Update: Medicare Quality Measurement and Reporting Programs

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Background

A February 2011 Implementation Brief titled “Medicare Quality Measurement and Reporting Programs” addressed Congress’ continuing efforts through the Affordable Care Act (ACA) to transition the Medicare program from a traditional volume-based fee for service purchaser of health care items and services to a value-based purchaser. The ACA took significant steps to move beyond financial and other incentives for quality measure development, measurement, and reporting to financial and other incentives for actual improvements in care delivery (e.g., value-based purchasing). Since the initial 2011 brief, the Centers for Medicare and Medicaid Services (CMS) has made significant progress in implementing Congress’ vision. That progress is described below.

Summary of Changes Made by the ACA (Pub. L. 111-148 §§ 3001-02, 3004-07, 3013-14, 10301, 10303-304, 10322, 10331, as modified by P.L. 111-152)

Quality Measure Development

- Quality Measure Development:1 Section 3013 requires the Secretary of HHS to identify gaps in existing quality measures and fund the development of quality measures to fill these gaps.
- Development of Outcome Measures:2 Section 10303 requires the Secretary to develop and update provider-level outcome measures for hospitals and physicians, as well as other providers as appropriate.
- Quality Measure Selection:3 The entity selected by the Secretary to develop quality measures (currently the National Quality Forum [NQF] as authorized under the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA)) must convene a multi-stakeholder groups to provide input on the selection of quality measures and national priorities through an open and transparent process (currently the “Measures Applications Partnership”). Section 10304 adds the development of efficiency measures to the process. Selected measures will be used for existing and new Medicare (as well as Medicaid and CHIP) quality reporting and payment programs described below.

Quality Measurement

- Improvements to Physician Quality Reporting System:4 Section 3002 re-authorizes incentive payments under the Physician Quality Reporting Program through 2014 (maximum one percent

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1 Patient Protection and Affordable Care Act (Pub. L. 111-148) §3013 (2010).
2 PPACA § 10303.
3 PPACA §§ 3014, 10304.
4 PPACA § 3002.

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of estimated allowed charges) and institutes a penalty for failure to report beginning in 2015 (maximum two percent).

- Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs: The ACA establishes new quality measurement and reporting programs for these providers. Once operational, if a facility does not report selected quality measures, the facility’s annual update will be reduced by two percentage points.
- Quality Reporting for PPS-Exempt Cancer Hospitals: The ACA establishes a new quality measurement and reporting program for cancer hospitals that are exempt from the PPS. Once operational, if a cancer hospital does not report selected quality measures, the hospital’s annual Medicare market basket update will be reduced.
- Value-based Purchasing Programs: The ACA requires the implementation of value-based purchasing programs for hospitals (other than psychiatric hospitals, rehabilitation hospitals, children’s hospitals, long-term care hospitals, and certain cancer treatment and research facilities) and for physicians (through the use of a payment modifier). In addition, ACA requires the Secretary to develop plans to implement value-based purchasing programs for ambulatory surgery centers, skilled nursing facilities, and home health services.

Public Reporting

- Public Reporting of Performance Information and Public Reporting of Quality Information for Other Providers: The ACA requires CMS to establish a “Physician Compare” website that will publicly report information on physicians and other eligible professionals who participate in the Physician Quality Reporting Program. CMS, on behalf of the Secretary, must also publically report quality information obtained from the newly authorized quality reporting programs.

Implementation Updates

Physician Quality Reporting System (PQRS)

- Status: CMS proposes revisions to the PQRS in the Proposed 2013 Physician Fee Schedule (PFS) Rule.
- Reporting Mechanisms: CMS currently accepts quality data from individual eligible professionals via claims-based, registry-based, or Electronic Health Record (EHR)-based reporting while group

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5 PPACA §§ 3004, 10322.
6 PPACA §§ 3004, 10322.
7 PPACA § 3005.
8 PPACA §§ 3001, 3007, 3006, 10301.
9 PPACA §§ 3004, 3005, 10322.
10 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face to Face Encounters, Elimination of the Requirement for Termination of Non- Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013; Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Quality Improvement Organization Regulations; Proposed Rules, 77 Fed. Reg. 44722, 44774 (July 30, 2012).
practices must report through the Group Practice Reporting Option (GPRO) web-interface. CMS proposes to allow group practices comprised of 2-99 physicians to utilize the methods available to individual physicians during future reporting periods.

