CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
1. Hospice Quality Reporting	ACA Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.	**Public reporting, pay-for-reporting** **Penalties for Failure to Report:** For fiscal year 2014, and each subsequent year, failure to submit required quality data shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year. **No date has been specified to begin public reporting of quality data**. Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html, accessed 6/26/12.	Medical record, survey, data collection tool	Patient/family experience, process
2. Inpatient Rehabilitation Facilities Quality Reporting	ACA Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.	**Public reporting, pay-for-reporting** Penalties for Failure to Report: For fiscal year 2014, and each subsequent year thereafter, failure to submit required quality data shall result in a 2 percentage point reduction to the annual increase factor for payments made for discharges occurring during that fiscal year. No date has been specified to begin public reporting of quality data. Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html, accessed 6/26/12	NHSN, patient assessment (IRF-PAI)	Outcome, process
3. Long-Term Care Hospitals Quality Reporting	ACA Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.	**Public reporting, pay-for-reporting** Penalties for Failure to Report: For fiscal year 2014, and each subsequent year, failure to submit required quality data shall result in a 2% reduction in the annual payment update. No date has been specified to begin public reporting of quality data. Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html, accessed 6/26/12.	NHSN, patient assessment (CARE)	Outcome, process

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
4. Hospital Inpatient Quality Reporting (IQR)	Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003; The Deficit Reduction Act of 2005 section 5001(a)	**Public reporting, pay-for-reporting** The MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. Initially, the MMA provided for a 0.4 percentage point reduction in the annual market basket update for hospitals that did not successfully report. The Deficit Reduction Act of 2005 increased that reduction to 2.0 percentage points. In addition to giving hospitals a financial incentive to report the quality of their services, the hospital reporting program provides CMS with data to help consumers make more informed decisions about their health care	Medical records, claims, survey (HCAHPS), web-based tool, NHSN	Outcome, process, patient experience, structure, cost/resource use
5. Hospital Value-Based Purchasing (VBP)	ACA Sec. 3001. Hospital Value-Based purchasing program.	**Value-based purchasing** Starting in October 2012 , Under the Hospital VBP Program, Medicare will make incentive payments to hospitals beginning in Fiscal Year (FY) 2013 based on either: 1) How well they perform on each measure, or 2) How much they improve their performance on each measure compared to their performance during a baseline. Hospitals will earn scores for their performance on measures and dimensions in two domains during the performance period of July 1, 2011, to March 31, 2012. The FY 2013 Baseline Performance Period is July 1, 2009 to March 31, 2010. Source: MLN ICN 907664 November 2011.	Medical records, claims, survey (HCAHPS)	Outcome, process, patient experience, cost/resource use
6. Prospective Payment System (PPS) Exempt Cancer hospitals	ACA Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.	**Public reporting, pay-for-reporting** Not later than October 1, 2012, the Secretary shall publish the measures selected that will be applicable with respect to fiscal year 2014. Source: ACA, pages 253-4.	Medical records, NHSN	Process, outcome

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
7. Inpatient Psychiatric Facility Quality Reporting	ACA Sec. 10322. Quality reporting for psychiatric hospitals	**Public reporting, pay-for-reporting** REDUCTION IN UPDATE FOR FAILURE TO REPORT.—(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points. (ii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected that will be applicable with respect to rate year 2014. Source: ACA pages 834-6.	Medical records	Process, outcome
8. Hospital Readmission Reduction Program	ACA Sec. 3025. Hospital readmissions reduction program.	**Public reporting, pay-for-reporting** **Background:** Requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. **Readmissions Measures:** In the FY 2012 IPPS final rule, CMS finalized the readmission measures for AMI, HF, and PN and the calculation of the excess readmission ratio, which will then be used, in part, to calculate the readmission payment adjustment under the Hospital Readmissions Reduction Program. CMS established a policy of using three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For FY 2013, the excess readmission ratio will be based on a discharges occurring during the 3-year period of July 1, 2008 to June 30, 2011. **Payment Adjustment:** CMS plans to continue implementation of this program in its FY 2013 IPPS rulemaking cycle. In the FY 2013 IPPS proposed rule, Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html, accessed 6/26/12.	Claims	Outcome

