use of healthcare services. The assessment of patient experience of care is a critical element in care quality. Patient experience measures focus important attention to the consumer experience of care delivery and receipt of services but fall short of focused attention to the broad scope of primary care.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in MIPS.

MUC20-0043: Preventive Care and Wellness (Composite)

This measure is the percentage of patients who received age- and sex-appropriate preventive screenings and wellness services. This measure is a composite of seven component measures that are based on recommendations for preventive care by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), and American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE).

MAP expressed support of upstream preventive healthcare, screening, and preventive care. However, MAP also expressed concerns that the measure may be a checkbox measure and may be more meaningful if directly connected to outcomes. MAP also expressed concern that some of the components may be topped out measures. MAP discussed the components of this composite measure and suggested that they should not be weighted equally. MAP expressed concern that some components may result in the use of small denominators as others use large ones resulting in an average for a single measure that is not representative of the care provided. MAP noted that this situation could indicate that a clinician is doing well when they are not. Some MAP members suggested that the components were disparate and not patient-centered. There was some support for keeping the components of the measure unbundled. In addition, it was suggested that the data gathering for this measure may be a heavy burden on the provider. The measure may be appropriate as data are increasingly digitized. However, it was also noted that the measure does not directly address patient outcomes.

MAP did not recommend the measure for rulemaking with potential for mitigation. Mitigation points include receipt of NQF endorsement, and that CMS ensure that the components of the measure are appropriately weighted. MAP noted that the seven components of this composite measures are all currently used in MIPS and the Medicare Part C and D programs. CMS has expressed their intention to remove the individual component measures if this composite measure is implemented in MIPS. MAP expressed divided concern for potential redundancy with the singular measures for the composite measure already in MIPS and concerns associated with the removal of the individual measures. MAP also expressed concerns related to some of the measure components being topped out.

MAP expressed support for preventive measures in general. MAP noted that this measure may impact the 37 million Medicare beneficiaries who receive one or more preventive services, and the one in six Medicare beneficiaries who are younger than 65 years old who would seek preventive services.

Public comment provided a general caution associated with MUC20-0043 due to its complexity.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in MIPS.

Program Measure Gaps

MAP had a limited discussion on measure gaps within the MIPS program. Within the MIPS measure set, MAP emphasized the need for measures associated with racism and equity rather than simply stratifying existing measures.

Medicare Shared Savings Program (SSP)

The Medicare SSP was established by Section 3022 of the Affordable Care Act (ACA). Eligible providers, hospitals, and suppliers may participate in the SSP by creating or participating in an accountable care organization (ACO). ACOs that meet the program requirements and quality standards are eligible for shared savings. There are four shared savings options: 1) one-sided risk model (providers do not assume shared losses); 2) two-sided risk model (providers assume limited losses [less than higher tracks]); 3) two-sided risk model (sharing of savings and losses, and possibly sharing in a greater portion of savings than track 1 ACOs); and 4) two-sided risk model (sharing of savings and losses with greater risk than track 2, but possibly sharing in the greatest portion of savings if successful). SSP aims to promote

accountability for a patient population, care coordination, and the use of high quality and efficient services.

MAP considered a single measure for the Medicare Shared Savings Program during the 2020-2021 cycle.

MUC20-0033: ACO-Level Days at Home for Patients with Complex, Chronic Conditions

This is a measure of days at home or in community settings (that is, not in unplanned acute or emergent care settings) for patients with complex, chronic conditions in Shared Savings Program (SSP) ACOs. The measure includes risk adjustment for differences in patient mix across ACOs, with an adjustment-based patient risk of death. A policy-based nursing home adjustment that accounts for patients' risk of transitioning to a long-term nursing home is also applied to incentivize community-based care.

MAP noted that the measure is being driven largely by inpatient stays and cost measures. Some MAP members suggested that the correlation between this measure and other measures such as rehospitalization and cost be analyzed.

MAP conditionally supported the measure for rulemaking contingent on NQF endorsement. MAP noted that MUC20-0033 addresses the Meaningful Measures areas of Management of Chronic Conditions and Preventive care, and the healthcare priority to Promote Effective Prevention and Treatment of Chronic Disease. The measure aims to promote high quality coordinated care to keep adults with complex, chronic conditions in home or community settings and out of acute care or long-term care settings.

MAP noted that remaining in the home is generally preferred by patients and associated with other important outcomes, including social activity and reduced depression. Timely and appropriate primary care and end-of-life care services can increase the number of days patients spend at home. Improved care coordination and care transitions can prevent unplanned hospital visits, leading to more days at home and high quality timely care.