- Reporting Requirements: CMS proposes to allow group practices comprised of 2-99 physicians to utilize the methods available to individual physicians during future reporting periods. For example, CMS proposes to require individual eligible professionals reporting quality measures via the registry mechanism to “report at least 3 measures AND report each measure for at least 80 percent of [their] Medicare Part B FFS patients seen [between January 1, 2014 and December 31, 2014]” in order to qualify for the 2014 incentive.

- Quality Measures: CMS proposes numerous NQF endorsed and MAP recommended measures for use during the 2013 reporting year and beyond. CMS has classified these proposed measures into six domains using the priorities established in the National Quality Strategy (Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Healthcare, and Clinical Processes/Effectiveness).

**Physician Value-Based Payment Modifier**

- Status: CMS issued proposed rules for a value-based payment modifier that will affect physician payments beginning in 2015. CMS believes that implementation of the value-based payment modifier should focus on: (1) “measurement and alignment;” (2) “physician choice;” (3) “shared accountability;” (4) “actionable information;” and (5) “gradual implementation.”

- Application: CMS proposes to apply the value-based modifier to all “physician groups” with at least 25 “eligible professionals.” CMS proposes to divide qualifying physician groups into two categories: (1) groups that submit PQRS quality measures during 2013 and 2014; and (2) groups that do not submit PQRS quality measures during 2013 and 2014. Groups that submit PQRS data will receive a default payment modifier of 0.0 percent unless, with the exception of groups participating in an ACO under the MSSP, they opt for CMS to apply a payment modifier calculated using a proposed quality tiering approach and their data submitted during 2013. Groups that opt into the payment modification risk a downward payment adjustment. Groups that fail to satisfactorily report PQRS quality measures during 2013 and 2014 will receive a payment modifier of -1.0 percent. CMS proposes to apply the value-based payment modification to all physicians and physician groups beginning in 2017. CMS seeks comment on whether to assess hospital-based physicians on the performance of their hospital.

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12 77 Fed. Reg. at 44818.
15 77 Fed. Reg. at 44997.
• Performance Period: CMS will use data reported during 2013 to calculate the 2015 payment modifier and data reported in 2014 to calculate the 2016 payment modifier.
• Payment Modifier: CMS proposes to derive the payment modifier from physicians’ performance on both a quality of care composite and a cost composite. The quality of care composite will contain quality measures divided into domains based on the six National Quality Strategy Principles (clinical care, patient experience, population/community health, patient safety, care coordination, and efficiency) while the cost composite will consist of the “total overall costs” and “total costs for beneficiaries with specific conditions.”

**PPS-Exempt Cancer Hospital Quality Reporting Program**

• Status: CMS finalized rules for this program in the 2013 Inpatient Prospective Payment System Rule (IPPS).
• Measures: CMS must select measures endorsed by the NQF unless an appropriate NQF-endorsed measure is unavailable. CMS finalized the use of three cancer process of care measures, one bloodstream infection measure, and one urinary tract infection measure for the initial stages of the program.
• Reporting Requirements: CMS will collect data through the QualityNet website and CDC/NHSN. PPS-Exempt Cancer Hospitals must, among other actions, register for QualityNet, appoint a QualityNet administrator, and submit a Data Accuracy and Completeness Attestation (DACA) following data submission.
• Public Reporting: CMS will publically report the quality performance of PPS-Exempt Cancer Hospitals on the Hospital Compare website.

**Long-Term Care Hospital Quality Reporting Program**

• Status: CMS implemented the LTCH Quality Reporting Program in the 2012 IPPS and has finalized the following revisions in the final 2013 IPPS.
• Quality Measures Retention: Once adopted, CMS will retain all measures unless they otherwise propose to remove, replace, or suspend an adopted measure.
• Retained Measures for 2014: CMS will retain the following measures that have undergone NQF revision: (1) National Health and Safety Network (NHSN) Catheter Associated Urinary Tract

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16 Id.
17 77 Fed. Reg. at 45007.
18 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals’ Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers, 77 Fed. Reg. 53258, 53555 (Aug. 31, 2012).
20 77 Fed. Reg. at 53563.
22 77 Fed. Reg. at 53614.
24 77 Fed. Reg. at 53623.
Infection (CAUTI) Outcome Measure (NQF #0138); (2) NHSN Central Line Associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139); and (3) Percent of Residents with Pressure Ulcers That are New or Worsened (Short-Stay) (NQF #0678).