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
9. End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)	Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c)	**Value-based purchasing** This first-of-its-kind program provides the ESRD community with the opportunity to enhance the overall quality of care that ESRD patients receive as they battle this devastating disease. CMS issued its final rule for the second and third years of the ESRD QIP, 2013 and 2014, in November 2011. From July 15 through August 15, 2012, dialysis facilities will be able to preview their ESRD QIP Performance Score Reports and submit clarification questions about their scores. During this time, facilities can review the data CMS will use to determine whether payment reductions will apply to the facility when the ESRD QIP begins to affect dialysis payments in 2013. Source: https://www.cms.gov/Medicare/End-Stage-Renal-Disease/ESRDQualityImproveInit/index.html?redirect=/ESRDQualityImproveInit/ , accessed 6/27/12.	Claims, data collection tool	Process, structure, outcome
10. Home Health Quality Reporting	42 CFR **§§** 484.55 OASIS Reporting as Condition of Participation for HHAs	**Public reporting** Since 1999, CMS has required Medicare-certified home health agencies to collect and transmit OASIS data for all adult patients whose care is reimbursed by Medicare and Medicaid with the exception of patients receiving pre- or postnatal services only. OASIS data are used for multiple purposes including calculating several types of quality reports which are provided to home health agencies to help guide quality and performance improvement efforts. Since fall 2003, CMS has posted a subset of OASIS-based quality performance information on the Medicare.gov website "Home Health Compare". Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html?redirect=/HomeHealthQualityInits/14_HHQIOASISUserManual.asp	Patient assessment (OASIS), survey, claims	Outcomes, process, patient experience

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
11. Hospital Outpatient Quality Reporting (OQR)	Tax Relief and Health Care Act of 2006	**Public reporting, pay-for-reporting** In addition to providing hospitals with a financial incentive to report their quality of care measure data, the Hospital OQR program provides CMS with data to help Medicare beneficiaries make more informed decisions about their health care. Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram.html	Medical records, claims	Process, efficiency

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
12. Ambulatory surgical centers	ACA Sec. 10301. Plans for a Value-Based purchasing program for ambulatory surgical centers.	**Pay for reporting, public reporting** The Affordable Care Act requires the Secretary of Health and Human Services to develop a plan to implement a value-based purchasing (VBP) program for payments under the Medicare program for ambulatory surgical centers (ASCs). The Report to Congress describes the current efforts to improve quality and payment efficiency in ASCs. In addition, it considers the steps required in designing and implementing an ASC VBP program for payments under the Medicare program. CMS views VBP as an important step forward in revamping how Medicare pays for health care services; moving the program towards rewarding better value, outcomes, and innovations, instead of merely volume. Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html, accessed 6/26/12. CMS is also proposing several requirements for the ASC Quality Reporting Program relating to the measures that were finalized for the CYs 2014, 2015, and 2016 payment determinations in the CY 2012 Outpatient Prospective Payment System/ASC Payment System final rule with comment period that appeared in the Nov. 30, 2011 *Federal Register*. Specifically, CMS is proposing new administrative, data completeness, and extraordinary circumstance waivers or extension request requirements, as well as a reconsideration process. ASCs that fail to report quality data or to comply with these requirements will incur a 2.0 percentage point reduction in their annual payment update for that payment determination year, beginning in CY 2014. Data collection for the CY 2014 payment determination will begin with services furnished on Oct. 1, 2012. Source: CMS Fact Sheet: https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4346&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date, accessed 6/26/12.	Claims, medical records, NHSN	Outcome, process, utilization

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
13. Physician Quality Reporting System	The ACA authorized incentive payments through 2014 and requires a penalty, beginning in 2015, for EPs who do not satisfactorily report. Also authorizes an additional 0.5 percent incentive for 2011 through 2014 for EPs who satisfactorily meet Maintenance of Certification Program requirements as described in the law. Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made PQRS permanent, authorized incentive payments through 2010. Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) authorized the continuation of the Physician Quality Reporting System for 2008 and 2009. Tax Relief and Health Care Act of 2006 (TRHCA) initially authorized the Physician Quality Reporting System.	**Pay-for-reporting** PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. The program provides an incentive payment to practices with eligible who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries Beginning in 2015, the program also applies a payment adjustment (penalty) to eligible professionals who do not satisfactorily report data on quality measures for covered professional services.	Claims (using Quality Data Codes), GPRO tool, registry, EHR	Process, Intermediate outcome, outcome
14. Medicare Shared Savings Program	ACA Sec. 3022. Medicare shared savings program.	**Value-based purchasing, public reporting, voluntary participation** The final rule establishes quality performance measures and a methodology for linking quality and financial performance that will set a high bar on delivering coordinated and patient-centered care by ACOs, and emphasize continuous improvement around the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures. The final rule requires ACOs to publicly report certain aspects of their performance and operations and CMS to publicly report certain quality data. Source: MLN ICN 907404 October 2011	GPRO tool, registry, EHR, claims	Process, Intermediate outcome, outcome, patient experience, structure