Public comment questioned if the measure is in addition to the existing measures or in place of a measure currently used. Additionally, it was asked what data concerning this measure will be shared with ACOs in quarterly reports. The concept was supported but there were concerns with the exceptions and risk adjustment for the measure. The National Association of Accountable Care Organizations did not support addition of the measure. The MAP Rural Health Workgroup noted few rural providers in their state are part of ACOs and provision of home-based care/home health services could be challenging for rural providers. The Workgroup was neutral in their voting on the suitability of the measure.

Program Measure Gaps

MAP identified measure gaps within SSP, namely that the shift in quality measures disagreed with the choice to move to eCQMs and suggested that there has been an over-reduction in the number of measures within the program. MAP suggestions also included the need for both MIPS and SSP measures to consider racism and equity rather than simply stratifying existing measures. A comment concerning the MIPS measure set noted that outcome measures tie meaningfully to quality improvement.

Hospital Program Measures

End Stage Renal Disease Quality Incentive Program Measures

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

MUC20-0039: Standardized Hospitalization Ratio for Dialysis Facilities

The standardized hospitalization ratio is defined as the ratio of the number of hospital admissions that occur for Medicare ESRD dialysis patients treated at a particular facility to the number of hospitalizations that would be expected given the characteristics of the dialysis facility's patients and the national norm for dialysis facilities. This measure is calculated as a ratio but can also be expressed as a rate. When used for public reporting, the measure calculation will be restricted to facilities with fewer than five patient years at risk in the reporting year. This restriction is required to ensure patients cannot be identified due to small cell size.

MAP supported this measure for rulemaking. This NQF-endorsed measure is currently implemented in the ESRD QIP. The developer reported updates to the risk adjustment method of the measure, which includes a prevalent comorbidity adjustment, the addition of Medicare Advantage patients and a Medicare Advantage indicator in the model, updates to parameterization of existing adjustment factors and re-evaluation of interactions, and an indicator for patient's time spent in a skilled nursing facility. These updates have been reviewed by the NQF All-Cause Admissions and Readmissions Standing Committee during the spring 2020 evaluation cycle, which recommended the measure for continued endorsement. Other similar measures in the ESRD QIP program evaluate different outcomes than MUC20-0039.

Hospitalization rates vary across dialysis facilities, even after adjusting for patient characteristics. This suggests that hospitalizations might be influenced by dialysis facility practices. This measure seeks to improve patient outcomes by measuring hospitalization ratios among dialysis facilities. In addition, this measure seeks to promote communication between the dialysis facilities and other care settings to improve care transitions.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in ESRD QIP.

Program Measure Gaps

During the discussion on measure gaps, MAP suggested that CMS identify opportunities to measuring culture obstacles to quality improvement that can further promote a commitment to doing quality improvement and a culture of knowledge sharing. MAP also suggested that CMS identify ways to make larger leaps to improving quality of care and patient safety, rather than using an incremental approach.

Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs) Measures

Beginning in 2011, the Promoting Interoperability programs (formerly the Medicare and Medicaid EHR Incentive Programs) were developed to encourage eligible entities to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified electronic health record technology (CEHRT). Eligible

hospitals and critical access hospitals are required to report on eQMs using CEHRT in order to qualify for incentive payments under the Medicare and Medicaid Promoting Interoperability Program.

MUC20-0032: Global Malnutrition Composite Score

This is a composite measure consisting of four component measures of optimal malnutrition care focusing on adults 65 years and older admitted to inpatient service who received care appropriate to their level of malnutrition risk and/or malnutrition diagnosis, if identified. Appropriate care for inpatients includes malnutrition risk screening, nutrition assessment for at-risk patients, and proper malnutrition severity indicated, along with a corresponding nutrition care plan that recommends treatment approach.

MAP offered conditional support for rulemaking, pending NQF endorsement of this measure. This measure addresses a clinical topic area not currently addressed by the measures in the Promoting Interoperability Program (PI) set. Furthermore, this measure may be considered to address the high priority Meaningful Measure area to “Promote Effective Communication and Coordination of Care” through EHR data source and as an eQM. The measure was voted on and passed by the Scientific Methods Panel in October 2020 and will be evaluated for endorsement for the first time as part of the Fall 2020 cycle.

