2024 Measures Under Consideration List

Program-Specific Measure Needs and Priorities

Contents

Overview

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The pre-rulemaking process is mandated by section 3014 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, enacted on March 23, 2010), which added Section 1890A to the Social Security Act (the Act), and which requires the Department of Health and Human Services (HHS) to establish a federal pre-rulemaking process for the selection of certain categories of quality and efficiency measures for use by HHS. These measures are described in section 1890(b)(7)(B) of the Act.

Every year, the Centers for Medicare & Medicaid Services (CMS) engages partners and advances transparency by inviting interested parties, including measure developers, measure stewards and other public and private interested parties, to submit candidate quality and efficiency measures for consideration by the Agency as a part of the statutorily required pre-rulemaking process.

The pre-rulemaking process requires that the Department of Health and Human Services (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 Medicare programs. This Measures under Consideration (MUC) List is reviewed by multi-interested party groups who provide recommendations on behalf of the public to HHS no later than February 1 annually. For additional information, please visit the CMS Pre-Rulemaking website. The following programs are included in the pre-rulemaking process:

Quality Programs

1. Ambulatory Surgical Center Quality Reporting (ASCQR) Program
2. End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
3. Home Health Quality Reporting Program (HH QRP)
4. Hospice Quality Reporting Program (HQRP)
5. Hospital-Acquired Condition Reduction Program (HACRP)
6. Hospital Inpatient Quality Reporting (IQR) Program
7. Hospital Outpatient Quality Reporting (OQR) Program
8. Hospital Readmissions Reduction Program (HRRP)
9. Hospital Value-Based Purchasing (VBP) Program
10. Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
11. Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
12. Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
13. Medicare Promoting Interoperability Program
14. Medicare Shared Savings Program (Shared Savings Program)
15. Merit-based Incentive Payment System (MIPS) Program
16. Medicare Part C and D Star Ratings
17. Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
18. Rural Emergency Hospital Quality Reporting (REHQR) Program
19. Skilled Nursing Facility Quality Reporting Program (SNF QRP)
20. Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

Annually, CMS publishes the needs and priorities for each of the above identified programs. For each program in the pages that follow, CMS provides a brief summary of the:

- program history and structure
- high priority areas for future measure consideration, and
- any program-specific measure requirements.

CMS encourages interested parties to consider each program's needs and priorities when developing measures and submitting them to CMS for consideration on the MUC List.

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CMS Agency-Wide Priorities

The Centers for Medicare & Medicaid Services (CMS) National Quality Strategy (NQS) aims to achieve optimal health and well-being for all individuals by helping to share a resilient, high-value American health care system that delivers high-quality, safe, and equitable care for all. Given quality measurements is a key lever central to implementing the NQS, CMS commits to a portfolio of quality measures that are rigorously tested, provide the highest value, and drive improvement in health outcomes. Two initiatives, Meaningful Measure 2.0 and the Cascade of Meaningful Measures, promote innovation and modernization of all aspects of quality measurement, addressing a wide variety of settings, interested parties, and measurement requirements. Meaningful Measures 2.0 addresses measurement gaps, reduces burden, and increases efficiency by:

- Using only high-value quality measures impacting key quality domains.
- Aligning measures across value-based programs and across partners, including CMS, federal, and private entities.
- Prioritizing outcome and patient-reported measures.
- Transforming measures to be fully digital and incorporating all-payer data.
- Developing and implementing measures reflecting social drivers/determinants of health (SDOH).

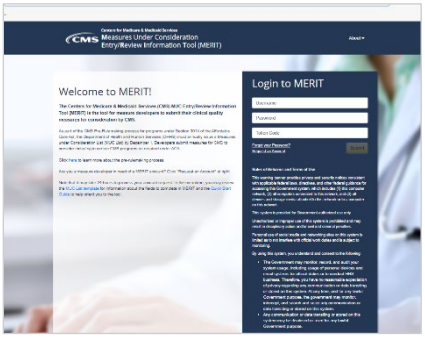
CMS continues to prioritize key measure focus areas including equity, behavioral health, maternal health, safety as well as measures that support appropriate utilization as well as culturally and linguistically appropriate services (CLAS).

Each CMS program listed in this report is committed to the public reporting of clinical quality measure data. This level of transparency not only educates patients and caregivers about the quality of care and services they seek, but also plays an important role in improving the overall quality of health care by promoting accountability.

Measure Requirements and Guidelines for CMS Quality Programs

CMS quality programs have identified requirements and guidance for selecting measures for future reporting years. For measures to be considered, review the following preferences and recommendations for submissions, in addition to program-specific requirements identified in each program description. Note that CMS is not required to adopt measures published on the MUC List. Quality and efficiency measure submissions are preferred to be:

- Fully developed and tested for the appropriate provider level (e.g., tested for clinicians' measurement if being submitted for consideration for the Merit-based Incentive Payment System Program), and adequate documentation to support testing results must be submitted. If insufficient information is submitted, CMS will be unable to further consider the measure for inclusion on a MUC List.



Measure Information Requirements

Submit measures for CMS review using CMS MERIT, the web-based submission tool including the following information:

a. Title
b. Numerator
c. Denominator
d. Exclusions
e. Measure steward
f. Link to full specifications
g. Information about testing
h. Information about evidence to support the measure
i. Estimated impact and cost
j. Established mechanism for data collection (e.g., CDC NHSN, AHRQ HCAHPS); and
k. Peer Reviewed Journal Article Requirement (Merit-based Incentive Payment System Program only)

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

l. Measure Authoring Tool (MAT) number
m. Bonnie test cases with 100% logic coverage
n. Attestation that value sets are published in the Value Set Authority Center (VSAC)
o. Feasibility scorecard
p. Attestation that the measure has a Health Quality Measures Format (HQMF) specification

Measure Selection Requirements

Selected measures must:

a. Support the CMS and national healthcare priorities, prioritizing outcome measures, patient-reported outcome measures, and digital measures
b. Address specific program goals and statutory requirements
c. Address important condition topic with a performance gap and strong scientific evidence base to demonstrate measure can lead to desired outcomes and/or more affordable care
d. Have written consent for any proprietary algorithms needed for measure production
e. Promote alignment with CMS program attributes and across HHS and private payer programs
f. Identify opportunities for improvement (e.g., not be "topped out")
g. Not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care)
h. Not duplicate other measures currently implemented in programs

Measure Submission Guidance

- Measures must contain complete and logical specifications
- Measures on a published MUC List but not selected by programs can be considered for selection in future rulemaking cycles
    - Measures do not need to be resubmitted unless
        - There are substantive changes to specifications
        - A measure steward would like the measure to be considered for a different program

- Measures may be part of mandatory quality reporting programs or optional quality reporting programs
- Measures must fulfill a measurement need and are assessed for alignment among CMS programs when applicable

CMS is not required to adopt measures that are published on the MUC List

Program-Specific Measure Needs and Priorities

The following sections provide history and statutory requirements, along with high priority areas and measure needs for each program covered by the CMS Pre-Rulemaking process. For more information on current measure details for each program, please visit The Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), or the latest final rule for each program.

