



NATIONAL
QUALITY FORUM

Measure Applications Partnership

MAP 2018 Considerations for Implementing Measures in Federal Programs: MIPS and MSSP

DRAFT REPORT FOR COMMENT

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Guidance on Cross-Cutting Issues

Summary

- **MAP recognized the need to incorporate cost measures into value based payment programs.**
- **Composite measures are well suited to capture the care provided for a condition and serve as a comprehensive view of performance.**
- **MAP reviewed and provided input on measure removal criteria. MAP emphasized the need for a balanced approach when selecting measures based on measure type, variation in performance, and measurement burden.**

The Measure Applications Partnership (MAP) provides multistakeholder, pre-rulemaking input to the Centers for Medicare & Medicaid Services (CMS) on measures under consideration for payment and reporting programs. This year, MAP reviewed measures under consideration for the following programs:

- **Merit-Based Incentive Payment System (MIPS)** – MIPS is one of two tracks in the Quality Payment Program (QPP) policy designed to reform Medicare Part B payments. Individual clinicians self-select quality measures to submit to CMS. A clinician who participates in an Advanced Alternate Payment Model (Advanced APM) is excluded from MIPS.
- **Medicare Shared Savings Program (MSSP)** – MSSP is a program designed to create incentives for healthcare providers to work together voluntarily to coordinate care and improve quality for their patient population. Eligible providers, hospitals, and suppliers may participate in the MSSP by creating or participating in an Accountable Care Organization (ACO). If ACOs meet program requirements and the ACO quality performance standard, they are eligible to share in savings, if earned.

MAP's pre-rulemaking recommendations for measures in these programs reflect the MAP Measure Selection Criteria (MSC) and how well the measures address the goals of the program. The MSC are designed to highlight characteristics of an ideal measure set. The MSC are intended to complement program-specific statutory and regulatory requirements. The MSC focus on selecting high-quality measures that optimally address the National Quality Strategy's (NQS) three aims, fill critical measure gaps, and increase alignment among programs. The selection criteria seek measures that are NQF-endorsed whenever possible; address a performance gap; diversify the mix of measures types; relate to person- and family-centered care and services; relate to disparities and cultural competency; and promote parsimony and alignment among public and private quality programs.

Overarching Themes

Cost Measurement

MAP recognized the importance of incorporating cost measures into value-based payment programs such as MIPS. CMS presented the development process for the cost measures under consideration to MAP. MAP members had the opportunity to review all aspects of the process, including the overall methodology, the technical details, and the methodology in which stakeholder input was incorporated. MAP members were encouraged to see episode level resource use measures, as they are more actionable for clinicians than total spending per capita approaches.

MAP acknowledged that cost measurement contains unique challenges that differ from traditional clinical quality measurement. While supporting the development of cost measures, MAP stressed the need to accurately capture the cost of care delivered. MAP noted that cost measures should appropriately risk adjust to ensure clinical and social risk factors are reviewed and included when appropriate. MAP cautioned the potential stinting of care and noted that appropriate risk adjustment could help safe guard against this practice.

MAP appreciated the use of claims data to mitigate the need for additional data collection. However, MAP cautioned that even with reduced data collection burden, CMS should consider the burden associated with reviewing the measure score results from these complex measures. MAP also noted that these measures need to be routinely re-evaluated and tested, especially during the early stages of implementation. MAP encouraged CMS seek NQF endorsement for these cost measures.

MAP noted several considerations when implementing these measures. MAP encouraged CMS to ensure that measures that evaluate a heterogeneous population, accurately represent the cost of each of those populations. MAP also noted that healthcare can be impacted by factors like cost of living and real estate prices and suggested CMS consider regional comparisons rather than comparison to a national average. Additionally, MAP suggested that CMS ensure that tertiary medical centers or other facilities that accept transfers of higher acuity patients are not unfairly penalized due to differences in the presenting condition severity.

Composite Measures

MAP members were encouraged to see additional composite measures under condition for use in the programs and noted that composite measures present a more comprehensive view of care provided for a condition; however, they also acknowledged that these measures may pose additional technical challenges during the measure development process. Specifically MAP noted that a composite measure for vaccinations, such as adult vaccinations, would be preferred over individual measures that address a particular vaccine administration. However, the MAP also recognized that a vaccine composite measure may be more difficult to develop and maintain due to changing clinical guidelines.

MAP was also encouraged to see on the MUC composite measures for particular conditions, such as diabetes care or vascular care. MAP noted that conditions such as these require multiple aspects of care to be managed in order to improve the underlying condition. In addition to the challenges noted above, MAP also acknowledged that composite measures could pose challenges at the clinician level if a

particular clinician or specialist does not have complete control over the care for that particular condition.