MAP observed that this measure encourages the identification and treatment of malnutrition upon hospital admission for adults age 65 years and older, leading to reduced risk of 30-day readmission, shortened length of stay, reduced risk of inpatient mortality, and lower hospital costs, as compared to malnourished patients who are not screened for risk and treated appropriately. While supportive of the measure in general, some MAP members questioned if this assessment would be most appropriate to conduct in outpatient or inpatient settings. This is a prevalent clinical issue, as recent research has found approximately one in three hospitalized patients are at risk for malnutrition (Sauer AC, et al., 2019)."

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in the Promoting Interoperability program.

Hospital Inpatient Quality Reporting Program (Hospital IQR) Measures

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

MAP considered two measures for potential inclusion in Hospital IQR:

- MUC20-0003: Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)
- MUC20-0032: Global Malnutrition Composite Score

MUC20-0003: Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

The measure will estimate a hospital-level, risk-standardized improvement rate for patient reported outcomes (PROs) following elective primary THA/TKA for Medicare fee-for-service (FFS) patients 65 years of age or older. Substantial clinical benefit improvement will be measured by the change in score on the joint-specific, patient-reported outcome measure (PROM) instruments, measuring hip or knee pain and functioning, from the preoperative assessment (data collected 90 to 0 days before surgery) to the postoperative assessment (data collected 270 to 365 days following surgery).

MAP supported this measure for rulemaking. This patient-reported outcome performance measure (PRO-PM) aligns with the goal of patient-centered approaches to healthcare quality improvement and targets high variability in hospital performance. MAP recognized that this measure addresses the high priority area of functional outcomes for the Hospital IQR program. The program currently does not include a measure that assesses PROs among THA/TKA patients at the hospital level.

Some MAP members expressed concern regarding data collection and reporting for this measure. The developer mentioned they have worked to mitigate burden by reducing the number of questions to a very small number. There is also an effort to create a strategic implementation plan to inform CMS strategy to minimize burden in data collection and reporting.

PROs among THA/TKA patients vary across hospitals, suggesting opportunities for improvement in quality of care. The measure seeks to improve patient outcomes following elective primary THA/TKA by providing information to patients, physicians, and hospitals about hospital-level, risk-standardized patient-reported outcomes, such as pain and functional status. This measure is risk-adjusted for patients' comorbid conditions and the goal of the measure is to provide hospitals with performance information in order to implement focused quality improvement efforts.

The Rural Health Workgroup was neutral on the suitability of the measure from a rural perspective.

MUC20-0032: Global Malnutrition Composite Score

MAP offered conditional support for rulemaking, pending NQF endorsement of the measure. This measure addresses a clinical topic area not currently addressed by the measures in the Promoting Interoperability Program (PI) set. Furthermore, this measure may be considered to address the high priority Meaningful Measure area to "Promote Effective Communication and Coordination of Care" through the EHR data source and as an electronic clinical quality measure. The measure was voted on and passed by the Scientific Methods Panel in October 2020 and will be evaluated for endorsement for the first time as part of the Fall 2020 cycle.

This measure encourages the identification and treatment of malnutrition upon hospital admission for adults age 65 years and older, leading to reduced risk of 30-day readmission, shortened length of stay, reduced risk of inpatient mortality, and lower hospital costs, as compared to malnourished patients who are not screened for risk and treated appropriately. While supportive of the measure in general, some MAP members questioned if this assessment would be most appropriate to conduct in outpatient or inpatient settings. This is a prevalent clinical issue, as recent research has found approximately one in three hospitalized patients are at risk for malnutrition.

The MAP Rural Health Workgroup discussed that this measure is an important area of measurement, especially given the impact of COVID-19, food deserts, and other issues. One Workgroup member felt the measure was achievable in rural hospitals while another Workgroup member expressed concerns

over possible low case-volume. The Workgroup vote indicated they thought this measure is suitable for use with rural providers.

Program Measure Gaps

During the discussion of gaps, MAP members encouraged CMS to be mindful of the transition of services being offered within the inpatient setting to the ambulatory setting and the relevance of these measures because of this shift. CMS commented that this was also shared during the MAP Rural Health Workgroup meeting.

Hospital Outpatient Quality Reporting Program (Hospital OQR) Measures

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

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

MAP considered two measures for potential inclusion in OQR:

- MUC20-0004: Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)
- MUC20-0005: Breast Screening Recall Rates

MUC20-0004: Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)

This measure is the percentage of emergency department (ED) patients with a diagnosis of ST-segment elevation myocardial infarction (STEMI) who received appropriate treatment. The measure will be calculated using EHR data and is intended for use at the facility level.