Ambulatory Surgical Center Quality Reporting Program

Program History and Structure:

- The Ambulatory Surgical Center Quality Reporting (ASCQR) Program 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 Ambulatory Surgical Centers (ASCs) paid under the ASC fee schedule to report data on services provided in this care setting
- ASCs will receive a two-percentage point payment reduction to their ASC fee schedule 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

High Priority Areas for Future Measure Consideration:

- The ASCQR Program seeks to measure and publicly report quality of care measures for this outpatient setting. Optimally, quality measures of different types, consistent with statutory authority, would align across facility types that provide comparable service and would be representative of services provided by ASCs given specialization. Importantly, information that is publicly reported should allow Medicare beneficiaries and other consumers to compare quality metrics across different facility types and between individual facilities.
- **Equity**
- **Safety**
- **Patient Experience**

Program-Specific Measure Requirements:

CMS applies the below criteria and considerations for measures that may be considered for potential adoption in the Ambulatory Surgical Center Quality Reporting (ASCQR) Program:

1. Measures must adhere to CMS statutory requirements
    a. Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act
    b. The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed by the entity with a contract under Section 1890(a) of the Social Security Act, if endorsed measures have been given due consideration
    c. Measures shall address quality of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in the ambulatory care setting
2. Measures optimally would be field tested for the ASC clinical setting or Outpatient setting
3. Measure is clinically relevant
4. Data collection and submission burden of selected measures should be limited to the fullest extent possible since many ASCs are small facilities with limited staffing
5. Measures should supply sufficient case numbers for differentiation of ASC performance
6. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

End-Stage Renal Disease Quality Incentive Program

Program History and Structure:

- The End-Stage Renal Disease Quality Incentive Program (ESRD QIP) was 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)
- The first of its kind in Medicare, ESRD QIP promotes high quality dialysis care by linking a portion of facilities' payment directly to their performance on an established set of quality care measures.
- Section 1881(h) of the Act requires the Secretary to establish an ESRD QIP by:

- Selecting measures that address anemia management, dialysis adequacy, and patient satisfaction, iron management, bone mineral metabolism and vascular access, as necessary.
- Establishing the performance standards that apply to the individual measures
- Specifying a performance period with respect to a year
- Developing a methodology for assessing the total performance of each facility based on the performance standards with respect to the measures for a performance period
- Apply payment reductions of up to 2% if a facility does not meet or exceed the minimum Total Performance Score (TPS)
- Publicly report results

High Priority Areas for Future Measure Consideration:

- **Outcomes:** The ESRD QIP will prioritize outcome measures over process measures
- **Home Dialysis**: Research has suggested that dialyzing at home is often preferred by patients and physicians and results in improved quality of life and overall lower medical expenditures. Although some measures in the ESRD QIP apply to home dialysis facilities, the majority of measures do not apply to facilities that have high rates of home dialysis
- **Transplantation**: Transplantation is widely viewed as the optimal treatment for most patients with ESRD, generally increasing survival and quality of life while reducing medical expenditures. While the ESRD QIP currently contains a measure that assesses the percentage of prevalent patients waitlisted, CMS recognizes the importance of measuring the extent to which patients actually receive transplants
- **Health Equity**: Research suggest that there are several racial and socioeconomic disparities in dialysis outcomes, access to high quality care and alternative renal replacement modalities. CMS is committed to achieving equity in healthcare outcomes for patients with ESRD by promoting efforts to expand the collection of social risk factor data, providing actionable and useful results to dialysis providers, and promoting dialysis provider accountability for healthcare disparities
- **Patient-and-Caregiver-Centered Experience of Care**: Sustaining and recovering patient quality of life was among the original goals of the Medicare ESRD QIP. This includes such issues as physical function, independence, and cognition. Quality of Life measures should also consider the life goals of the patient where feasible, to the point of including Patient-Reported Outcomes

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the End-Stage Renal Disease Quality Incentive Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measures for anemia management reflecting FDA labeling, as well as measures for dialysis adequacy
2. Measure(s) of patient satisfaction, to the extent feasible
3. Measures of iron management, bone mineral metabolism, and vascular access, to the extent feasible
4. Measures specific to conditions treated with oral-only drugs and, to the extent feasible, that such measures be outcomes measures
5. Measures should be Consensus-Based Entity (CBE) endorsed, save where due consideration is given to endorsed measures of the same specified area or medical topic
6. Must consider the availability of measures that address the unique treatment needs of children and young adults with kidney failure
7. May incorporate Medicare claims and/or EQRS data, alternative data sources will be considered dependent upon available infrastructure
8. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Requirements 1-4 above are mandated by statute

Home Health Quality Reporting Program

Program History and Structure:

- The Home Health Quality Reporting Program (HH QRP) was established in accordance with Section 1895 (b)(3)(B)(v)(II) of the Social Security Act
- Home Health Agencies (HHAs) are required by the Act to submit quality data for use in evaluating health care quality
- HHAs that do not submit quality data to the Secretary are subject to a 2-percentage point reduction in the annual payment update (Section 1895(b) (3)(B)(v)(I))

Expanding the Home Health Value-based Purchasing Model:

- The original Home Health Value-Based Purchasing (HHVBP) Model was established by Section 1115A of the Affordable Care Act and finalized in the Calendar Year (CY) 2016 Home Health Prospective Payment System (HH PPS) final rule (80 FR 68624), and implemented in nine states by the Center for Medicare and Medicaid Innovation (Innovation Center)
- In CY 2022 HH PPS Final rule finalized the expansion of the HHVBP Model to include Medicare-certified HHAs in all fifty (50) states, District of Columbia, and the U.S. territories
- The expanded HHVBP Model currently includes 12 measures including 2 claims-based, 5 OASIS based and 5 Patient Satisfaction Measures (CAHPS). After measure set updates being implemented in CY 2025, the model will use 10 measures, including 2 claims based, 3 OASIS based, and 5 CAHPS measures.
- HHA will have their payment adjusted +/- 5% based on the level of quality the HHA provides in the performance period
- When the expanded HHVBP Model adds measures in the future, they may be measures that have been in use in the HH QRP
- CY 2022 was a pre-implementation year. CY 2023 was the first year in which performance will be tied to payment in CY 2025
- Performance reports are in IQIES
- Public reporting of performance in the Model will be on the Care Compare website

High Priority Areas for Future Measure Consideration:

HH QRP identified the following as high priorities for future measure consideration:

- **Health Equity**: Measures that would address health equity
- **Universal Foundation Measures:** Develop and adopt measures from the Universal Foundation measure set
- **Pain Measure:** Develop and adopt a measure focusing on improvement in patient pain

Program-Specific Measure Requirements:

For the Home Health Quality Reporting Program (HH QRP), The IMPACT Act requires the development and reporting of standardized quality measures addressing 5 domains in addition to resource use, hospitalization, and discharge to the community. These domains and categories are listed below

1. Quality Measure Domains:
    a. Skin integrity and changes in skin integrity
    b. Functional status, cognitive function, and changes in function and cognitive function
    c. Medication reconciliation
    d. Incidence of major falls
    e. Transfer of health information and care preferences when an individual transitions
2. Resource Use and Other Measure Domains:
    a. Resource use measures, including total estimated Medicare spending per beneficiary
    b. Discharge to community
    c. All-condition risk-adjusted potentially preventable hospital readmissions rates
3. Measures implemented in the HH QRP are statutorily required to reflect consensus among stakeholders affected
4. Measures adopted in the HH QRP must be available for public reporting on *Care Compare*
5. Preference will be given to measures that are endorsed by the CBE
6. Measure performance should demonstrate variation amongst home health agencies and opportunities for improvement, exception for function maintenance measure
7. Measures are preferred to be fully developed, with completed testing results at the national level and ready for implementation at the time of submission (CMS' internal evaluation)
8. No new measures adopted into the HH QRP will duplicate other measures currently/previously implemented into the program
9. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Hospice Quality Reporting Program

