Appendix B – Description of Included CMS Quality Measure Programs and Initiatives

Acute Care

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Section 109(b) of the Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA)[1] amended section 1833(i)(7) of the Social Security Act (the Act), which authorizes, but does not require, the implementation of a revised ambulatory surgical center (ASC) payment system that would reduce any annual increase under the system for failure to submit on selected measures. The ASCQR Program was finalized through rulemaking and implemented with data submission beginning October 1, 2012. The ASCQR Program is a pay-for-reporting program in which ASCs report quality data on measures and fulfill other program requirements in order to receive the full annual increase to their ASC annual payment rate that began with the calendar year (CY) 2014 payment determination. The ACSQR Program measures are publicly reported on Hospital Compare.[2]

Hospital-Acquired Condition Reduction Program (HACRP)

The Affordable Care Act, section 3008,[3] added subsection 1886(q) to the Act, which established the HACRP. The HACRP was designed to provide an incentive for hospitals to reduce hospital-acquired conditions (HACs). The program became effective in fiscal year (FY) 2015 (discharges beginning on October 1, 2014). The HACRP reduces payments to applicable hospitals that rank in the worst-performing quartile of all subsection (d) non-Maryland hospitals with respect to risk-adjusted HAC performance measures. These hospitals have their payments reduced to 99 percent of what otherwise would have been paid for all discharges for the fiscal year following the performance period. Hospital performance scores for each hospital are made publicly available on Hospital Compare.[4]

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)

The Hospital IQR Program is a pay-for-reporting program authorized by section 1886(b)(3)(B)(viii) of the Social Security Act (the Act), which was added by section 501(b)[5] of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and updated by section 5001 of the Deficit Reduction Act of 2005,[6] extending the program and increasing the reduction to the annual update to the payment rates for hospitals that do not meet program requirements. Measures from the Hospital IQR Program are publicly reported on the Hospital Compare website.[7]

Hospital Outpatient Quality Reporting Program (Hospital OQR Program)

The Hospital OQR Program is authorized by section 1833(t)(17) of the Social Security Act (the Act), which was added by section 109(a)[8] (Title I) of MIEA-TRHCA, which requires hospitals to submit data on measures on the quality of care furnished by hospitals in outpatient settings. The Hospital OQR Program is a pay-for-reporting quality program under which hospitals must meet program requirements or receive a reduction in their Outpatient Prospective Payment System (OPPS) increase factor. The Hospital OQR Program data are publicly reported on Hospital Compare.[7]

Hospital Readmissions Reduction Program (HRRP)

The Hospital Readmissions Reduction Program (HRRP) was mandated by section 3025[9] of the Affordable Care Act, which added new subsection 1886(q) to the Act. The HRRP is a pay-for-performance program that reduces payments to subsection (d) hospitals with excess readmissions by up to 3 percent. The program includes readmission measures on specific conditions and procedures that significantly affect the lives of large numbers of Medicare fee-for-service patients. Prior research has shown that hospital readmission rates for these patients vary across the nation, indicating an opportunity to improve the quality of care and save taxpayer dollars by incentivizing subsection (d) hospitals to reduce excess readmissions.

Hospital Value-Based Purchasing (Hospital VBP) Program

The Hospital VBP Program is authorized by section 1886(o) of the Social Security Act, which was added by section 3001(a)(1)[10] of the Affordable Care Act. Participating hospitals are paid for inpatient acute care services, in part, based on a system that rewards better value, patient outcomes, and high-quality care. Under the program, hospitals are generally scored using a subset of data on measures that they also report under the Hospital Inpatient Quality Reporting Program. Beginning with discharges occurring on or after October 1, 2012, payment adjustments are made to hospitals based on their performance on measures included in the program with respect to a year. Hospital performance scores—total and for each of the four domains currently used in scoring (clinical care, patient and caregiver-centered experience of care/care coordination, safety, and efficiency and cost reduction)—are posted on Hospital Compare.[7]