MAP noted that there may be an issue with the comparison of hospitals because complying with and hitting targets will not be at the same level of difficulty across providers based on the types of services provided.

MAP offered conditional support for rulemaking, pending NQF endorsement. This measure addresses the Meaningful Measure Areas and Hospital OQR Program priorities of “Effective Prevention and Treatment” and “Promote Effective Communication and Coordination of Care.” This eCQM is a combination of two existing chart extracted measures in the Hospital OQR Program set, “Fibrinolytic Therapy Received within 30 Minutes of Emergency Department Arrival” (OP-2) and “Median Time to Transfer for Acute Coronary Intervention” (OP-3), and includes a third option to transfer patients to a percutaneous coronary intervention-capable facility. The developer states the inclusion of this eCQM could reduce data collection burden from the previous chart-based measure collection.

MAP noted that 550,000 new cases of myocardial infarction and 200,000 recurrent cases are estimated to occur in the United States annually, with approximately 38 percent of acute coronary syndrome presentations due to STEMI. The addition of this EHR-based quality measure can improve adherence to fibrinolytic therapy in accordance with clinical practice guideline recommendations and median time to transfer for acute coronary intervention. MAP recommended that the NQF endorsement process should evaluate the EHR feasibility, reliability, and validity testing conducted by the developer.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in the Hospital OQR Program.

MUC20-0005: Breast Screening Recall Rates

The Breast Screening Recall Rates measure calculates the percentage of beneficiaries with mammography or digital breast tomosynthesis (DBT) screening studies that are followed by a diagnostic mammography, DBT, ultrasound, or magnetic resonance imaging (MRI) of the breast in an outpatient or office setting within 45 days.

MAP commended CMS for addressing this issue and indicated that the measure focus is very important to women. MAP considered that this measure is not based on a specific clinical guideline but is supported by expert clinical consensus and support in the literature. MAP noted that there is a wide variety of accuracy of screening results and turnaround times by facility. MAP agreed that ranges for both over-recall and under-recall are extremely important. The potential need for the incorporation of social determinants of health as a factor in the measure was raised. MAP discussed a perceived need for more definitive recommendations for rulemaking. There was discussion concerning the possibility of inclusion of the individual measure into a composite measure or as part of a suite of measures. MAP outlined that this might be a long-term goal, but it was agreed that the measure should not be delayed.

MAP offered conditional support for rulemaking, pending NQF endorsement of the measure. This measure addresses the Hospital Outpatient Quality Reporting Program high priority areas, “Making Care Safer” and “Making Care Affordable.” No CMS hospital programs include measures of breast screening recall rates. The measure has been fully specified and gone through initial beta testing, reliability testing, and face validity testing. MAP discussed that this measure would be more useful as either a composite or as part of a broader suite of measures associated with breast cancer screening and recall rates, but as that suite of measures does not currently exist, MAP did not specify this as a condition for support.

This claims-based measure identifies recall rates from breast screenings at the facility level. Recall rates adhering to recommended benchmarks (5-12 percent) can ensure that abnormal screenings receive appropriate follow-up while avoiding over-diagnosing and causing undue anxiety and testing for patients. The measure is not based on a specific clinical guideline but is supported by expert clinical consensus and support in the literature. No other CMS measure addresses breast screening recall rates. This measure has not been submitted to NQF for endorsement and is not currently in use.

The Rural Health Workgroup was neutral on the suitability of this measure for use with rural providers in the Hospital OQR Program.

Program Measure Gaps

During the measure gaps discussion, MAP encouraged CMS to explore measures of effective use and shared decision making. MAP also recommend that there be a composite measure for breast cancer screening. MAP further emphasized that CMS be sensitive to the changes in healthcare and the migration of services to the ambulatory setting. Finally, MAP suggested that CMS explore the major groupings of the types of services and procedures offered in the outpatient setting to identify gaps for measure development.

PAC/LTC Program Measures

Hospice Quality Reporting Program (HQRP)

The Hospice Quality Reporting Program (HQRP) was established under section 3004 of the Affordable Care Act (ACA). The HQRP applies to all hospices, regardless of setting. Under this program, hospice providers must submit quality reporting data from sources such as the Hospice Item Set (HIS) data collection tool and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey or be subject to a 2-percentage-point reduction in the applicable annual payment update.