Program History and Structure:

- The Hospice Quality Reporting Program (HQRP) was established in accordance with Section 1814(i)(5) of the Social Security Act, as amended by section 3004(c) of the Affordable Care Act and further amended by Consolidated Appropriations Act (CAA) of 2021
- The HQRP applies to all patients receiving care from Medicare-certified hospices, regardless of payer source
- HQRP measure development and selection activities are considered established national priorities and requires input from multi-stakeholder groups
- Beginning in FY 2014, Hospices that fail to submit quality data are subject to a two-percentage point reduction to their annual payment update that changes to a four-percentage point reduction beginning in FY 2024

High Priority Areas for Future Measure Consideration:

HQRP identified the following as high priorities for future measure consideration:

- The Hospice Outcome & Patient Evaluations (HOPE) tool Measure Concepts
  - **Process Measures**
  - **Outcome Measures**
- **Hybrid Measures**: Develop hybrid measures which would combine data from different sources, such as claims, assessments, or other data sources
- **Health Equity**: Measures that address health equity and focus on underserved populations' access to care

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospice Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measures implemented in the HQRP are statutorily required to reflect consensus among stakeholders affected
2. Measures adopted in the HQRP are available for public reporting on *Care Compare*
3. Measures are preferred to be fully developed, with completed testing results at the national level and ready for implementation at the time of submission
4. Preference will be given to measures that are endorsed by the CBE

5. Measure performance should demonstrate variation amongst Hospices and opportunities for improvement
6. Measures adopted into HQRP fill a gap or high priority area as determined by OIG, MedPAC, or other interested parties
7. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Hospital-Acquired Condition Reduction Program

Program History and Structure:

- Created under Section 1886(p) of the Social Security Act (the Act), the HAC Reduction Program (HACRP) provides an incentive for hospitals to reduce the number of hospital-acquired conditions (HACs)
- Effective Fiscal Year (FY) 2015 and beyond, the HAC Reduction Program, requires the Secretary to make payment adjustments to applicable hospitals that rank in the worst-performing quartile of all subsection (d) hospitals relative to a national average of HACs acquired during an applicable hospital stay
- HACs include a condition identified in subsection 1886(d)(4)(D)(iv) of the Act and any other condition determined appropriate by the Secretary
- Section 1886(p)(6)(C) of the Act requires the HAC information be posted on the *Care Compare* website
- The program uses the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) and five healthcare-associated infections (HAI) as collected by the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)
- HACRP scoring methodology assigns equal weighting to each measure for which a hospital has sufficient data
- The Total HAC Score is the sum of the equally weighted average of the hospital's measure scores

High Priority Areas for Future Measure Consideration:

Making Care Safer

- Measures that meet the Measure Requirements below that are eCQMs
- Measures that address adverse drug events during the inpatient stay
- Additional surgical site infection locations that are not already covered within an existing measure in the program
- Outcome risk-adjusted measures that capture outcomes from hospital-acquired conditions and are risk-adjusted to account for patient and/or facility differences (e.g., multiple comorbidities, patient care location)
- Measures that address diagnostic errors such as harm from receiving improper tests or treatment, harm from not receiving proper tests or treatment, harm from failure to diagnose, or harm from improper diagnosis
- Measures that address causes of hospital harm such as an all-cause harm measure or a measure that encompasses multiple harms
- Measures that demonstrate safety and/or high reliability practices and outcomes

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital-Acquired Condition Reduction Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measures identified as a HAC under Section 1886(d)(4)(D) or be a condition identified by the Secretary
2. Measures can address high cost or high-volume conditions
3. Measures should be easily preventable by using evidence-based guidelines
4. If feasible, measure should be digital, such as an eCQM
5. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Hospital Inpatient Quality Reporting Program

Program History and Structure:

- 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 Hospital IQR Program requires the reporting of hospital safety metrics and shares performance data with the public
- Acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) are required to report on measures in the program
- Failure to meet the requirements of the Hospital IQR Program will result in a reduction by 1/4 to a hospital's fiscal year IPPS annual payment update (APU)
- Certain hospital types are excluded from the program based on the program statute. Hospitals that are excluded 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 to have their results publicly reported, but are not financially penalized if they do not participate
- Performance of quality measures are publicly reported on the CMS *Care Compare* website

High Priority Areas for Future Measure Consideration:

- **PRO-PM**
- **Care Coordination**
- **Health Equity**
- **Maternal Health**
- **Safety**
- **Outcome eCQMs**
- **Behavioral Health**
- **Cancer**
- **Geriatric/Age Friendly**

The Hospital IQR Program and Medicare Promoting Interoperability Program have a completely aligned eCQM measure set in each program. Hospitals receive credit for both programs by submitting eCQM files just once through the Hospital Quality Reporting System. CAHs are not required to report under the Hospital IQR Program, but are required to report under the Promoting Participants in the PIP are also required to report on four scored objectives and their measures (i.e., Electronic Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange) and required to report (yes/no) on the Protect Patient Health Information objective among other program requirements.

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital IQR Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must adhere to CMS statutory requirements. For more detail on statutory requirements, please refer to the CMS website
2. If feasible, measure should be digital, such as claims-based or an eCQM
3. A MAT number must be provided for all eCQMs, created in the HQMF specification
4. eCQMs must undergo reliability and validity testing and must have successfully passed feasibility testing
5. Measure is preferred to be fully developed, tested, and validated in the acute inpatient setting
6. Measure may not require reporting to a proprietary registry or use of a proprietary tool unless available to the public for free
7. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Hospital Outpatient Quality Reporting Program

Program History and Structure:

- 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 measures
- Pay-for-Reporting Program
- Facilities will receive a two-percentage point reduction from their APU under the OPPS for not meeting program requirements
- Data publicly reported on the CMS *Care Compare* website

High Priority Areas for Future Measure Consideration:

The key strategy for the Hospital Outpatient Quality Reporting (OQR) Program is to measure and publicly report quality of care measures for the hospital outpatient and emergency departments. Specifically, quality measures of different types, consistent with statutory authority, would align to the extent feasible and appropriate, so that Medicare beneficiaries and other consumers can compare quality metrics across different facility types. More importantly, ensure equivalent high quality and equitable care across the board as care/procedures move toward outpatient settings

- **Safety**
- **Equity**
- **Person-Centered Care**
- **Behavioral Health**
- **PRO-PM**
- **Outcome eCQMs**

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital OQR Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must adhere to CMS statutory requirements
    a. The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care, including quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities; as well as, make these data publicly available on the Internet website of the Centers for Medicare and Medicaid Services under Section 1833 (t)(17)(C) of the Act
    b. Nothing in this paragraph shall be construed as preventing the Secretary from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii) of the Act
2. Measure is preferred to be fully developed, tested, and validated in the hospital outpatient setting
3. Feasibility of Implementation: An evaluation of feasibility is based on factors including, but not limited to:

a. The level of burden associated with collecting, reporting, and validating measure data, both for CMS and for the end user.

b. Feasibility and readiness of CMS system for data collection.