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

The IPFQR Program is authorized by section 1886(s)(4) of the Social Security Act, as added and amended by sections 3401(f)[11] and 10322(a)[12] of the Affordable Care Act. The IPFQR Program is a pay-for-reporting program under which inpatient psychiatric facilities (IPFs) submit quality data and otherwise fulfill program requirements or receive a 2.0 percentage point reduction to the annual update in their standard federal rate for that year. IPFQR Program requirements, including public reporting of the measure data, are set forth through rulemaking.[13]

Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for Eligible Hospitals and Critical Access Hospitals

The Medicare and Medicaid EHR Incentive Programs were established beginning in 2011 as authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act provided HHS with the authority to establish certain programs to improve health care quality, safety, and efficiency through the promotion of health information technology (IT). Sections 4001–4201 of the HITECH Act establish the Medicare and Medicaid EHR Incentive Programs to provide incentive payments to eligible professionals, eligible hospitals, critical access hospitals (CAHs), and Medicare Advantage organizations to promote the adoption and meaningful use of interoperable health IT and qualified EHRs.[14]

Prospective Payment System-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

The PCHQR Program is authorized by section 1866(k) of the Social Security Act, which was added by section 3005[15] of the Affordable Care Act. Eleven hospitals are eligible to participate in the program because they are PPS-excluded cancer hospitals under section 1886(d)(1)(B)(v) of the Social Security Act. The PCHQR Program is a pay-for-reporting program intended to

provide consumers with quality of care information to make more informed decisions about health care options and to encourage hospitals and clinicians to improve the inpatient care provided to beneficiaries.[16]

Post-Acute and Long-Term Care

Dialysis Facility Compare/ESRD Quality Initiative

The Balanced Budget Act of 1997, section 4558(b),[17] required CMS to publicly report on the quality of renal dialysis services. Since 1994, CMS had monitored the quality of dialysis facilities on a regional and national basis; however, data collection methods did not allow facility-specific reporting. To meet this requirement, CMS created the Dialysis Facility Compare (DFC) website, which was launched in January 2001 with three facility-specific quality measures and other information about the facilities. DFC served as a template for CMS to develop public reporting initiatives for other Medicare providers. Additional facility-specific measures developed since then are reported on DFC.[18] Since 2015, CMS has reported the DFC Star Ratings based on performance on a subset of quality measures publicly reported on DFC.

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

The End-Stage Renal Disease Quality Incentive Program (ESRD QIP) is authorized by section 1881(h) of the Social Security Act, which was added by section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).[19] Beginning with renal dialysis furnished on or after January 1, 2012, the ESRD QIP reduces payments to facilities that do not meet or exceed certain performance standards with respect to a payment year. The payment reductions, imposed on a sliding scale based on performance, can result in a reduction of up to 2% of the facility's Medicare reimbursement for services under the ESRD PPS for a payment year. CMS publicly reports facility ESRD QIP scores as well as their performance on each of the quality measures included in the program for that year on Dialysis Facility Compare.[20]

Home Health Quality Reporting Program (HH QRP)

The Home Health Quality Reporting Program (HH QRP) is authorized by section 1895(b)(3)(B)(v) of the Social Security Act. Beginning with 2007, home health agencies that do not meet the reporting requirements with respect to a year are subject to a 2-percentage-point reduction to their HH market basket percentage increase otherwise applicable for that year. The data reported by HHAs under the program are made public.

Hospice Quality Reporting Program (HQRP)

HQRP is mandated by section 1815(i)(5) of the Social Security Act, as added by 3004(c)[21] of the Affordable Care Act. This provision directs the Secretary to establish quality reporting requirements for hospice programs. For FY 2014 and each subsequent year, failure of a hospice to submit required quality data generally results in a 2-percentage point reduction to the market basket percentage increase for that fiscal year (unless the hospice is exempt by regulation). Section 3004 of the Affordable Care Act requires the establishment of procedures for making data available to the public. No date has been specified to begin public reporting of quality data.[22] Data from this program were not available for the 2018 Impact Report.