MUC20-0030: Hospice Care Index

The *Hospice Care Index* monitors a broad set of leading claims-based indicators of hospice care processes. The 10 indicators reflect care throughout the hospice stay and by the care team within the domains of higher levels of care, visits by nursing staff, patterns of live discharge, and per-beneficiary spending. Index scores are calculated as the total instances a hospice meets a point criterion for each of the 10 indicators. The index thereby seeks to identify hospices that are outliers across an array of multifaceted indicators, simultaneously.

MAP noted that the measures seem to be a mix of program-integrity measures and quality-of-care measures, suggesting that the quality-of-care measures are more likely to be easily understood by patients and their families while the program-integrity measures might need more explanation for why they are significant. Furthermore, MAP felt that the spending per-beneficiary measure is difficult to interpret when there may be significant patient case mix variation between hospice programs (for example, patients with a terminal diagnosis of cancer have different spending patterns than patients with a terminal diagnosis of dementia). MAP indicated that there may be some concern among providers about the lack of control over the costs issues that this measure seeks to address. The developer reinforced that the strength of the *Hospice Care Index* measure is in the combination of all of the indicators into the overall index score and that in studies with patients, patients understood the index and found it useful.

MAP offered conditional support for rulemaking, contingent on NQF endorsement. The *Hospice Care Index* describes provider performance across a broad array of leading indicators of hospice service representing care throughout the hospice stay and represented by the multi-discipline team. The index augments the reporting program with new measurement domains that were either directly recommended for CMS to publicly report or identified as areas for improvement by the Office of Inspector General, MedPAC, and academic literature. The index design monitors 10 indicators simultaneously to best ensure the reliability of the providers it assigns as consistent outliers, which identifies hospices underperforming relative to expectations of the hospice philosophy. By identifying hospices which meet the thresholds across multiple areas, the index overcomes the limitations of single-

outcome measures. More broadly, the *Hospice Care Index* monitors the performance for a broad and holistic set of indicators for hospice care processes not otherwise addressed within the current quality measures of CMS' Quality Reporting Program.

The *Hospice Care Index* will introduce new domains and measurement concepts to the HQRP. Burdensome transfers/live discharges and spending-per-beneficiary are new domains not currently covered by existing measures. Combining multiple indicators into one index is a new approach to measurement for this program. Patients may find a single indicator of care quality to be more useful than 10 separate indicators.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in the HQRP.

Program Measure Gaps

MAP identified several measure gaps within HQRP, including safety (in particular polypharmacy and medication reconciliation); patient-reported outcomes around symptom management; care aligned with and meeting patient goals; communication of patient goals to the next site of care if patient leaves hospice; coordination of care especially with primary care and hospital staff; patient and family education; perceived caregiver burden and how caregiver burden is managed/impacted through hospice care; and capturing the quality of care provided for those who contribute to hospice care but may not be represented in claims data. MAP also encouraged ongoing work to maintain a portfolio of measures that show variation in performance across providers and to incorporate telehealth into the program measures. MAP also noted that hospice is an area where the patient voice is not currently captured.

Skilled Nursing Facility Quality Reporting Program

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) was established under section 1899B of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act). SNFs that do not submit the required data are subject to a 2-percentage-point reduction in their annual payment rates. The COVID vaccination measures are discussed in a separate section.

MUC20-0002: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

This measure estimates the risk-adjusted rate of healthcare-associated infections (HAIs) that are acquired during skilled nursing facility (SNF) care and result in hospitalizations. The measure is risk-adjusted to level the playing field and to allow comparison of measure performance based on residents with similar characteristics between SNFs. It is important to recognize that HAIs in SNFs are not considered "never-events." The goal of this risk-adjusted measure is to identify SNFs that have notably higher rates of HAIs that are acquired during SNF care and result in hospitalization, when compared to their peers.

MAP had several questions regarding the measure results, which are calculated and reported as a single rate and not broken out by type of infection. MAP raised concerns that this would limit facilities' ability to improve quality based on their results. The developer responded that the quality improvement goal associated with the measure is for facilities to focus on foundational safety interventions, such as rates of hand washing that will reduce all instances of infection, rather than focusing on interventions targeting a single infection. The measure is intended to reflect global infection control for a facility.

MAP offered conditional support for rulemaking, contingent on NQF endorsement. This measure adds value to the program measure set by adding one overall measurement of all HAIs acquired in SNFs that result in hospitalizations, information that is not currently available. This measure focuses on severe infections and captures several infection types in the SNF setting. There is variation in performance on this measure and SNFs can improve their performance.