MAP also discussed the use of composites to capture multiple appropriate use measures. MAP noted that a composite measure that pairs the appropriate use of a test (i.e. only being used when it should) with the effective screening (i.e. using the test on everyone who should get it) would be a stronger measure than each component individually. MAP acknowledged that there may be technical challenges in measure development, such as the individual measures may have different target subpopulations. Additionally, the collection of data for such measure might not be feasible in all electronic health records (EHRs).

In summary, MAP is supportive of the direction and priority placed on composite measures to address important quality challenges. However, MAP notes that these measures have had several challenges, some of which are unique to the individual clinician level of analysis. MAP recommends continued measure development in this area while still supporting the individual components of a composite measure that might be more actionable.

Considerations for Specific Programs

Merit-Based Incentive Payment System (MIPS)

The Merit-Based Incentive Payment System (MIPS) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MIPS consolidates Medicare's existing incentive and quality reporting programs for clinicians into a single program. MIPS makes positive and negative payment adjustments for Eligible Clinicians (ECs) based on performance in four categories:

- Quality: replaces the current Physician Quality Reporting System (PQRS) program
- Cost: replaces the current Value-Based Payment Modifier (VBPM) program
- Advancing Care Information: replaces the Meaningful Use program
- Improvement Activities: new component

To meet the quality component of the program, individual ECs or ECs in groups choose six measures to report to CMS. One of these measures must be an outcome measure or other high- priority measure. Clinicians can also choose to report a specialty measure set.

In the 2017-2018 pre-rulemaking deliberations, MAP reviewed twenty-two measures for the MIPS program. MAP supported three measures. MAP supported MUC 17-194 Optimal Vascular Care, a composite measure that addressed multiple components of high quality vascular care. MAP recognized the importance of this measure given its clinical prevalence. MAP also acknowledged the utility of the individual subcomponents of the measure to drive quality improvement.

MAP also supported two NQF-endorsed patient-reported outcome-based performance measures: MUC 17-168 Average change in functional status following lumbar spine fusion surgery and MUC 17-169 Average change in functional status following total knee replacement surgery. MAP stressed the need for more patient-reported outcome-based performance measures.

MAP conditionally supported nineteen measures. Of these, eight cost measures were conditionally supported pending review for NQF endorsement. MAP recommended the NQF Cost and Efficiency Standing Committee review the measures to ensure appropriate clinical and social risk adjustment, exclusions, and attribution methodology. MAP noted the importance of cost measurement to improving value across the healthcare system but cautioned that measures should be appropriately specified to avoid potential unintended consequences.

MAP also reviewed and conditionally supported one measure of appropriate use, MUC17-173 Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture. This measure addresses the inappropriate use of DXA scans for patients, women age 50 – 64 years without risk factors for osteoporosis. MAP recognized the need for early detection of osteoporosis but reiterated the importance of appropriate use of this screening technique. MAP noted this measure could be complementary to the existing osteoporosis screening measure, QPP#039: Screening for Osteoporosis for Women Aged 65-85 Years of Age. MAP recognized the potential need for a balancing measure to prevent the potential underuse of DXA scans. While MAP acknowledged that ideally one measure would address both the appropriate and inappropriate use of DXA scans, MAP recognized the potential challenges to developing such a measure. MAP recommends that this measure be conditionally supported with the condition of NQF endorsement. MAP also recommended that the relevant NQF Standing Committee specifically consider the question of feasibility across EHRs.

MAP acknowledged the role of public health in addressing opioid use disorder and noted the gap of measures in this area; however, MUC17-139 Continuity of Pharmacotherapy for Opioid Use Disorder is specified and tested at the health plan and state level. MAP conditionally supported this measure with the condition that it is tested and endorsed at the clinician and clinician group level. MAP encourages the relevant Standing Committee to specifically evaluate the attribution method, reliability and validity of this measure at the individual clinician and practice level.

MAP deliberated on vascular care and diabetes care composite measures, as well as two corresponding individual subcomponents of the composite measures: A1c control and use of aspirin or anti-platelet medication. MAP agreed that the composite measures would address multiple components of high quality care and recognized the importance of the measures given the clinical prevalence of the measure focus. MAP was supportive of the composites measure but also acknowledged the utility of the individual subcomponents to drive quality improvement. MAP conditionally supported the measures with the condition that there are no competing measures in the program.

MAP acknowledged the importance of adult immunizations and the measure focus of MUC17-310 Zoster (Shingles) Vaccination. MAP discussed the new guidelines under development for the Zoster vaccination that could impact the amount of doses, the age of administration, and the specific vaccine that is used but also noted that guidelines are constantly evolving and measures should be routinely updated based on changing guidelines. MAP further emphasized the need for a composite adult vaccination measure, but acknowledged the challenges in developing such a measure. MAP acknowledged a number of comments that were made during the pre-comment period and during the in-person meeting about the cost and coverage of the Zoster vaccination and recommended that

coverage is considered when implementing this measure. MAP recommended that that this measure be conditionally supported pending NQF endorsement, with the most current clinical guidelines.