- New Measures for 2016 and Beyond: CMS has adopted the following measures for 2016 and beyond: (1) Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680); (2) Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay) (NQF #0682); (3) Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431); and (4) Ventilator Bundle (NQF #0302). CMS did not finalize their proposed adoption of a Restraint Rate per 1,000 Patient Days measure after receiving comments that cast doubt on its appropriateness for use in LTCH Quality Reporting Program. CMS intends to propose an appropriate patient restraint measure in the future.

- Data Submission Timelines: LTCHs must submit quarterly data on discharges occurring between January 1, 2013 and December 31, 2013 and January 1, 2014 and December 31, 2014 in order to meet, respectively, the 2015 payment determination and 2016 payment determination requirements.

Hospice Quality Reporting Program

- Status: CMS finalized initial requirements for the Hospice Quality Reporting Program in the Hospice Wage Index Year 2012 Final Rule and proposes additional requirements in the proposed 2013 Home Health Prospective Payment System (PPS) Rule.

- Quality Measures and Data Submission Requirements: Hospices must submit the following measures for 2014: (1) NQF measure “#0209: The percentage of patients who report being uncomfortable because of pain on the initial assessment (after admission to hospice services) who report pain was brought to a comfortable;” and (2) “Participation in a Quality Assessment and Performance Improvement (QAPI) program that includes at least three quality indicators related to patient care.” Hospices must collect data for these measures between October 1, 2012 and December 31, 2012 and submit the NQF measure by April 1, 2013 and the QAPI measure by January 31, 2013. CMS notes that hospices’ performance on these measures is immaterial to satisfying the Hospice QRP requirements. Hospices must report their data through a CMS provided Internet tool. CMS proposes to use these measures for 2015 and beyond.

- Data Availability: CMS plans to publically report quality data, as required by the ACA, once they finish developing standardized and uniform data sets. Details regarding such reporting will appear in future notices of rulemaking.

Inpatient Psychiatric Facilities (IPF) Quality Reporting Program

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26 Id.
28 77 Fed. Reg. at 41573-75.
29 77 Fed. Reg. at 41573.
• Status: CMS finalized rules for the IPF Quality Reporting Program in the 2013 IPPS.
• Quality Measures: CMS finalized the use of six NQF-endorsed measures for use in the program beginning in 2014. These measures include two care coordination measures: “Post-Discharge Continuing Care Plan Created” and “Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge.”
• Reporting Procedures: CMS finalized its plan to collect data through the QualityNet website. IPFs must, among other actions, register for QualityNet, appoint a QualityNet administrator, and submit a Data Accuracy and Completeness Attestation (DACA) following data submission.

Key Issues

- Administrative Burden: Many of the providers participating in the Medicare Meaningful Use EHR Incentive Program must also submit quality data pursuant to one of the quality reporting programs described above in order to avoid a payment reduction. Reporting to multiple programs has the potential to increase providers’ administrative burden. CMS must continue to identify opportunities to align the quality reporting programs with the EHR Meaningful Use Incentive Program’s Requirements.
- Measure Maintenance: CMS will subject quality reporting measures to formal rulemaking if the NQF makes substantive changes to the measures during the maintenance process. However, CMS will simply update the applicable specifications manual if the NQF maintenance process results in non-substantive changes to the measures. CMS provides examples of substantive and non-substantive changes, but does not clearly define either term. The lack of a clear standard could lead to future confusion related to measure revisions.
- Disparate Impact: The quality reporting programs may have a disparate impact on smaller, rural, and/or community health providers as these providers may not have the resources and infrastructure necessary to satisfy CMS’s quality reporting criteria and thus cannot participate in the quality reporting programs. This is particularly concerning as the quality reporting programs begin to transition from providing incentives to participants to adjusting the payment of nonparticipants. The physician payment-modifier, though risk-adjusted, may also have a disparate impact on physicians that serve high-risk populations as their population base may lead to payment adjustments that do not accurately reflect the quality of care.
- Impact: As the volume of quality measurement information continues to grow from a broader scope of providers, CMS will need to remain vigilant that the information is publicly reported in a manner that in meaningful and actionable for consumers and other stakeholders and that fosters greater care coordination.

30 77 Fed. Reg. at 53644.
31 77 Fed. Reg. at 53652.
33 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals’ Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers, 77 Fed. Reg. 27870,28092 (May 11, 2012).

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