Collecting information on severe HAIs and providing SNFs with information and feedback will encourage SNFs to assess processes and perform interventions to reduce the one in four adverse events among SNF residents that are due to HAIs, more than half of which are potentially preventable. Among 14,347 SNFs included in the 2018 sample, risk-adjusted measure scores ranged from 2.19 (min) to 19.83 (max) percent indicating there is wide variation in HAI rates across SNFs, and opportunities for safer and more efficient patient care.

The Rural Health Workgroup agreed this measure is suitable for use with rural providers in the SNF QRP.

Program Measure Gaps

Within the SNF QRP measure set, MAP identified several gaps, including care aligned with and meeting patient goals, care coordination and patient and caregiver involvement in care design, bi-directional transfer of information, quality and safety of care transitions, and patient and family engagement.

Further PAC/LTC Program Measure Gaps

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

Within the LTCH QRP measure set, MAP identified several gaps including care aligned with and meeting patient goals, care coordination and patient and caregiver involvement in care design, and availability of palliative care.

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

Within the IRF QRP measure set, MAP identified several gaps including care aligned with and meeting patient goals, care coordination and patient and caregiver involvement in care design, and pain management and impact on patient function. MAP also called on CMS to review how the measures in the program currently align with the CMS Quality Measurement Action Plan and Meaningful Measures 2.0.

Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

SNF VBP will undergo some changes resulting from the Consolidated Appropriations Act (CAA) of 2021. The CAA allows CMS to consider expansion of the program measures up to 10 measures beginning on or after October 2023. Previously the program was limited to a single readmissions measure.

MAP strongly encouraged CMS to engage patients and caregivers in a discussion of what concepts or measures they would find most valuable. With a 10-measure limit, MAP discussed priorities and methodology. Some Workgroup members encouraged CMS to pursue a composite measure, similar to the *Hospice Care Index*, that would encompass the quality of care across the continuum of the patient stay. Other Workgroup members expressed concern that a composite could dilute the impact of any one measure. MAP expressed support for continued work in infection control, which they identified as one of the highest stake areas for patients. MAP also felt there was a need to assess value that may not be represented in claims data, including direct costs to patients and families such as co-pays, out of pocket

costs, and parking. Finally, MAP reaffirmed the importance of measuring beyond the SNF stay, including referral to effective services after the stay; caregiver burden; and care coordination after the stay, noting that the ability to manage care and all of the services after discharge has a direct impact on patient readmissions.

Home Health Quality Reporting Program (HH QRP)

MAP identified several measure gaps within HH QRP, including care aligned with and meeting patient goals, care coordination and patient and caregiver involvement in care design, long-term tracking of functional status, healthcare-acquired infections, telehealth, vaccination status (patient and HCP), and capturing wound care holistically. Holistic wound care specifically relates to measures addressing whether all appropriate services and supplies were provided for patients with wounds. The gap related to long-term tracking of functional status recognized that current measures in the HH QRP address short-term improvements in activities of daily living (ADLs) such as bathing and dressing. MAP noted that for longer home health episodes, patients may have different functional goals such as the ability to shop independently or to walk to the mailbox.

COVID-19 Measures

MAP considered three measures to address COVID-19 vaccination rates among healthcare personnel and patients for a variety of programs. The MAP Workgroups and Coordinating Committee discussed the COVID-19 measures separately from their discussions of other measures.

MAP expressed support for CMS' efforts to use these measures as part of the solution for the COVID-19 public health crisis. MAP suggested that the MSC dictate an approach to MAP's evaluation of the measures that may require flexibility during a national healthcare emergency. MAP offered conditional support for rulemaking for all COVID-19 measures and encouraged CMS to fully specify the measures as soon as possible.

MUC20-0044: SARS-CoV-2 Vaccination Coverage Among Healthcare Personnel

MUC20-0044 was considered for multiple hospital and PAC/LTC programs:

- Hospital Outpatient Quality Reporting Program (Hospital OQR)
- Hospital Inpatient Quality Reporting Program (Hospital IQR)
- Ambulatory Surgical Center Quality Reporting Program (ASCQR)
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
- End-Stage Renal Disease Quality Improvement Program (ESRD QIP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) SARS-CoV-2 Measure
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP) SARS-CoV-2 Measure
- Skilled Nursing Facility Quality Reporting Program (SNF QRP) SARS-CoV-2 Measure

This measure tracks SARS-CoV-2 vaccination coverage among healthcare personnel (HCP) in IPPS hospitals, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), inpatient psychiatric facilities, ESRD facilities, ambulatory surgical centers, hospital outpatient departments, skilled nursing facilities, and PPS-exempt cancer hospitals. MAP noted that reporting occurs via the National Healthcare Safety Network (NHSN). MAP suggested that the rules associated with NHSN reporting should be

clarified. MAP also noted that the premise of “up-to-date” on vaccination as the endpoint of the measure is an appropriate one.