MAP also deliberated on MUC17-367 HIV Screening. MAP acknowledged the importance of HIV screening from a population health perspective but also questioned whether encouraging HIV screening through the MIPS program is the most effective strategy. MAP also expressed concern that the measure under consideration identified individuals who may have a HIV screening in the community. MAP conditionally supported this measure with the condition of NQF endorsement. MAP requested that the relevant Standing Committee review the patient cohort definition and how community screening is handled in the endorsement review of this measure. In addition, MAP briefly discussed stigma of HIV screening and a MAP Workgroup member expressed that stigma should not be a concern for this measure.

MAP conditionally supported three measures addressing improvement in function or symptom management pending NQF review and endorsement: MUC17-170 Average change in functional status following lumbar discectomy laminotomy surgery, MUC17-177 Average change in leg pain following lumbar spine fusion surgery, and MUC17-239 International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia. MAP was encouraged to see additional patient reported outcome measures.

Finally, MAP recommended one measure under consideration be refined and resubmitted: MUC17-345 Patient reported and clinical outcomes following ilio-femo venous stenting. MAP noted the importance of this composite measure that evaluates patient reported and clinical outcomes following ilio-femoral venous stenting. However, the MAP noted that the measure is early in development and has not been fully- tested at the clinician level and therefore recommended it for Refine and Resubmit. MAP encouraged the measure developer to demonstrate that the measure adequately accounts for patients who are lost to follow-up.

Medicare Shared Savings Program (MSSP)

MSSP was established by Section 3022 of the Affordable Care Act (ACA). Eligible providers, hospitals, and suppliers may participate in MSSP by creating or participating in an Accountable Care Organization (ACO). ACOs that meet the program requirements and quality standards are eligible for shared savings. There are three shared savings options: (1) one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year), (2) two- sided risk model (sharing of savings and losses for all three years), and (3) two-sided risk model (sharing of savings and losses for all three years) with prospective assignment.

MAP considered three measures for the Medicare Shared Savings Program (MSSP). MAP conditionally supported all three measures: MUC17-181 Optimal Diabetes Care, MUC17-215 Diabetes A1c Control (<8.0), and MUC17-234 Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication. MAP recognized the importance of these measures given the clinical prevalence of diabetes. MAP was supportive of the composite measure (MUC17-181) but also acknowledged the utility of the individual subcomponent (MUC17-215) of the measure to drive quality improvement.

MAP conditionally supported the measures with the condition that there are no competing measures in the program and that the measure is updated with the most current clinical guidelines.

Measure Removal Criteria

As part of the pre-rulemaking process, CMS reviewed the current criteria and considerations for measure removal that guide decision-making on which existing measures in federal programs to propose for removal. The presented criteria are meant to be broadly applicable across programs and settings, and are not intended to enumerate specific measures for removal. Criteria include:

- Emphasis on patient-centered high-priority quality measures meaningful to patients and providers
- Preference for outcome measures & measures with a significant performance gap
- Consideration for measures with limited burden to providers, and measures without unintended consequences
- Consideration for the operational needs of the program measure set, and internal alignment

MAP recommended other criteria for CMS to consider for removal of items in program measure sets including:

Burden

While MAP supported the reduction of measurement burden, members also expressed the need to balance the value of a measure with measurement burden. MAP noted that some of the most meaningful measures may have a high measurement burden. There may be unintended consequences if low burden measures are prioritized over meaningful measures with a higher burden.

Patient-Centered Measurement

MAP emphasized the importance of patient-centered measures throughout the discussion. MAP recommended that the patient voice remain a priority when removing or adding measures to the programs.

Preference for Outcome Measures

MAP discussed the need for a balance of measure types in programs. While outcomes are often preferred, process measures that are proximal to important outcomes with a solid evidence base should be considered. MAP also supported the use of composite measures that provide a comprehensive view of performance. Finally, MAP highlighted the need for a broad range of measures applicable to providers, their relevant specialties, and their patients.

Variation in Performance

MAP discussed the complexity of using variation in performance as a measure removal criteria. Some members noted that there are several measures essential to quality maintenance and safety that lack performance variation or may have less than optimal performance across providers. The removal of these measures could lead to negative unintended consequences. MAP also noted that it is important to understand why performance on a measure does not improve over time. Understanding why performance on a measure has not improved is an important input to determining whether a measure should be removed.

Appendix A: Program Summaries

The material in this appendix was drawn from the [CMS Program Specific Measure Priorities and Needs document](#), which was released in April 2017.