4. If feasible, measure would be digital, such as an eCQM
5. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Hospital Readmissions Reduction Program

Program History and Structure:

- The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program established under Section 1886(q) of the Social Security Act, which reduces payments to subsection (d) hospitals for excess readmissions beginning October 1, 2012 (fiscal year 2013).
- The 21st Century Cures Act directs CMS to assess a hospital's performance relative to other hospitals with a similar proportion of beneficiaries who are dually eligible for Medicare and full Medicaid benefits. The Cures Act changed the way CMS calculates payment reductions from using a non-peer grouping methodology (FY 2013 to FY 2018) to a peer grouping methodology (FY 2019 and onward).
- In addition, the peer grouping methodology is required to produce the same amount of Medicare savings that would be generated under the non-peer grouping methodology to maintain budget neutrality.
- The following steps are taken to calculate payment reductions under HRRP:
    1. For each of the conditions/procedures in HRRP, CMS calculates an excess readmission ratio (ERR) currently using Medicare fee-for-service claims (FFS)
    2. Calculates the dual proportion for each hospital using Medicare FFS and managed care claims.
    3. Sorts hospitals into 1 of 5 similarly sized peer groups (i.e., quintiles) based on hospitals' dual proportions.
    4. Identify the median ERR for each condition or procedure within each peer group.
    5. Determine which measures will contribute to the payment reduction based on following criteria
        - ERR is greater than the peer group median ERR
        - A minimum of 25 eligible discharges for each measure

6. Calculate each measure's contribution to the payment reduction, payment reduction, and payment adjustment factor (PAF), subsequently apply the PAF

High Priority Areas for Future Measure Consideration:

- Improving scope by covering more clinical conditions, procedures, or topics
- Considering Agency priorities (e.g., behavioral, or mental health, including substance use disorders)

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital Readmissions Reduction Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must adhere to CMS statutory requirements,
2. Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists for under-served and under-resourced populations groups, and that measure implementation can lead to improvement in desired outcomes, costs, resource utilization or seamless care coordination.
3. Measure is preferred to be fully developed, tested, and validated in the acute inpatient setting
4. Measure must address a Meaningful Measure area, with preference for measures addressing the high priority domains and/or measurement gaps for future measure consideration
5. Measure must promote alignment across HHS and CMS programs
6. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed
7. If feasible, measure must be digital, such as an eCQM

Hospital Value-Based Purchasing Program

Program History and Structure:

- The Hospital Value-Based Purchasing (VBP) Program was established by Section 3001(a) of the Affordable Care Act, under which value-based incentive payments are made each fiscal year to hospitals meeting performance standards established for a performance period for such fiscal year

- Measures are eligible for adoption in the Hospital VBP Program based on the statutory requirements, including the requirement to public report new or substantively modified measures for one year prior to be included in the Hospital VBP Program
- The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. In addition, a cost efficiency measure, currently the Medicare Spending Per Beneficiary measure, must be included
- In the FY 24 Inpatient Prospective Payment System/Long-term Care Hospital Prospective Payment System final rule, CMS finalized a modification to the existing scoring methodology to reward excellent care in underserved populations. This takes the form of a new adjustment that rewards hospitals based on their performance and the proportion of their patients that are dually eligible for Medicare and Medicaid and includes health equity adjustment bonus points applied to a hospital's total performance score (TPS).

High Priority Areas for Future Measure Consideration:

- **PRO-PM**
- **Outcome eCQMs**
- **Care Coordination**
- **Health Equity**
- **Maternal Health**
- **Behavioral Health**

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital Value-Based Purchasing Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must adhere to CMS statutory requirements, including requirement to publicly report new or substantively modified measures for one year prior to inclusion in the Hospital VBP Program
2. Measure may not require reporting to a proprietary registry or use of a proprietary tool unless available to the public for free
3. Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists, and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization
4. Measure is preferred to be fully developed, tested, and validated in the acute inpatient setting

5. Measure must address a Meaningful Measure area, with preference for measures addressing the high priority domains and/or measurement gaps for future measure consideration
6. Measure must promote alignment across HHS and CMS programs
7. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed
8. If feasible, measure must be digital, such as a claims-based measure, hybrid measure or eCQM

Inpatient Psychiatric Facility Quality Reporting Program

Program History and Structure:

- Section 1886(s)(4) of the Social Security Act requires the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units
- Section 4125(b) of the Consolidated Appropriations Act, 2023, amended section 1886(s)(4) of the Act by requiring a quality measure of patients' perspective on care
- Applies to all psychiatric hospitals and psychiatric units paid under Medicare's Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)
- IPFQR is a "pay-for-reporting" program.
  - Non-compliance results in a two-percentage point reduction to the market basket update
  - Update reductions are noncumulative across payment years
- Designed to provide patients, and their families and caregivers, with quality-of-care information to help make informed decisions about their health care options
- Intended to improve the quality of inpatient psychiatric care provided to beneficiaries by ensuring that providers are aware of and reporting on practices related to quality care
- FY 2014 was the first payment determination
- Payment reductions for non-participation or failure to submit quality measures are effective as of October 1 of each applicable fiscal year, i.e., for FY 2015, the payment reduction is effective for services provided starting on October 1, 2014

High Priority Areas for Future Measure Consideration:

- **Psychiatric condition-specific PRO-PMs**
- **Measures to reduce suicide risk**
- **Measurement-based care**
- **Outcome measures for psychiatric conditions**

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Inpatient Psychiatric Facility Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must adhere to CMS statutory requirements, including specification under the IPFQR Program
2. Measure results and performance should identify opportunities for improvement
3. If feasible, measure must be digital, such as an eCQM
4. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Inpatient Rehabilitation Facility Quality Reporting Program

Program History and Structure:

- The Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) was implemented with the fiscal year (FY) 2012 IRF PPS Final Rule. Quality reporting requirements were mandated in section 3004(b) of the Patient Protection and Affordable Care Act (ACA) of 2010 which amended section 1886(j)(7) of the Social Security Act (SSA)
- The IRF QRP is a pay for reporting program where successfully meeting the requirements for each FY means IRFs must submit data on quality measures. IRFs must also submit standardized patient assessment data with regard to quality measures and standardized patient assessment data elements.
- Failure to meet the IRF QRP requirements results in a two-percentage point reduction in IRFs Annual Increase Factor (AIF) for the corresponding, future FY payments.
- Measures adopted in the IRF QRP are publicly reported on the *Care Compare* website.

High Priority Areas for Future Measure Consideration:

- **Health Equity**: Develop and adopt measures which focus on health equity.
- **Universal Foundation Measures:** Develop and adopt measures from the Universal Foundation measure set.
- **Pain Measure:** Develop and adopt a measure focusing on improvement in patient pain.

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Inpatient Rehabilitation Facility Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. For the Inpatient Rehabilitation Facility Quality Reporting Program, The IMPACT Act requires the development and reporting of quality measures addressing 5 domains in addition to resource use, hospitalization, and discharge to the community. These domains and categories are listed below:
    a. Quality Measure Domains:
        i. Skin integrity and changes in skin integrity
        ii. Functional status, cognitive function, and changes in function and cognitive function
        iii. Medication reconciliation
        iv. Incidence of major falls
        v. Transfer of health information and care preferences when an individual transitions
    b. Resource Use and Other Measure Domains:
        i. Resource use measures, including total estimated Medicare spending per beneficiary
        ii. Discharge to community
        iii. All-condition risk-adjusted potentially preventable hospital readmissions rates
2. Quality measures selected for the IRF QRP must be endorsed by the CBE unless they meet the statutory criteria for exception.
3. Reporting of measures is feasible to implement, and measures have preferably been fully developed and tested.
4. Results for and performance of measures should identify opportunities for improvement.