MAP discussed the timing for rulemaking and reporting related to this measure, namely when would this occur. CMS clarified that rulemaking would be for Spring 2021 and this measure would then be introduced into programs in 2022. Some MAP members questioned whether this measure will be critical in 2023, due to the availability of vaccines. Other MAP members pointed out that the duration of immunity conferred by COVID-19 vaccination is as yet unknown. Some MAP members recommended CMS consider narrowing the denominator to frontline HCP, while other members affirmed that including the full range of HCP is appropriate and potentially less burdensome to facilities. MAP suggested that non-employee, non-contracted hospice workers should also be considered for inclusion in the measure denominator.

MAP offered conditional support for rulemaking for each program that MUC20-0044 was considered, contingent on CMS bringing the measures back to MAP once the specifications are further refined, CMS considering an expedited process for the measures for both NQF and CMS, and CMS exploring the inclusion of pediatric hospitals within the COVID-19 measures. The proposed measure represents a promising effort to advance measurement for an evolving national pandemic. The incomplete specifications require immediate mitigation and further development should continue. This measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections in healthcare personnel and the patients for whom they provide care.

Collecting information on SARS-CoV-2 vaccination coverage among healthcare personnel and providing feedback to facilities will allow facilities to benchmark coverage rates and improve coverage in their facility. Reducing rates of COVID-19 in healthcare personnel will reduce transmission among patients and reduce instances of staff shortages due to illness.

The MAP Rural Health Workgroup agreed this was an important measure. A Workgroup member noted facilities may have employees that work at multiple facilities, and asked whether the measure accounts for workers who are vaccinated at one facility but also work in another facility. The developer shared the specifications include “vaccination at this facility or elsewhere.” The Workgroup voted that the measure is suitable for use with rural providers across all programs.

MUC20-0045: CoV-2 Vaccination by Clinicians

This measure was under consideration for the MIPS program. The measure is the percentage of patients aged 18 years and older seen for a visit during the measurement period who have ever received or reported having ever received a SARS-CoV-2 vaccination dose OR who have ever received or reported having ever received a full SARS-CoV-2 vaccination course.

MAP noted that the rate of vaccination is helpful, but qualitative data associated with patient refusal is also important to understand and address vaccine hesitancy. CMS asked if the measure should be mandatory in MIPS to which MAP responded that it should perhaps be mandatory but initially not connected to payment. MAP recognized that the measure was introduced during a time of national emergency and encouraged CMS to move forward with development and implementation. MAP expressed concerns over the alignment of the MIPS measure with the measures considered by the MAP Hospital and PAC/LTC workgroups for healthcare personnel and for patients in dialysis facilities in that

this measure does not require an “up to date” vaccination status. MAP encouraged CMS to consider alignment with the other two measures. MAP also expressed concern that patients who have “ever received” a COVID-19 vaccination are included in the measure as this may have implications over multiple years should COVID-19 vaccines prove to be an annual need.

MAP offered conditional support for rulemaking contingent on CMS bringing the measures back to MAP once the specifications are further refined, CMS considering an expedited process for the measures for both NQF and CMS, and CMS exploring the inclusion of pediatric hospitals within the COVID-19 measures. MAP noted that the proposed measure represents a promising effort to advance measurement for an evolving national pandemic. The incomplete specifications require immediate mitigation and further development should continue. This measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections. Some MAP members noted the misalignment between this measure and the other COVID-19 measures and suggested that CMS consider aligning this measure to include only those who receive the full course of the vaccine. Collecting information on SARS-CoV-2 vaccination coverage and providing feedback to clinicians will facilitate benchmarking and quality improvement. Vaccination coverage will reduce transmission and associated mortality and morbidity.