Merit-Based Incentive Payment System

PROGRAM HISTORY AND STRUCTURE:

The Merit-Based Incentive Payment System (MIPS) is established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repeals the Medicare sustainable growth rate (SGR) and improves Medicare payment for physician services. The MACRA consolidates the current programs of the Physician Quality Reporting System (PQRS), The Value-Based Modifier (VM), and the Electronic Health Records (EHR) Incentive Program into one program (MIPS) that streamlines and improves on the three distinct incentive programs. MIPS will apply to doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in the 2019 payment year. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in the 2021 payment year, provided there are viable performance metrics available. Positive and negative adjustments will be applied to items and services furnished beginning January 1, 2019 based on providers meeting a performance threshold for four performance categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology. Adjustments will be capped at 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and future years.

HIGH PRIORITY MEASURES FOR FUTURE CONSIDERATION:

CMS will not propose the implementation of measures that do not meet the MIPS criteria of performance and measure set gaps. MIPS has a priority focus on outcome measures and measures that are relevant for specialty providers. CMS identifies the following as high-priority for future measure consideration:

1. *Person and caregiver-centered Experience and Outcomes:* This means that 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.
 - a. CMS wants to specifically focus on patient reported outcome measures (PROMs). Person or family-reported experiences of being engaged as active members of the health care team and in collaborative partnerships with providers and provider organizations.
2. *Communication and Care Coordination:* This means that the measure must address the promotion of effective communication and coordination of care; and coordination of care and treatment with other providers.
3. *Efficiency/Cost Reduction:* This means that 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 change in efficiency and reward value over volume.
4. *Patient Safety:* This means that 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. This means that the structure, process or outcome described in “a” must occur as a part of or as a result of the delivery of care.

5. *Appropriate Use*: CMS wants to specifically focus on appropriate use measures. This means that the measure must address appropriate use of services, including measures of over use.

In addition, CMS identified outcome measures as high-priority for future measure consideration.

MEASURE REQUIREMENTS:

CMS applies criteria for measures that may be considered for potential inclusion in the MIPS. At a minimum, the following criteria and requirements must be met for selection in the MIPS:

CMS is statutorily required to select measures that reflect consensus among affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities. To the extent practicable, quality measures selected for inclusion on the final list will address at least one of the following quality domains: Communication and Care Coordination, Community/Population Health, Effective Clinical Care, Efficiency and Cost Reduction, Patient Safety, Person and Caregiver-Centered Experience and Outcomes. In addition, before including a new measure in MIPS, CMS is required to submit for publication in an applicable specialty-appropriate, peer-reviewed journal the measure and the method for developing the measure, including clinical and other data supporting the measure.

- Measures implemented in MIPS may be available for public reporting on Physician Compare.
- Preference will be given to electronically specified measures (eCQMs)
- eCQMs must meet EHR system infrastructure requirements, as defined by MIPS regulation.
 - The data collection mechanisms must be able to transmit and receive requirements as identified in MIPS regulation. For example, eCQMs being submitted as Quality Reporting Data Architecture (QRDA) III must meet QRDA – III standards as defined in the CMS QRDA Implementation Guide.
- Measures must be fully developed and tested.
 - Reliability and validity testing must be conducted for measures.
 - Feasibility testing must be conducted for eCQMs.
 - eCQMs must have MAT output.
 - Testing data must accompany submission. For example, if a measure is being reported as registry and eCQM, testing data for both versions must be submitted.
- Measures should not duplicate other measures currently in the MIPS. Duplicative measures are assessed to see which would be the better measure for the MIPS measure set.
- Measure performance and 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, e.g., measures that are “topped out.”
- Measures must be fully developed and ready for implementation at the time of submission.
- Section 101(c)(1) of the MACRA requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals prior to implementing in MIPS. The Peer-Review Journal template provided by CMS, must accompany each measures submission. Please see the template for additional information.

Medicare Shared Saving Program

PROGRAM HISTORY AND STRUCTURE:

Section 3022 of the Affordable Care Act (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Shared Savings Program that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery. The Medicare Shared Savings Program (Shared Savings Program) was designed to facilitate coordination and cooperation among 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 providers, hospitals, and suppliers may voluntarily participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). If ACOs meet program requirements and the ACO quality performance standard, they are eligible to share in savings, if earned. There are three shared savings options:

- 1) one- sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year),
- 2) two-sided risk model (sharing of savings and losses for all three years), and
- 3) two-sided risk model (sharing of savings and losses for all three years) with prospective assignment

MEASURE REQUIREMENTS:

Specific measure requirements include:

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 initiatives, such as the Quality Payment Program.
4. Measures that support improved individual and population health.
5. Measures that align with recommendations from the Core Quality Measures Collaborative.

Appendix B: MAP Clinician Workgroup Roster and NQF Staff

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