5. Potential use of a measure in a program does not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care).
6. Measures adopted in the IRF QRP are publicly reported on *Care Compare.*
7. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Long-Term Care Hospital Quality Reporting Program

Program History and Structure:

- The Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) was established in the Fiscal Year (FY) 2012 Inpatient Prospective Payment System (PPS)/LTCH PPS Final Rule, as authorized by Section 3004(a) of the Patient Protection and Affordable Care Act of 2010
- The LTCH QRP is a pay for reporting program where successfully meeting the requirements for each fiscal year means LTCHs must meet or exceed two separate data completeness thresholds:
  - One threshold set at 85% for completion of quality measure data collected using the LTCH Continuity Assessment and Record of Evaluation (CARE) Data Set (LCDS).
  - The second set at 100% for quality measure data collected and submitted using the Centers for Disease Control (CDC) National Healthcare Surveillance Network (NHSN)
- Any LTCH who does not meet reporting requirements may be subject to a two-percentage point reduction in their Annual Payment Update

High Priority Areas for Future Measure Consideration:

- **Health Equity**: Develop and adopt measures which focus on health equity
- **Long-term Care**: Measures that reflect care specific to LTCHs, such as long-term ventilator care
- **Universal Foundation Measures:** Develop and adopt measures from the Universal Foundation measure set
- **Pain Measure:** Develop and adopt a measure focusing on improvement in patient pain

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Long-Term Care Hospital Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. The IMPACT Act requires CMS to develop and implement quality measures to satisfy at least five measure domains:
    a. functional status, cognitive function, and changes in function and cognitive function
    b. skin integrity and changes in skin integrity
    c. medication reconciliation
    d. incidence of major falls
    e. 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
2. The IMPACT Act also requires the implementation of resource use and other measures in satisfaction of at least these following domains:
    a. total estimated Medicare spending per beneficiary
    b. discharge to the community
    c. all condition risk adjusted potentially preventable hospital readmission rates
3. The LTCH QRP measure development and selection activities consider established national priorities and input from multi-stakeholder groups
4. Measure reporting is feasible to implement, and measures have preferably been fully developed and tested
5. Measure results and performance should identify opportunities for improvement
6. Potential use of the measure in a program does not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care)
7. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Medicare Promoting Interoperability Program

Program History and Structure:

- Sections 1886(b)(3)(B)(ix) and 1814(l)(4) of the Social Security Act (as amended by the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) authorize downward payment adjustments under Medicare, beginning with fiscal year (FY) 2015 for eligible hospitals and CAHs that do not successfully demonstrate meaningful use of certified electronic health record technology (CEHRT) for the applicable electronic health record (EHR) reporting periods. Section 602 of Title VI, Division O of the Consolidated Appropriations Act, 2016 (Pub. L. 114–113) added subsection (d) hospitals in Puerto Rico as eligible hospitals under the Medicare EHR Incentive Program and extended the participation timeline for these hospitals such that downward payment adjustments were authorized beginning in FY 2022 for section (d) Puerto Rico hospitals that do not successfully demonstrate meaningful use of CEHRT for the applicable EHR reporting periods.

High Priority Areas for Future Measure Consideration:

- For MUC, high priority areas for us are those eCQMs where Hospital IQR Program and the Medicare Promoting Interoperability Program are in alignment for proposing/finalizing. Other measures developed for the Medicare Promoting Interoperability Program are discussed, developed, and implemented outside of the MUC/MAP process. One thing to note is that reporting of eCQMs is required for CAHs under the Medicare Promoting Interoperability Program, where it is not required for the Hospital IQR Program.
- For awareness only: what is central to the Medicare Promoting Interoperability Program is the tie to using certified electronic health record technology (CEHRT). Essentially, statute says that anything we propose must use CEHRT. Our measure requirements are more about using technology than the measure areas themselves. Also, we will likely [never] propose eCQMs outside of the IQR/PI partnership.

Program-Specific Measure Requirements:

- Measure must adhere to CMS statutory requirements. For more detail on statutory requirements, please refer to the CMS website
- A MAT number must be provided for all eCQMs, created in the HQMF specification
- eCQMs must undergo reliability and validity testing and must have successfully passed feasibility testing

- Measure is preferred to be fully developed, tested, and validated in the appropriate inpatient setting
- Measure may not require reporting to a proprietary registry or use of a proprietary tool unless available to the public for free
- Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Medicare Shared Savings Program

Program History and Structure:

- The Medicare Shared Savings Program (Shared Savings Program) is Medicare's national value-based payment program for Accountable Care Organizations (ACO). ACO's facilitate coordination and cooperation among health care providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs
- Eligible clinicians, hospitals, and other health care providers can voluntarily join or form an ACO
- ACOs share in savings by meeting the quality performance standard for the performance year and lowering the growth in Medicare spending
- ACOs participating under a two-sided shared savings/losses model may owe losses if they increase costs and the amount owed is based on quality performance depending on track
- For performance year2024, ACOs will be required to report quality data via the Alternative Payment Model (APM) Performance Pathway (APP).
    - ACOs can choose to report either the 10 measures under the CMS Web Interface or the 3 eCQMs/Merit-based Incentive Payment System (MIPS) Clinical Quality Measures (CQMs)/Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs)
    - ACOs must field the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) for MIPS survey
    - CMS will calculate 2 claims-based outcome measures using administrative claims data: the Hospital Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure and the Clinician and Clinician Group Risk-

Standardized Hospital Admissions Rates for Patients with Multiple Chronic Conditions measure

High Priority Areas for Future Measure Consideration:

- **Shared Savings Measures**: The Shared Savings Program goals include identification measures of success in the delivery of high-quality health care at the individual and population levels and align with HHS and CMS priorities (such as the Adult Universal Foundation measure set), with a focus on outcomes
- **Health Equity**: Measures that promote health equity and address social determinants of health

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Shared Savings Program. At a minimum, the following requirements must be met for consideration in the program:

1. Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients
2. Measures that are targeted to the needs and gaps in care of Medicare Fee-For-Service patients and their caregivers
3. Measures that align with CMS quality reporting and value-based initiatives, including Quality Payment Program
4. Measures that support improved population health
5. Measures addressing high-priority healthcare issues, such as health equity and opioid use
6. Measures that align with recommendations from the Core Quality Measures Collaborative
7. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Merit-based Incentive Payment System Program

Program History and Structure:

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS, by law, to implement an incentive program for clinicians. This program, referred to as the Quality Payment Program, provides two participation pathways for clinicians:
  - The Merit-based Incentive Payment System (MIPS): Traditional MIPS or MIPS Value Pathways (MVPs); and
  - Advanced Alternative Payment Models (Advanced APMs).
- MIPS combines three Medicare "legacy" programs – the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals – into a single program. Under MIPS, there are four connected performance categories that will affect a clinician's future Medicare payments.
- Starting with the 2023 performance period, MIPS eligible clinicians, groups, virtual groups, subgroups, and APM Entities may choose to report traditional MIPS or MIPS MVPs, as applicable. MVPs include a subset of measures and activities that are related to a given specialty or medical condition. MVPs offer reduced reporting requirements, allowing MVP participants to report on a smaller, more cohesive subset of measures and activities (within the measures and activities available under traditional MIPS).
- Each performance category (Quality, Promoting Interoperability, Improvement Activities, and Cost) is scored independently and has a specific weight, indicating its contribution towards the MIPS Final Score.
- For the 2024 performance period, the weights for each MIPS performance category are as follows: Quality (30%), Cost (30%), Promoting Interoperability (25%), and Improvement Activities (15%). The MIPS Final Score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.