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
15. Physician Compare	ACA Sec. 10331. Public Reporting Of Performance Information.	**Public reporting** The Physician Compare Web site was launched December 30, 2010 and serves as a healthcare professional directory on Medicare.gov. The site currently allows individuals to search for a physician or other healthcare professional by specialty, type of professional, and location. Additional search criteria allow the user to search by gender and whether or not the healthcare professional accepts the Medicare-approved amount as payment in full on all claims. Other information available includes languages spoken, group practice locations, education, and hospital affiliation. Information on the Physician Compare Web site is updated monthly. The Physician Compare Web site also includes information about physicians and other professionals who satisfactorily participated in the Physician Quality Reporting System (formerly known as Physician Quality Reporting Initiative) and those who successfully participated in the Electronic Prescribing (eRx) Incentive Program. The Web site does not yet contain physician and eligible professional performance information. CMS is required to implement a plan for making information on physician performance publicly available through Physician Compare by January 1, 2013. The reporting period can begin no earlier than January 1, 2012. Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html, accessed 6/26/12.	Claims (using Quality Data Codes), claims, GPRO tool, registry, EHR, survey	Process, Intermediate outcome, outcome, patient experience, cost/resource use
16. Medicare and Medicaid EHR Incentive Programs (EH and EP)	Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the American Recovery and Reinvestment Act (ARRA) of 2009	A reimbursement incentive for physician and hospital providers who are successful in becoming "meaningful users" of an electronic health record (EHR). These incentive payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the "meaningful use" definition or they will be subject to financial penalties under Medicare.	EHR	Process, intermediate outcome
17. Children's Health Insurance Program Reauthorization Act Quality Reporting	Title IV of Children's Health Insurance Program Reauthorization Act (CHIPRA) 2009	CHIPRA encourages voluntary, standardized reporting of a core set of child health quality measures for children enrolled in Medicaid and CHIP	Claims, medical records, survey (CAHPS)	Process, outcome, patient experience

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
18. CMS Nursing Home Quality Initiative and Nursing Home Compare Measures	Omnibus Budget Reconciliation Act (OBRA) of 1987. OBRA 87 requires nursing homes to use a uniform Resident Assessment Instrument for all nursing home residents. The Resident Assessment Instrument includes a standardized set of data elements (the Minimum Data Set).	**Public reporting** CMS adopted a set of nursing home quality measures in 2002 and launched NHQI to "provide consumers with an additional source of information about the quality of nursing home care by providing a set of MDS-based quality measures on Medicare's Nursing Home Compare Web site	Patient assessment (MDS), claims	Outcome, process
19. Medicaid Health Home Programs	ACA Subtitle I—Improving the Quality of Medicaid for Patients and Providers: Sec. 2703. State option to provide health homes for enrollees with chronic conditions.	**Report on quality measures** As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements, as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information. Source: Pages 202-203	No measures	No measures
20. Health Insurance Exchange Quality Reporting	ACA SEC. 2201. Enrollment Simplification And Coordination With State Health Insurance Exchanges.	The ACA helps create a competitive private health insurance market through the establishment of Affordable Insurance Exchanges. These State-based, competitive marketplaces, which launch in 2014, will provide millions of Americans and small businesses with "one-stop shopping" for affordable coverage. Source: http://cciio.cms.gov/resources/factsheets/ffe-forum-factsheet.html, accessed 6/26/12.	No measures	No measures
21. Initial Core Set of Health Care Quality Measures For Medicaid-Eligible Adults	ACA Section 2701	**Voluntary, for State use** For voluntary use by State programs administered under title XIX of the Social Security Act, health insurance issuers and managed care entities that enter into contracts with Medicaid, and providers of items and services under these programs.	Claims, registry, EHR, survey	Outcome, intermediate outcome, process patient perspective, efficiency