Inpatient Rehabilitation Facilities Quality Reporting Program (IRF QRP)

The Inpatient Rehabilitation Facilities Quality Reporting Program (IRF QRP) is authorized by section 1886(j)(7) of the Social Security Act, which was added by section 3004(b) of the

Affordable Care Act[23]. Beginning with fiscal year 2014, IRFs that do not submit data as required under the IRF QRP with respect to a fiscal year are subject to a 2 percentage point reduction to their increase factor for discharges occurring during that fiscal year. CMS began reporting IRF QRP data publicly on Hospital Compare in late 2016.[24,25]

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

The LTCH QRP is authorized by section 1886(m)(5) of the Social Security Act, which was added by section 3004(a)[26] of the Affordable Care Act. Beginning with FY 2014, LTCHs that do not report data as required under the LTCH QRP with respect to a fiscal year are subject to a 2 percentage point reduction to their annual update to the standard federal rate for discharges during that rate year. CMS began reporting LTCH quality data publicly on Hospital Compare in late 2016.[27]

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) is authorized by section 1888(e)(6) of the Social Security Act, as added by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act).[28] Beginning in FY 2018, SNFs that do not submit data as required under the SNF QRP for a fiscal year are subject to a 2 percentage point reduction to their market basket percentage for that fiscal year. Data from this program were not available for the 2018 Impact Report.

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

The SNF VBP is authorized by section 1888(h) of the Social Security Act, which was added by section 215(b) of the 2014 Protecting Access to Medicare Act (PAMA).[29] CMS will begin to make value-based incentive payments to SNFs under the program for services furnished on or after October 1, 2018. The program must first use a SNF all-cause, all-condition hospital readmission measure to assess performance and then replace that measure with an all-condition, risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities as soon as practicable.[30] Data from this program were not available for the 2018 Impact Report.

Nursing Home Quality Initiative (NHQI)

CMS began a national NHQI in November 2002, and nursing home quality performance data were first posted on Nursing Home Compare in 2003. The nursing home quality measures were based on information in the Minimum Data Set (MDS), a standardized tool used to assess residents in Medicare- and Medicaid-certified nursing homes. Nursing homes are federally mandated to collect information to complete the MDS for all residents at specified intervals during their stay, regardless of payment source. Data from the MDS are converted to quality measures. Separate measure sets are reported for short-stay patients (whose cumulative days in a facility are less than or equal to 100), who often are admitted to a nursing home after an acute care hospitalization, and for long-stay patients, who reside in the nursing home for more than 100 days.[31]

Clinician and ACO

Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Eligible Professionals

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs were established beginning in 2011 as authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act provided HHS with the authority to establish certain programs to improve health care quality, safety, and efficiency through the promotion of health information technology (IT). Sections 4001–4201 of the HITECH Act establish the Medicare and Medicaid EHR Incentive Programs[14] to provide incentive payments to eligible professionals (EPs), eligible hospitals, critical access hospitals (CAHs), and Medicare Advantage organizations to promote the adoption and meaningful use of interoperable health IT and qualified EHRs. Participation in the Medicare EHR Incentive Program for Eligible Professionals is shown on Physician Compare profile pages for clinicians. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule (PFS) and replaces it with a new Merit-based Incentive Payment System (MIPS) for MIPS eligible clinicians or groups. MIPS consolidates components of three programs—the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals—and continues the focus on quality, resource use, and use of certified EHR technology (CEHRT) in a cohesive program that avoids redundancies. The MIPS payment adjustments will apply beginning in 2019, based on 2017 performance.[32,33] Advancing care information under MIPS will also be available for public reporting on Physician Compare starting with the 2017 data available for public reporting in late 2018.