Quality – MIPS

High Priority Areas for Future Measure Consideration:

The following specialties, clinical conditions, and topics have been identified as gaps within the MIPS quality performance category and are considered priority areas for future measure consideration.

Specialties:

- Interventional Cardiology
- Electrophysiology
- Non-Patient Facing (i.e., Pathology, Radiology)
- Dentistry
- Podiatry
- Nutrition/Dietician
- Pain Management
- Plastic Surgery
- Hospitalists
- Nephrology
- Pulmonology
- Radiation Oncology
- Speech Language Pathology
- Allergy/Immunology
- Hematology
- Anesthesiology
- Interventional Radiology

Clinical Conditions:

- Opioid Epidemic
- Maternal Health
- Mental and Behavioral Health
- Chronic Conditions
  - Arrhythmias
  - Chronic Obstructive Pulmonary Disease
  - Hepatitis B
  - Septicemia
  - Respiratory Failure
  - Ashma
  - Diabetes
- Avoidance of Amputation for Diabetes
- "Age Friendly" (Older Adult/Geriatrics)
- Kidney Care and Organ Transplantation
- Sickle Cell Disease
- HIV and Hepatitis C
- Genetic Testing/Counseling
- Oral Health

Topics:

- Outcome Measures (outcome, intermediate outcome, and patient reported outcome measures (PRO-PMs) (patient voice))
- Coordination/Communication/Team-Based Care
- Interoperability/Digital Measures (i.e., quality measures with sources from administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, wearable/medical instruments, patient portals or applications, health information exchanges (HIEs) or registries, and other sources)
- Measures that provide new measure options within a topped-out specialty area
- Health Equity
- COVID-19
- Shared Decision-Making (patient voice)
- Person-Centered Care/Experience of Care (patient voice)

CMS identifies the following as high priority MIPS quality measures for future consideration:

- **Patient Engagement/Experience**: The measure should address the experience of each person and their family; and the extent to which they are engaged as partners in their care.
- **Care Coordination**: The measure must address the promotion of effective communication and coordination of care; and coordination of care and treatment with other providers.
- **Efficiency**: The measure must address the affordability of health care including unnecessary health services, inefficiencies in health care delivery, high prices, or fraud. Measures should cause a change in efficiency and reward value over volume.
- **Patient Safety**: The measure must address either an explicit structure or process intended to make care safer, or the outcome of the presence or absence of such a structure or process; and harm caused in the delivery of care. The structure, process, or outcome must occur as a part of or because of the delivery of care.
- **Appropriate Use**: CMS wants to specifically focus on appropriate use measures. The measure must address appropriate use of services, including measures of over-use.
- **Opioid-Related**: CMS wants to focus on opioid related measures to address the national Opioid Epidemic.
- **Health Equity-Related**: The measure must relate to health equity and work toward the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identify, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.
- CMS prioritizes quality measures that:
  - Provide new measure options within a topped-out specialty area.
  - Reduce reporting burden – includes digital quality measures (dQMs), administrative claims measures and measures that align across programs.
  - Capture relevant specialty clinicians.
  - Reflect the quality of a group's overall health and wellbeing including access to care, coordination of care and community services, health behaviors, preventive care screening, and utilization of health care services.
  - Support health equity.

Program-Specific Measure Requirements:

CMS applies criteria for quality measures that may be considered for potential adoption in MIPS. At a minimum, the following requirements must be met for consideration in the program:

1. CMS is statutorily required to select measures that reflect consensus among affected parties, and to the extent feasible, include measures set forth by a national CBE.
2. Before including a new measure in MIPS, CMS is required to submit the measure for publication in an applicable specialty-appropriate, peer-reviewed journal and the method for developing the measure, including clinical and other data supporting the measure. The Peer-Review Journal Article Template provided by CMS, must accompany each measure submission. Please review the Peer-Review Journal Article Template for additional information available on the Pre-Rulemaking Resources | The Measures Management System (cms.gov).
3. Measures submitted should be linked to a Cost Measure, Improvement Activity, and/or an applicable MVP.
4. Measures implemented in MIPS may be available for public reporting on *Care Compare*.
5. Measures are preferred to be fully developed, with completed testing results at the clinician level (and group level as appropriate) and ready for implementation at the time of submission (CMS' internal evaluation).
6. Measures should include testing data to support the MIPS collection type to be used for reporting (MIPS CQM, Administrative Claims, or eCQM). If the measure is being submitted for implementation as multiple MIPS collection types, testing data submitted should meet the requirements for each applicable MIPS collection type.
7. Preference will be given to measures that are endorsed by a CBE.
8. Measures should not duplicate other measures currently in MIPS. Duplicative measures are assessed to see which would be the better measure for the MIPS quality measure inventory.
9. Measure performance data from testing and research evidence should identify opportunities for improvement. CMS does not intend to implement measures in which evidence identifies high levels of performance with little variation or opportunity for improvement (i.e., measures that are "topped out").
10. eCQMs must meet electronic health record (EHR) system infrastructure requirements, as defined by MIPS regulation.
11. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

For additional information, please review the MIPS 2024 Annual Call for Quality Measures Fact Sheet (cms.gov)

Cost – Merit-based Incentive Payment System

High Priority Areas for Future Measure Consideration

- The specialties below are those which have limited applicability from the current MIPS episode-based cost measures:
    - Anesthesiology
    - Audiology
    - Certified Nurse Midwife
    - Certified Registered Nurse Anesthetist (CRNA)
    - Dentist
    - Diagnostic Radiology
    - Hand Surgery
    - Maxillofacial Surgery
    - Nuclear Medicine
    - Obstetrics/Gynecology
    - Optometry
    - Oral Surgery (dentists only)
    - Pathology
    - Podiatry
    - Radiation Oncology
    - Registered Dietician/Nutrition Professional
    - Speech Language Pathology
- These were identified from empirical analyses using administrative claims data. The list of specialties represents those where the specialty has <10% of clinicians who are

attributed at least 1 episode. This analysis is on 2019 data and does not apply restrictions for MIPS participation.[1]

- While the global cost measures may apply to these specialties, we nonetheless include the specialties here as many stakeholders have expressed interest in having measures focused on types of care in addition to the broad, population-based measures

MIPS Value Pathways (MVPs) Development Criteria:

CMS applies criteria for measures that may be considered for potential adoption in MVPs. If applicable and feasible, use measures and improvement activities across all 4 performance categories (Quality, Cost, Promoting Interoperability, and Improvement Activities). At a minimum, the following requirements must be met for consideration in the program:

1. Have a clearly defined intent of measurement.
2. Align with the Meaningful Measure Framework.
3. Have measure and activity linkages within the MVP.
4. Be clinically appropriate for the MVP under development.
5. Be developed collaboratively across specialties in instances where the MVP is relevant to multiple specialties.
6. Be understandable by clinicians, groups, and patients.
7. To the extent feasible, include electronically specified quality measures.
8. Incorporate the patient voice (patient reported outcome-based performance measure or shared decision-making measure).
9. Support health equity.

