List of Measures under Consideration for December 1, 2019

TABLE OF CONTENTS

OVERVIEW

Background

The Centers for Medicare & Medicaid Services (CMS) is issuing this List of Measures under Consideration (MUC) to comply with statutory requirements[1], which require the Secretary of the Department of Health and Human Services (HHS) to make publicly available a list of certain quality and efficiency measures it is considering for adoption through rulemaking under Medicare. Among the measures, the list includes measures we are considering that were suggested to us by the public. When organizations, such as physician specialty societies, request that CMS consider measures, CMS evaluates the submission for inclusion on the MUC List so the Measure Applications Partnership (MAP), the statutorily required[2] multi-stakeholder groups, can provide their input on potential measures. Inclusion of a measure on this list does not require CMS to adopt the measure for the identified program. Therefore, this list is likely larger than what will ultimately be adopted by CMS for optional or mandatory reporting programs in Medicare.

CMS will continue its goal of aligning measures across programs. Measure alignment includes looking first to existing program measures for use in new programs. Further, CMS programs must balance competing goals of establishing parsimonious measure sets, while including sufficient measures to facilitate multi-specialty provider and supplier participation.

[1] Section 1890A(a)(2) of the Social Security Act (42 U.S.C. § 1395aaa-1).
[2] Section 1890A(a) of the Social Security Act (42 U.S.C. § 1395aaa-1).

Statutory Requirement

HHS is statutorily required[3] to establish a federal pre-rulemaking process for the selection of certain quality and efficiency measures[4] for use by HHS. One of the steps in the pre-rulemaking process requires that HHS make publicly available, not later than December 1 annually, a list of quality and efficiency measures HHS is considering adopting, through the federal rulemaking process, for use in certain Medicare quality programs.

The pre-rulemaking process includes the following additional steps:

1. Providing the opportunity for multi-stakeholder groups to provide input not later than February 1 annually to HHS on the selection of quality and efficiency measures;
2. Considering the multi-stakeholder groups' input in selecting quality and efficiency measures;
3. Publishing in the Federal Register the rationale for the use of any quality and efficiency measures that are not endorsed by the entity with a contract under Section 1890 of the Act, which is currently the National Quality Forum (NQF)[5]; and
4. Assessing the quality and efficiency impact of the use of endorsed measures and making that assessment available to the public at least every three years. (The 2012, 2015, and 2018 editions of that report and related documents are available at the website of the CMS National Impact Assessment.)

[3] Section 1890A of the Social Security Act (42 U.S.C. § 1395aaa-1).
[4] As listed in Section 1890(b)(7)(B) of the Social Security Act (42 U.S.C. § 1395aaa).
[5] The rationale for adopting measures not endorsed by the consensus-based entity will be published in rulemaking where such measures are proposed and finalized.

Fulfilling HHS's Requirement to Make Its Measures under Consideration Publicly Available

The attached MUC List, which is compiled by CMS, will be posted on the NQF website and the CMS Pre-Rulemaking site. This posting will satisfy an important requirement of the pre-rulemaking process by making public the quality and efficiency measures that HHS is considering for use under certain Medicare quality programs. Additionally, the CMS website will indicate the MUC list is being posted on the NQF website.

Included Measures

This MUC List identifies the quality and efficiency measures under consideration by the Secretary of HHS for use in certain Medicare quality programs. Measures that appear on this list but are not selected for use under the Medicare program for the current rulemaking cycle will remain under consideration for future rulemaking cycles. They remain under consideration only for purposes of the particular program or other use for which CMS was considering them when they were placed on the MUC List. These measures can be selected for those previously considered purposes and programs/uses in future rulemaking cycles. This MUC List as well as prior year MUC Lists and Measure Applications Partnership (MAP) Reports can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-RuleMaking.html.

Applicable Programs

The following programs that now use or will use quality and efficiency measures have been identified to take part in pre-rulemaking. Not all programs have measures on the current list.

