APPENDIX

FEDERAL QUALITY REPORTING PROGRAMS

The Centers for Medicare and Medicaid Services administers many federal quality pay-for-reporting and pay-for-performance programs, which (as of January 2016) include:

- Hospital Inpatient Quality Reporting Program;
- Hospital Value-Based Purchasing Program;
- Hospital Readmission Reduction Program;
- Hospital-Acquired Condition Reduction Program;
- Hospital Outpatient Quality Reporting Program;
- Ambulatory Surgery Center Quality Reporting Program;
- Long-Term Care Hospital Quality Reporting Program;
- Inpatient Psychiatric Facility Quality Reporting Program;
- Inpatient Rehabilitation Facility Quality Reporting Program;
- End-Stage Renal Disease Facility Quality Reporting Program;
- PPS-Exempt Cancer Hospital Quality Reporting Program;
- Home Health Quality Reporting Program; and
- Physician Quality Reporting Program.

In addition, CMS is expected to soon finalize a quality reporting program for skilled nursing facilities.

FEDERAL RULEMAKING PROCESS

Changes to the federal quality pay-for-reporting and pay-for-performance programs are made through the annual federal rulemaking process, which includes the following steps:

1. **PUBLICATION OF PROPOSED RULE:** A Notice of Proposed Rule Making (NPRM) is published in the *Federal Register* at www.federalregister.gov. The proposed rule often contains specific program proposals, as well as future topics and issues for consideration for which CMS is seeking comments.
2. **COMMENT PERIOD:** Each NPRM is followed by a period set aside for public comment. Comments are accepted via email and by postal mail for 60 days following publication. The purpose of the comment period is to provide an opportunity for the public and interested and affected parties to influence the outcome by raising issues and questions that can be addressed before the regulation is finalized.

3. **PUBLIC INSPECTION OF COMMENTS:** Comments received are made available for public inspection. Traditionally, comments submitted by mail are available for public viewing in a room at U.S. Department of Health and Human Services (HHS) headquarters in Washington, D.C. Comments will be available for public viewing on the CMS website after the comment period has ended.
4. **ANALYSIS OF COMMENTS:** Comments are analyzed and summarized by CMS, and responses are prepared by the implementation teams responsible for the content.
5. **PUBLICATION OF FINAL RULE:** The final rule is published in the *Federal Register*. It includes a summary of the comments and responses to the comments, including any changes that were made to the proposed regulation as a result of the comments.

MEASURES

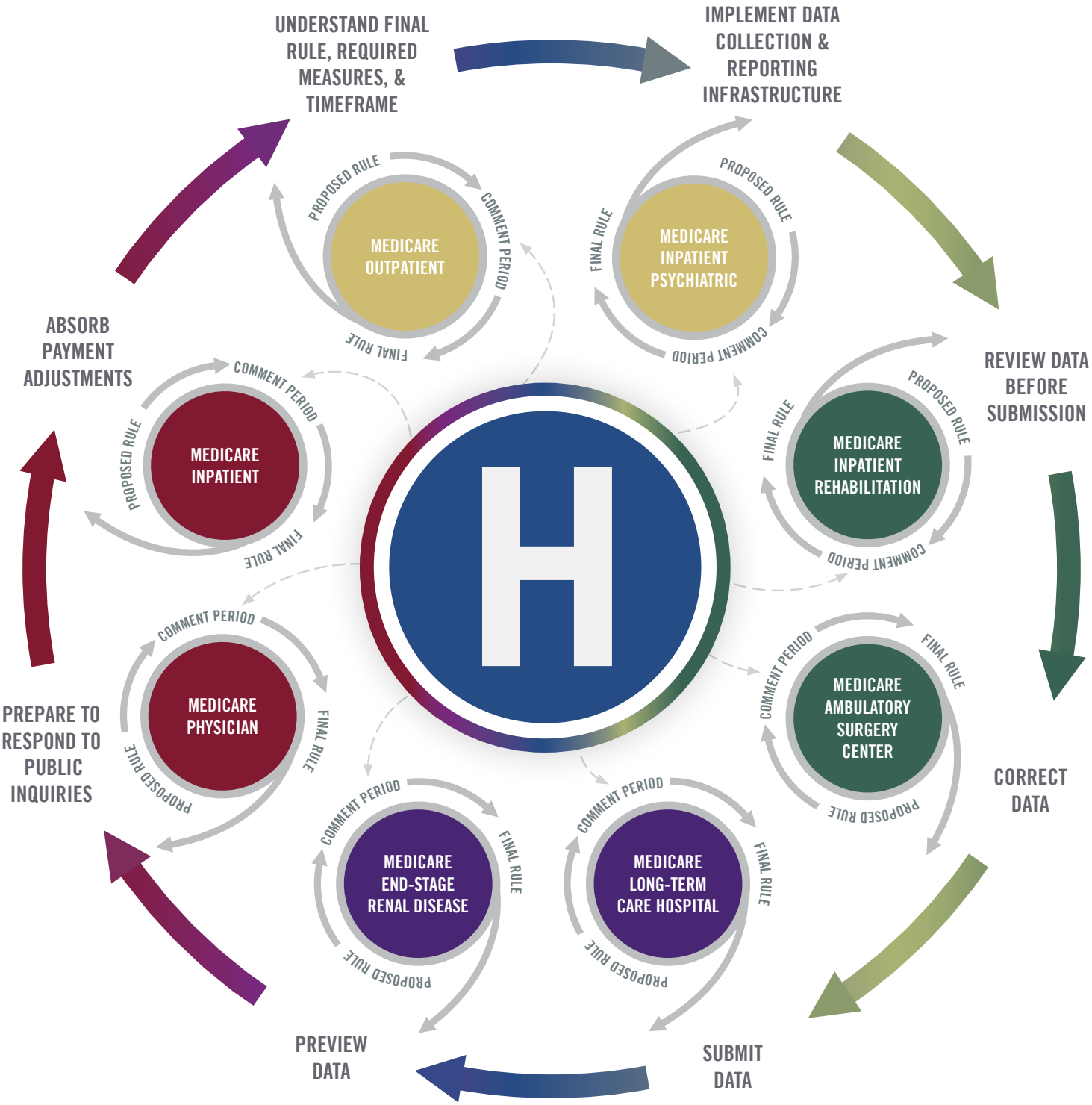
Each of the federal programs has a distinct set of measures outlined in each program's specification manual; however, in an effort to achieve program alignment, some measures cross programs. This trend will increase in the coming years with the adoption of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act). The Act requires the submission of standardized data by long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs).