Physician Quality Reporting System (PQRS)

The Physician Voluntary Reporting Program (PVRP) was launched in January 2006 with a starter set of 16 measures. The PQRS, initially referred to as the Physician Quality Reporting Initiative (PQRI), replaced PVRP and was first implemented in 2007. PQRS was a result of section 101 of Division B – Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA), enacted December 20, 2006. Section 101(b)[1]of the MIEA-TRHCA established a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. Section 101(b)(1)[34]of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), enacted December 29, 2007, extended the authority to continue PQRS, and section 131(b)[35] of the Medicare Improvements for Patients and Providers Act (MIPPA), enacted July 15, 2008, made PQRS permanent. The Affordable Care Act made further changes to the Physician Quality Reporting System, including authorizing incentive payments until 2014 and requiring negative payment adjustments beginning in 2015 for eligible professionals who do not satisfactorily report data on quality measures during the applicable reporting period for the year. MACRA created the Merit-based Incentive Payment System (MIPS)[36] that combines parts of the PQRS, the Value-Based Payment Modifier (Value Modifier or VM), and the Medicare and Medicaid EHR Incentive Program for Eligible Professionals into a single program. The MIPS payment adjustments will be effective in

2019, based on 2017 reporting. Public reporting of PQRS data on Physician Compare began in February 2014 for a small subset of measures reported by large group practices for program year 2012. As part of a phased approach to public reporting, each year a larger set of measures, including measures reported by individual clinicians starting in December 2015, was reported. CMS chooses which measures to display on the website based on reliability, validity, accuracy, and patient and caregiver relevance.[37,38] Under MIPS, performance information on the quality, cost, improvement activities, and advancing care information performance categories will be available for public reporting on Physician Compare.

Physician Value-Based Payment Modifier Program (Physician VM Program)

The Physician Resource Use Measurement and Reporting Program began under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.[39] Confidential feedback reports, called Quality and Resource Use Reports (QRURs), have been provided twice a year to individual practitioners and group practices. Annual QRURs reported quality and cost measures and Value Modifier payment adjustments. Mid-Year reports included claims-based quality and cost measures. Supplemental QRURs reported episode-based cost measures. Section 3007[40] of the Affordable Care Act enhanced the program to phase in a value modifier that would adjust fee schedule payments to physicians based on the quality and cost of care delivered to Medicare beneficiaries. The program became known as the Physician Value-Based Payment Modifier (VM). CMS phased in the VM gradually to different sizes of physician groups. In 2015, based on performance in 2013, the VM was applied to groups of physicians with 100 or more eligible professionals. In 2016, the VM was applied to groups of physicians with 10 or more eligible professionals, based on 2014 performance. The Affordable Care Act required CMS to apply the VM to all physicians and groups of physicians starting in 2017. For 2018, the VM will also apply to Medicare PFS payments made to non-physician eligible professionals who are nurse practitioners, physician assistants, clinical nurse specialists, or certified registered nurse anesthetists. The 2018 payment year will be the final year of the VM program. MIPS, created by MACRA, combines parts of the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier, and the Medicare EHR Incentive Program for Eligible Professionals into a single program. The MIPS payment adjustments will apply beginning in 2019, based on 2017 performance.[38,41] CMS continued to provide the Annual QRURs to clinicians as the program transitioned to MIPS. The 2016 VM quality tiers, noting whether the group or clinician is high, low, or neutral on cost and quality, will be publicly reported on Physician Compare via the downloadable database when available in early 2018. Also, a notation of the payment adjustment—upward, downward, or neutral—will be indicated in the downloadable database starting with the 2016 VM data.

Medicare Shared Savings Program (Shared Savings Program)

The Shared Savings Program is a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act. The program, established by section 3022[42] of the ACA, is intended to facilitate coordination and cooperation among providers and suppliers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce the rate of growth in health care costs. Eligible suppliers and providers, including hospitals, may participate in the Shared Savings Program by creating or participating in an accountable care organization (ACO).[43] More than 100,000 clinicians get credit for PQRS and receive their Value Modifier payment adjustments based on the quality performance of their Medicare Shared Savings Program ACO.

Merit-Based Incentive Payment System (MIPS)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule (PFS) and replaces it with a new Merit-based Incentive Payment System (MIPS) for MIPS eligible clinicians or groups. MIPS consolidates components of three programs—the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals—and continues the focus on quality, resource use, and use of certified EHR technology (CEHRT) in a cohesive program that avoids redundancies. The MIPS payment adjustments will apply beginning in 2019, based on 2017 performance.[32,33] Data from this program were not yet available for the 2018 Impact Report.