- Ambulatory Surgical Center Quality Reporting Program (ASCQR)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Home Health Quality Reporting Program (HH QRP)
- Hospice Quality Reporting Program (HQRP)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Inpatient Quality Reporting Program (HIQR)
- Hospital Outpatient Quality Reporting Program (HOQR)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing Program (HVBP)
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs)
- Medicare Shared Savings Program (SSP)
- Merit-based Incentive Payment System (MIPS)—Cost[6]
- Merit-based Incentive Payment System (MIPS)—Quality
- Part C and D Star Rating [Medicare][7]
- Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

Measures List Highlights

By publishing this list, CMS will make publicly available and seek the multi-stakeholder groups' input on 19 measures under consideration for use in Medicare programs. We note several important points to consider and highlight:

- Of the applicable programs covered by the statutory pre-rulemaking process, all programs contributed measures to this list in 2019 *except* the Ambulatory Surgical Center Quality Reporting Program, the Hospital-Acquired Condition Reduction Program, the Hospital Outpatient Quality Reporting Program, the Hospital Readmissions Reduction Program, the Hospital Value-Based Purchasing Program, the Inpatient Rehabilitation Facility Quality Reporting Program, the Long-Term Care Hospital Quality Reporting Program, the Merit- Based Incentive Payment System—Cost, the Skilled Nursing Facility Quality Reporting Program, and the Skilled Nursing Facility Value-Based Purchasing Program.
- The 2019 MUC List includes measures that CMS is currently considering under Medicare.
- Inclusion of a measure on this list does not require CMS to adopt the measure for the identified program.
- If CMS chooses not to adopt a measure under this list in the current rulemaking cycle, the measure remains under consideration by the Secretary and may be proposed and adopted in subsequent rulemaking cycles without being published again as part of a future MUC list.
- The following components of the Department of Health and Human Services contributed to and supported CMS in publishing a majority of measures on this list:

[6] Measures submitted for MIPS, which is one program, are divided for convenience between Cost and Quality measures, so that separate reviews can be conducted at CMS.
[7] Due to recent rulemaking requirements, the Part C and Part D Star Rating programs will now participate in the CMS pre-rulemaking process. They are separate programs, but are presented as one program for pre-rulemaking purposes.

- Office of the Assistant Secretary for Health
- Office of the National Coordinator for Health Information Technology
- National Institutes of Health
- Agency for Healthcare Research and Quality
- Health Resources and Services Administration
- Centers for Disease Control and Prevention
- Substance Abuse and Mental Health Services Administration
- Office of the Assistant Secretary for Planning and Evaluation
- Indian Health Service
- Food and Drug Administration

- CMS will continue aligning measures across programs whenever possible with the goals of moving payment toward value, improving outcomes for patients, and reducing regulatory burden for clinicians and providers through focusing everyone's efforts on the same quality areas. In an effort to provide a more meaningful List of Measures under Consideration, CMS included only measures that contain adequate specifications. Measures contained on this list had to fill a quality and efficiency measurement need and were assessed for alignment across CMS programs when applicable. To achieve this goal of alignment across programs, measures in the 2019 MUC list were reviewed using the Meaningful Measures Framework.

Meaningful Measures

Regulatory reform and reducing regulatory burden are high priorities for CMS. To reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative.[8] This initiative is one component of

our agency-wide Patients Over Paperwork Initiative,[9] which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve beneficiary experience. The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. The Meaningful Measures Initiative represents a new approach to quality measures that will reduce the collection and reporting burden while producing quality measurement that is more focused on meaningful outcomes.

Meaningful Measures will move payment toward value through focusing everyone's efforts on the same quality areas and lend specificity, with the following principles for identifying measures that:

- Address high-impact measure areas that safeguard public health;
- Are patient-centered and meaningful to patients;
- Are outcome-based where possible;
- Fulfill each program's statutory requirements;
- Minimize the level of burden for health care providers;
- Offer significant opportunity for improvement;
- Address measure needs for population based payment through alternative payment models; and
- Align across programs and/or with other payers.

In order to achieve these objectives, we have identified 19 Meaningful Measure areas and mapped them to six overarching quality priorities as shown in the first tab of the accompanying Excel file.

By including Meaningful Measures in our programs, we believe that we can also address the following cross-cutting measure criteria:

[8] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html

[9] https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html

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By including Meaningful Measures in our programs, we believe that we can also

address the following cross-cutting measure criteria:

- Eliminating disparities;
- Tracking measurable outcomes and impact;
- Safeguarding public health;
- Achieving cost savings;
- Improving access for rural communities; and
- Reducing burden.

Through the Meaningful Measures Initiative, CMS will continue to improve outcomes for patients, their families, and health care providers while reducing burden and costs for clinicians and providers as well as promoting operational efficiencies.

For more information, please contact Kimberly Rawlings at Kimberly.Rawlings@cms.hhs.gov or Helen Dollar-Maples at Helen.Dollar-Maples@cms.hhs.gov.