While HANYS supports alignment of measures across settings, we have serious concerns that providers could be subject to multiple payment penalties for their performance on a single measure. For example, hospitals are subject to payment penalties for hospital-acquired conditions (HACs) in both the HAC Reduction Program and the Hospital Value-Based Purchasing Program.

REPORTING

Each of the programs requires a specific process for reporting quality data, which can also vary by each individual measure with the quality reporting program. For some measures, the data are automatically conveyed to CMS via Medicare claims. In other programs, providers must submit data through MyQualityNet.org or another specific data portal. Still other measures require submission of chart abstracted data through the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). The table beginning on page 31 summarizes the various mechanisms for federal quality data reporting.

QUALITY REPORTING MADNESS



PROGRAM	NUMBER OF REQUIRED MEASURES	DATA SUBMISSION MECHANISM(S)	REFERENCE MATERIAL
Hospital Inpatient Quality Reporting Program	44 plus 4 out of 28 electronic clinical quality measures (eCQMs)	• QualityNet Secure Portal • NHSN • Medicare Claims	www.qualitynet.org https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu.html http://www.qualityreportingcenter.com/inpatient/iqr/tools/
Hospital Outpatient Quality Reporting Program	25	• QualityNet Secure Portal • NHSN • Medicare Claims	www.qualitynet.org https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/hospitalOutpatientQualityReportingProgram.html
Ambulatory Surgery Center Quality Reporting Program	6	• QualityNet Secure Portal • NHSN • Medicare Claims	www.qualitynet.org https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting/
Long-Term Care Hospital Quality Reporting Program	12	• Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System • NHSN • Medicare Claims	www.qualitynet.org https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/
Inpatient Psychiatric Facilities Quality Reporting Program	13	• QualityNet Secure Portal • NHSN • Medicare Claims	www.qualitynet.org http://www.qualityreportingcenter.com/inpatient/ipf/tools/

Current as of January 2016

PROGRAM	NUMBER OF REQUIRED MEASURES	DATA SUBMISSION MECHANISM(S)	REFERENCE MATERIAL
Inpatient Rehabilitation Facility	7	• IRF Patient Assessment Instrument (IRF PAI) submitted via QIES ASAP system • NHSN • Medicare Claims	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/
End-Stage Renal Disease Facility Quality Incentive Program	16	• NHSN • Consolidated Renal Operations in a Web-Enabled Network (CROWNWeb) • Medicare Claims	www.qualitynet.org https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/esrdqip/index.html http://esrdny.ipro.org/
PPS Exempt Cancer Hospitals	22	• QualityNet Secure Portal • NHSN	www.qualitynet.org http://www.qualityreportingcenter.com/inpatient/pch/tools/

RECONSIDERATION PROCESS

CMS pay-for-reporting and pay-for-performance programs include a reconsideration process, during which providers can request that CMS reconsider whether the provider met the program requirements for a particular calendar year (CY). The request must identify the hospital's specific reason(s) for believing it has met the Annual Payment Update (APU) requirements and should receive the full payment update.

CMS will officially respond to the reconsideration request submitted by each facility. If a facility is dissatisfied with the result of reconsideration, the facility may file a claim under 42 Code of Federal Regulations (CFR) Part 405, Subpart R (a Provider Reimbursement Review Board appeal). Some programs—Inpatient Quality Reporting (IQR), Outpatient Quality Reporting (OQR), LTCH Quality Reporting Program (QRP), IPF QRP—allow an additional judicial review or appeal of the reconsideration determination, while other programs do not (Ambulatory Surgical Center Quality Reporting).

PREVIEW PERIODS

Data collected through the IQR program are displayed for public viewing on Hospital Compare at www.medicare.gov/hospitalcompare. Prior to the release of data on Hospital Compare, hospitals are given the opportunity to review data during a 30-day preview period via the QualityNet Secure Portal. During this time, hospitals have the opportunity to work with CMS to resolve errors in CMS calculations, but are not able to make changes to their data.

The End-Stage Renal Disease Quality Incentive Program also includes a preview period—a 30-day timeframe (normally occurring in late summer each year) during which a facility has the opportunity to review the preliminary performance scores calculated by CMS. During that time, a facility may submit one or more clarification questions and/or a single formal inquiry in the event that it believes an error in calculating its scores has been made. Only one formal inquiry will be permitted per facility, but that inquiry may include as many questions as necessary.

EXTRAORDINARY CIRCUMSTANCES WAIVER

In the event that a hospital is unable to submit data or access medical records due to an extraordinary circumstance, such as a natural disaster, the hospital may request an extension or waiver. Hospitals need to complete the Extraordinary Circumstances Extension or Waiver form and submit the form and any supporting documentation within 45 days of the date of the extraordinary circumstance.

Hospitals that are included under a blanket waiver by CMS (due to widespread natural disasters such as hurricanes, tornadoes, etc.) will not be required to submit the Extraordinary Circumstances Extension or Waiver form.