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
22. Medicare Part C Plan Rating – Quality and Performance Measures	ACA Subtitle C—Provisions Relating to Part C SEC. 3201. Medicare Advantage Payment**.**	**Public reporting, value-based purchasing, mandatory** In 2012, CMS will start a three-year demonstration project for Medicare Advantage plans wherein CMS will award "quality bonus payments" (QBPs) to plans based on the plan's star ratings. Plan Star Ratings can be used as a Measure of Administrative and Management Performance and as a Basis for Termination or Non-Renewal of a Medicare Contract. Beginning in 2015, CMS may terminate contracts with plans that have been consistently unable to maintain a 3-start rating. Source: Pages 330-331	For Part C, the HEDIS measure set from NCQA is used for evaluation and uses data from: •HEDIS (claims, other administrative data and chart review) •Surveys: CAHPS and HOS •Call Center	Outcome, intermediate outcome, process, efficiency, access, cost/resource, patient perspective
23. Medicare Part D Plan Rating – Quality and Performance Measures	24. Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) amended Title XVIII of the Social Security Act (the Act) by establishing the Voluntary Prescription Drug Benefit Program (Part D).	**Public reporting** Part D sponsors' performance and quality data star ratings which are displayed at three levels: summary score, domain, and measure level on the Medicare Prescription Drug Plan Finder (MPDPF), prepared for open enrollment period to help beneficiaries make informed decisions about selecting a Part D plan in which to enroll	Call Center Independent Review Entity (IRE) Medicare Advantage Prescription Drug System (MARx) Complaints Tracking Module CMS Administrative Data Medicare Beneficiary Database Suite of Systems CAHPS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan	Intermediate outcome, process, efficiency, access, cost/resource, patient experience

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
25. Physician Feedback/Value-Based Modifier Program	ACA Sec. 3007. Value-based payment modifier under the physician fee schedule. Physician feedback reporting was initiated under Section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), and was expanded by section 3003 of the Affordable Care Act of 2010	**Value-based purchasing** The Program contains two primary components: 1) The Physician Quality and Resource Use Reports (QRURs), also referred to here as "the Reports") and 2) the development and implementation of a Value-based Payment Modifier (VBPM). The ACA mandates that, by 2015, CMS begin applying a VBPM under the Medicare Physician Fee Schedule (MPFS). Both cost and quality data are to be included in calculating payments for physicians. Reports – 2009 to 2017 and beyond: CMS will use the physician QRURs as the primary means of informing individual physicians and medical practice groups how their performance compares to that of their counterparts and peers within Fee-For-Service Medicare. Over the next several years, the number of physicians and groups of physician who will receive a QRUR will increase. In 2015 and beyond, for physicians who will be impacted by the VBPM, the QRURs will contain composite measures of quality and cost that display the bases for the VBPM. Value-based Payment Modifier – Starting in 2015, some physicians' payments by Medicare will be affected by application of the VBPM. Value-based Payment Modifier – By 2017, most physicians paid under the MPFS will see the VBPM applied to claims they submit to Medicare. Source: http://www.cms.gov/PhysicianFeedbackProgram/02_Background.asp#TopOfPage	Claims, registry, GPRO	Process, outcome, cost/resource use

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
26. Dual Eligibles Core Quality Measure Set	The Medicare-Medicaid Coordination Office (MMCO) was established pursuant to Section 2602 of the Affordable Care Act.	**Promoting integrated care, ensuring cultural competence, health equity** To develop this national measurement strategy for the dual eligible population, the Department of Health and Human Services (HHS) engaged the Measure Applications Partnership (MAP), a multi-stakeholder group of public and private-sector organizations and experts convened by the National Quality Forum (NQF).	Efforts have been under way at CMS to link a comprehensive database of Medicare and Medicaid claims data from which to draw measurement information. MMCO may also consider stratifying information about dual eligible beneficiaries within measures reported to CMS for other programs.	Outcome, process, patient experience, structure

CMS Quality Measurement Programs Characteristics				
Program	**Authorizing Legislation or other Reason for the Program**	**Program Goals/Design**	**Data Sources**	**Measure Types**
27. HAC program	The Deficit Reduction Act of 2005 (DRA). Section 5001(c)	**Pay-for-reporting, mandatory** The HACs payment policy, which was mandated by the DRA prevents hospitals from being paid at the higher MS-DRG rate for patients with complications or major complications if the sole reason for the higher payment is the occurrence, during the beneficiary's hospital stay, of one of the conditions on the HACs list. The DRA required the Secretary to identify, by October 1, 2007, at least two conditions that: 1. Are high cost or high volume or both, 2. Result in the assignment of a case to an MS-DRG that has a higher payment when present as a secondary diagnosis, and 3. Could reasonably have been prevented through the application of evidence-based guidelines. Source: MLN ICN 901045 May 2012 CMS is proposing to add Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization as conditions subject to the HAC payment provision for FY 2013. CMS is also proposing to add two codes, 999.32 (Bloodstream infection due to central catheter) and 999.33 (Local infection due to central venous catheter) to the existing Vascular Catheter-Associated Infection HAC Category. Source CMS Fact Sheet: https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4346&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date	Claims	Outcome