The MAP Rural Health Workgroup discussed they would feel comfortable using this measure for rural populations after the COVID-19 vaccine has passed emergency use authorization and has received full approval from the Food and Drug Administration (FDA). The Workgroup shared that the measure was important in rural communities and could encourage distribution and tracking of vaccine distribution in rural communities and noted that supply chain problems would be resolved by 2022 when the measure would be implemented. A Workgroup member noted that there is a high degree of pushback on COVID-19 and vaccinations from some patients in rural communities, which might reduce vaccination rates. The measure developer noted there are exceptions for contraindications and for patient refusal. The Workgroup voted that the measure is suitable for use with rural providers.

MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease

This measure was under consideration for ESRD QIP. This measure tracks SARS-CoV-2 vaccination coverage among patients in End-Stage Renal Disease (ESRD) facilities.

MAP offered conditional support for rulemaking contingent on CMS bringing the measures back to MAP once the specifications are further refined, CMS considering an expedited process for the measures for both NQF and CMS, and CMS exploring the inclusion of pediatric hospitals within the COVID-19 measures. The proposed measure represents a promising effort to advance measurement for an evolving national pandemic. The incomplete specifications require immediate mitigation and further development should continue. This measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections in healthcare personnel and the patients for whom they provide care.

Collecting information on SARS-CoV-2 vaccination coverage among healthcare personnel and providing feedback to IRFs will allow facilities to benchmark coverage rates and improve coverage in their facility. Reducing rates of COVID-19 in healthcare personnel will reduce transmission among patients and reduce instances of staff shortages due to illness.

The MAP Rural Health Workgroup agreed that patients with ESRD are a high-priority group that should be vaccinated and it seemed appropriate to measure vaccination in these patients. The Workgroup did not identify any rural-specific problems or disadvantages for rural providers, taking the measure exclusions into consideration. The Workgroup noted that this measure would be applied to rural patients visiting any ESRD facility, any patients visiting a rurally based ESRD facility, and rural patients in rurally located ESRD facilities. The Workgroup voted that the measure is suitable for use with rural providers.

Appendix A: Program Summaries

This appendix includes short descriptions of programs with measures under consideration for the MAP 2020-21 cycle. The material in this appendix was extracted from CMS' Program Specific Needs and Priorities which was released in March 2020, as well as the CMS website.

Clinician Program Summaries

Medicare Shared Savings Program

Section 3022 of the ACA requires CMS to establish a Shared Savings Program (SSP) 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 SSP was designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce the rate of growth in healthcare costs. Eligible providers, hospitals, and suppliers may participate in the SSP by creating or participating in an ACO. If ACOs meet program requirements and the ACO quality performance standard, they are eligible to share in savings, if earned. There are three shared savings options: 1) one-sided risk model (sharing of savings only for the first two years and sharing of savings and losses in the third year); 2) two-sided risk model (sharing of savings and losses for all three years); and 3) two-sided risk model (sharing of savings and losses for all three years) with prospective assignment.

Merit-Based Incentive Payment System Program

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

Hospital Program Summaries

Ambulatory Surgical Center Quality Reporting Program

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-percentage-point payment penalty to their ASCFS annual payment update for not meeting program requirements. CMS implemented this program so that payment determinations were effective beginning with the Calendar Year (CY) 2014 payment update.

End-Stage Renal Disease Quality Incentive Program

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.

Hospital Inpatient Quality Reporting Program

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.

Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals

Beginning in 2011, the Promoting Interoperability programs (formerly the Medicare and Medicaid EHR Incentive Programs) were developed to encourage eligible entities to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record technology (CEHRT). 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 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 requirements as well.

Inpatient Psychiatric Facility Quality Reporting Program

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.

Hospital Outpatient Quality Reporting

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-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.

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

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.

PAC/LTC Program Summaries

Hospice Quality Reporting Program

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-percentage-point reduction to their annual payment update.

Inpatient Rehabilitation Facility Quality Reporting Program

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 (IRFPAI) 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-percentage-point reduction of the applicable IRF PPS payment update. Public reporting of IRF QRP measures on IRF Compare 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.

Long-Term Care Hospital Quality Reporting Program

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 multistakeholder groups. Beginning in FY 2014, LTCHs that fail to submit data will be subject to a 2-percentage-point reduction of the applicable Prospective Payment system (PPS) annual payment update. (APU). Public reporting of LTCH QRP measures on LTCH Compare began in December 2016. LTCH Compare began in December 2016.

Skilled Nursing Facility Quality Reporting Program

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 multistakeholder groups. Beginning in FY 2018, providers that fail to submit required quality data to CMS will have their annual updates reduced by 2-percentage-points.

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