[1] Centers for Medicare & Medicaid Services. (2024). See *CMS 2024 MIPS Annual Call for Cost Measures Fact Sheet* for details about the methodology [Fact Sheet]. U.S. Department of Health & Human Services. https://mmshub.cms.gov/sites/default/files/2024-mips-annual-call-for-cost-measures-fact-sheet.pdf

Program-Specific Measure Requirements

CMS applies criteria for measures that may be considered for potential inclusion in MIPS cost measures. At a minimum, the following requirements (questions) must be met for consideration in the program:

1. Is the measure based on measure specifications that have clinical face validity? Are the specifications consistent with practice standards?
2. Does the measure have clear attribution to clinicians? Could clinicians anticipate when their responsibility for a patient begins under the measure?
3. Does the measure include the cost of services that reflect the role of attributed clinicians?
4. Is the construction methodology readily understandable to clinicians?
5. Can the measure be presented in a way that conveys clear information on how clinicians can alter their practice to improve measured performance?
6. Do the measure specifications allow for consistent calculation and reproducibility using Medicare claims data?
7. Does the testing information in the submission demonstrate variation to help distinguish cost performance across individual clinicians?
8. Can the measure be used in an existing or future potential MVP to assess the value of care for a defined clinical topic?
9. CMS will also consider the extent to which the measure shares the same components as current MIPS cost measures and any other factors as appropriate. This helps to promote consistency within the MIPS cost performance category
10. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Part C and D Star Ratings

Program History and Structure:

- The Part C & D Star Ratings program is based on sections 1851(d), 1852(e), 1853(o) and the 1854(b)(3)(iii), (v), and (vi) of the Social Security Act
- General authority under section 1856(b) of the Act: establishment of standards consistent with and to carry out Part C & D as basis for the 5-Star Ratings system
- The methodology for the Part C & D Star Ratings program was codified in contract year (CY) 2019 Medicare Part C and D Final Rule

- CMS must propose through rulemaking any changes to the methodology for calculating the Star Ratings, the addition of new measures, the removal of a measure within the Star Ratings, and substantive measure changes per §423.184 and §422.164
- Non-substantive measure specification changes for the Star Ratings will be announced through the advance notice process per §423.184(d)(1) and §422.164(d)(1)
- The Star Ratings Program is consistent with CMS's Quality Strategy of optimizing health outcomes by improving quality and transforming the health care system. The CMS Quality Strategy goals reflect the six priorities set out in the National Quality Strategy:
  - Safety, person and caregiver-centered experience and outcomes, care coordination, clinical care, population/community health, efficiency and cost reduction
  - CMS highlights contracts receiving an overall rating of 5 stars with the High Performing Icon (HPI) on the MPF:
    - Beneficiaries may enroll in a 5-Star PDP, MA-PD, or MA-only plan through a Special Election Period (SEP). 5-Star Plans may market year-round
- Beneficiaries may not enroll online via the MPF in a Low Performing Icon (LPI) plan. Beneficiaries must contact the plan directly
  - The LPI Icon is displayed for contracts rated less than 3 stars for at least the last 3 years in a row for their Part C or D summary rating
  - Beneficiaries in LPI plans are eligible for a Special Enrollment Period (SEP) to move to a higher quality plan
- Per the Affordable Care Act, CMS makes Quality Bonus Payments (QBPs) to MA organizations that meet quality standards measured using a five-star quality rating
- The QBP percentage for each Star Rating for 2020 payments:

Star Rating	QBP Percentage
3.5 stars or below	0%
4 stars or more	**5%**

- The MA rebate level for plans is tied to the contract's Star Rating

High Priority Areas for Future Measure Consideration for Part C:

- **Promote Effective Support of Behavioral Health**
  - One primary goal is to focus attention on treating substance use disorders (SUD)
  - Initiation and Engagement of Substance Use Disorder Treatment (IET)
    - At the contract-level, the Initiation of SUD Treatment rate assesses the percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
    - At the contract-level, the Engagement of SUD Treatment rate assesses the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of the SUD treatment initiation visit.
  - This measure most recently underwent the National Quality Forum (NQF) Endorsement and Maintenance Cycle in Fall 2018 and will undergo full review with Partnership for Quality Measurement (PQM) in 2025. Additionally, this measure underwent a rigorous review process during the measure's recent re-evaluation for measurement year 2022, in which the updated measure specification was tested across different product lines and vetted by numerous clinical expert and stakeholder panels.
  - This measure supports CMS's efforts to implement the Universal Foundation of quality measures.

High Priority Areas for Future Measure Consideration for Part D:

- **Management of Chronic Conditions**: The Medicare population includes many individuals and older adults with high-risk multiple chronic conditions who often receive care from multiple providers and settings which can subsequently lead to fragmented care and adverse healthcare outcomes. Using evidence-based clinical practice guidelines, high priorities for the program include:
  - Improving the coordination of care for Medicare beneficiaries
  - Improving medication management for Medicare beneficiaries
- **Equity of Care**: to incentivize Part C and D contracts to perform well for socially at-risk enrollees
- **Functional Outcomes**
- **Prevention and Treatment of Opioid Use Disorders**
- **Promote Effective Communication of Coordination of Care**

- A primary goal is to coordinate care for beneficiaries in the effort to provide quality care.

- **Promote Effective Prevention and Treatment of Chronic Disease**
  - Another primary goal is to focus attention on preventing and treating chronic disease.

Program-Specific Measure Requirements:

In addition to rulemaking, the following guiding principles are used in making enhancements and updates to the Part C and D Star Ratings program:

1. Ratings align with the current CMS Quality Strategy
2. Measures developed by consensus-based organizations are used as much as possible
3. Ratings are a true reflection of plan quality and enrollee experience; the methodology minimizes risk of misclassification
4. Ratings are stable over time
5. Ratings treat contracts fairly and equally
6. Measures are selected to reflect the prevalence of conditions and the importance of health outcomes in the Medicare population
7. Data are complete, accurate, and reliable
8. Improvement on measures is under the control of the health or drug plan
9. Utility of ratings is considered for a wide range of purposes and goals
   a. Accountability to the public
   b. Enrollment choice for beneficiaries
   c. Driving quality improvement for plans and providers
10. Ratings minimize unintended consequences
11. Process of developing methodology is transparent and allows for multi-stakeholder input
12. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

Program History and Structure:

- Section 1866(k) of the Social Security Act established a quality reporting program for hospitals described in section 1886(d)(1)(B)(v), referred to as a "PPS-Exempt Cancer Hospitals," or PCHs
    - These hospitals are excluded from payment under the inpatient prospective payment system (IPPS)
- PCHQR is a voluntary quality reporting program, in which data will be publicly reported on the Provider Data Catalog website (PDC)
    - If a PCH participates in the program, the facility is required to submit data for selected quality measures to CMS
    - There are no payment implications for PCHs related to the PCHQR program

High Priority Areas for Future Measure Consideration:

- **PRO-PM**
- **Care Coordination**
- **Behavioral Health**

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure is responsive to specific program goals and statutory requirements
2. Measure specifications must be publicly available
3. Measure steward will provide CMS with technical assistance and clarification on the measure as needed
4. Promote alignment with specific program attributes
5. Potential use of the measure in a program does not result in negative unintended consequences
6. Measures are preferred to be fully developed and tested, preferably in the PCH environment
7. Measures must be feasible to implement across PCHs

8. CMS has the resources to operationalize and maintain the measure
9. If feasible, measure should be digital, such as an eCQM

Rural Emergency Hospital Quality Reporting Program

Program History and Structure:

- A new quality reporting program for Rural Emergency Hospitals (REHs), a new Medicare provider type, is being implemented by the Centers for Medicare and Medicaid Services (CMS)
- The REH Quality Reporting Program seeks to gather and publicly report information on care provided by these hospitals so that such information is available to inform patient choice for choosing where to obtain care; as well as, toward improving quality and efficiency of care
- Quality measure information collected through the REHQR Program will be publicly reported
- Initial program implementation was initiated through rulemaking in the CY 2023 and CY 2024 Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Payment System Final Rules

What hospitals can become an REH:

Section 1861 (kkk)(7) of the Social Security Act, as added by Division CC, section 125, of the Consolidated Appropriations Act (CAA) of 2021, defines an REH as a facility that, as of December 27, 2020, was:

1. a critical access hospital (CAH); or
2. a subsection (d) hospital with not more than 50 beds that was treated as being in a rural area pursuant to Section 1886(d)(8)(E) of the Social Security Act.