Quality Payment Program

The Quality Payment Program, authorized by MACRA and implemented in 2017, allows eligible clinicians to participate via one of two paths: MIPS[32] or an Advanced Alternative Payment Model (Advanced APM).[32] The Quality Payment Program focuses on moving the Medicare payment system to rewarding clinicians for high-quality, patient-focused care. Clinicians in MIPS (MIPS eligible clinicians) will receive payment adjustments in 2019 based on the 2017 MIPS performance period. The Quality Payment Program allows multiple ways for eligible clinicians to participate. For MIPS eligible clinicians, Medicare payments in the 2019 payment year can be adjusted upward, downward, or not at all based on performance in four MIPS performance categories. CMS will implement policies for MIPS payment adjustments for 2020 and beyond in future rulemaking. Eligible clinicians in Advanced APMs who receive 25% of their payments for Medicare covered professional services or see 20% of their Medicare patients through an Advanced APM in the 2017 performance period will earn a 5% lump sum APM incentive payment in the 2019 payment year.[44] Data from this program were not available for the 2018 Impact Report.

Health/Drug Plan

Medicare Part C Star Ratings and Display Measures

Medicare Advantage health plans must submit performance measures as part of their quality assurance programs, which were originally required by the 1997 Balanced Budget Act.[45] In addition, CMS has been required since the beginning of the Part C program to provide comparative information to beneficiaries about benefits, costs, and quality of Medicare Advantage plans. The Medicare Advantage Star Ratings program began in 2008, based on (among other things) performance data collected by the Healthcare Effectiveness Data Information System (HEDIS®), the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and health plan surveillance data collected by CMS. CMS expanded the performance measures used in the Star Ratings to include the Health Outcomes Survey (HOS). The Star Ratings and information about the performance measures were posted on the Medicare Plan Finder to assist Medicare beneficiaries in choosing a health plan. The Affordable Care Act authorized bonus payments to high-performing plans; CMS has since then allowed the highest-performing plans to enroll beneficiaries year-round.[46,47] Display measures for Part C plans are reported at the contract level on the CMS.gov website and are not used in the Star Ratings. Display measures may be new measures being tested for possible inclusion in the Star Ratings or

may have been transitioned from the Star Ratings and no longer be in use for public reporting or rating plan performance. Relatively high performance across plans or low volume of cases, making comparisons difficult, may be a reason for transitioning a measure to a display measure. Display measures also include measures that are posted for informational purposes only. CMS collects and monitors display measures as well as measures that are part of the Ratings. Plans with consistently poor Ratings are subject to compliance actions by CMS.[48]

Medicare Part D Star Ratings (Part D) and Display Measures

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), section 101, established the Voluntary Prescription Drug Benefit Program (Part D).[49] Effective January 1, 2006, Part D was offered as an optional prescription drug benefit for individuals entitled to Medicare benefits under Part A or enrolled in Medicare benefits under Part B. Beneficiaries who qualified for both Medicare and Medicaid (full-benefit dual eligibles) automatically received Part D. Since fall 2006, CMS has posted Part D plan performance ratings on the Medicare Plan Finder tool. In 2006, CMS assigned ratings based on a three-star scale; in 2007, CMS began using a five-star scale. Quality measures were added to the Star Ratings beginning with 2007 data used for CY 2009 Part D Plan Ratings.[50-52]

Display measures for Part D plans are reported at the contract level on the CMS.gov website and are not used in the Part D Star Ratings. Display measures may be new measures that are being tested for possible inclusion in the Star Ratings or may have been transitioned from the Star Ratings and no longer be in use for public reporting or rating plan performance. Relatively high performance across plans or low volume of cases, making comparisons difficult, may be a reason for transitioning a measure to a display measure. Display measures also include measures that are posted for informational purposes only. CMS collects and monitors display measures as well as measures that are part of the Ratings. Plans with consistently poor Ratings are subject to compliance actions by CMS.[48]

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