For CY 2023, CAHs and subsection (d) hospitals eligible to convert to an REH may do so beginning January 3, 2023. Once converted, the REH may receive the adjusted payment fee schedule.

CMS is required to set up REH quality data requirements; REHs are required to submit such data:

- Under Section 1861(kkk)(7) of the Act, as added by section 125 of Division CC of the CAA of 2021, the Secretary is required to establish quality measurement reporting requirements for REHs, which may include the use of a small number of claims-based measures or patient experience surveys. An REH must submit quality measure data to the Secretary, and the Secretary shall establish procedures to make the data available to the public on a CMS website
- Per the initial set up requirements, a data submission account with the Hospital Quality Reporting Secure Portal and a Security Official to oversee that account are required. If an account already exists for the hospital, this existing account may be used; however, the account will need to be updated with any new REH Medicare identifier. Requirements for quality measure specifications and quality reporting will be available in the near future through rule making. Note that there is no statutory language regarding payment and REH quality reporting

High Priority Measures Areas for Future Consideration

High priority measure areas for quality measures appropriate to the REH setting for future consideration are:

1. Outpatient procedures including diagnostic procedures
2. Patient Safety
3. Telehealth
4. Maternal Health
5. Behavioral Health
6. Emergency Department Services
7. Equity

Program-Specific Measures Requirements

1. The number of hospitals that convert to an REH and their characteristics may inform the selection of quality measures as measures that are useable by REHs and that have sufficient numbers of REHs with sufficient volume of services to have meaningful measurement for individual facilities and, importantly, the public, are sought
2. It is essential that a concise set of important, impactful, reliable, accurate, and clinically relevant measures for REHs that would inform consumer decision-making regarding care and further quality improvement efforts in the REH setting
3. If feasible, measures would be digital, such as an eCQM

4. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Skilled Nursing Facility Quality Reporting Program

Program History and Structure:

- The Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) was established in the Fiscal Year (FY) 2016 SNF Prospective Payment System (PPS) Final Rule, as authorized by the Improving Medicare Post-Acute Care Transformation Act of 2014
- The SNF QRP is a pay for reporting program. SNFs must submit standardized patient assessment data with regard to quality measures and standardized patient assessment data elements
- Any SNF who does not meet reporting requirements may be subject to a two-percentage point reduction in their Annual Payment Update

High Priority Areas for Future Measure Consideration:

- **Health Equity**: Develop and adopt measures which focus on health equity
- **Universal Foundation Measures:** Develop and adopt measures from the Universal Foundation measure set
- **Pain Measure:** Develop and adopt a measure focusing on improvement in patient pain
- **Patient Satisfaction Measure:** Develop and adopt a patient reported satisfaction measure

Program-Specific Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Skilled Nursing Facility Quality Reporting Program (SNF QRP). For the SNF QRP, The IMPACT Act requires the development and reporting of quality measures addressing 5 domains in addition to resource use, hospitalization, and discharge to the community. These domains and categories are listed below. At a minimum, the following requirements must be met for consideration in the program:

1. Quality Measure Domains:
    a. Skin integrity and changes in skin integrity
    b. Functional status, cognitive function, and changes in function and cognitive function
    c. Medication reconciliation
    d. Incidence of major falls

e. Transfer of health information and care preferences when an individual transitions.

2. Resource Use and Other Measure Domains:
   a. Resource use measures, including total estimated Medicare spending per beneficiary
   b. Discharge to community
   c. All-condition risk-adjusted potentially preventable hospital readmissions rates
3. Quality measures selected for the SNF QRP must be endorsed by the CBE unless they meet the statutory criteria for exception
4. Measure addresses an important condition/topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure when implemented can lead to the desired outcomes and/or more affordable care
5. Measure reporting is feasible to implement, and measures have preferably been fully developed and tested
6. Measure results and performance should identify opportunities for improvement
7. Potential use of the measure in a program does not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care)
8. Measures adopted in the SNF QRP are publicly reported on *Care Compare*
9. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Skilled Nursing Facility Value-Based Purchasing Program

Program History and Structure:

- The Protecting Access to Medicare Act (PAMA) of 2014 established the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program
- The SNF VBP Program rewards incentive payments to SNFs per the quality of care provided to Medicare beneficiaries
  - The SNF VBP Program currently measures quality of care with 8 quality measures, as mandated by statute
    - Beginning with the FY 2028 program year and FY 2025 performance year, we proposed the replacement of the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) with the Skilled Nursing Facility Within Stay

Potentially Preventable Readmissions (SNF WS PPR) measure as required by section 1888(h)(2)(B) of the Social Security Act.

- CMS withholds 2 percent of SNF Medicare FFS payments to fund the Program, and 60 percent of these withheld funds are redistributed to SNFs in the form of incentive payments
  - CMS is increasing the payback percentage policy under the SNF VBP program from the current 60% to a level such that the bonuses provided to the high-performing, high duals SNFs do not come at the expense of the other SNFs. The estimated payback percentage for the FY 2027 program year is 66%.
  - The SNF VBP Program began awarding incentive payments to SNFs on October 1, 2018

- To prioritize the achievement of health equity, improve care that all beneficiaries receive and reduce disparities in health outcomes in SNFs, CMS is adopting a Health Equity Adjustment in the SNF VBP Program. This adjustment rewards SNFs that perform well and whose resident population during the applicable performance period include at least 20% of residents with dual eligibility status. This adjustment will begin with the FY 2027 program year. CMS is adjusting the scoring methodology to provide bonus points to high-performing facilities that provide care to a higher proportion of duals. This approach of rewarding excellent care for underserved populations is consistent with other approaches in other quality and value-based programs, including the Medicare Shared Savings Program, Medicare Advantage and Part D Star Ratings, and the policy changes in the Hospital VBP program.

- CMS is adopting an audit portion of the validation process for MDS-based measures beginning with the FY 2027 program year.

High Priorities for Future Measure Consideration:

- **Health Equity**: Develop and adopt measures which focus on health equity
- **Composite Staffing Measure:** Develop and adopt a composite staffing measure which combines the 2 current staffing measures in the program
- **Patient Satisfaction Measure:** Develop and adopt a patient reported satisfaction measure

Program-Specific Measure Requirements:

1. Consolidated Appropriations Act, 2021, authorizes the Secretary to, with respect to payments for services furnished on or after October 1, 2023, apply up to 10 additional measures determined appropriate by the Secretary, which may include measures of:

    a. Functional Status
    b. Patient Safety
    c. Care Coordination
    d. Patient Experience

2. In addition to the above measurement areas, and the aim to minimize burden, CMS may consider measures where SNFs and nursing homes are largely familiar with through the SNF Quality Reporting Program, Five-Star Quality Rating System, and/or the Nursing Home Quality Initiative
3. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

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