

MEASURE APPLICATIONS PARTNERSHIP

MAP 2017 Considerations for Implementing Measures in Federal Programs: MIPS and MSSP

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GUIDANCE ON CROSS-CUTTING ISSUES

Summary

- Higher value measures, including outcome measures, are needed in the MIPS and MSSP programs.
- Appropriate attribution is essential to ensuring clinician and provider buy-in to the MIPS and MSSP programs.
- MIPS needs to balance greater participation by eligible clinicians with reduction of measures that may add burden without offering potential for further improvement.

The Measure Applications Partnership (MAP) provides multistakeholder, pre-rulemaking input to the Centers for Medicare & Medicaid Services (CMS) on clinician-level measures for several 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

Move to High-Value Measures

MAP stressed the importance of developing and including high-priority measures in each of the programs. Measures used in the programs should clearly address the NQS aims and priorities, align with other initiatives, focus on patient outcomes, and be sensitive to the burden of reporting the measures. MAP recommended moving beyond the process measures that make up the majority of the current measures and emphasized a need for higher value measures. MAP has identified the following measure types as high-value:

- Outcome measures (e.g., mortality, adverse events, functional status, patient safety, complications, or intermediate outcomes)
- Patient-reported outcomes where the patients provide the data about the results of their treatment, level of function, and health status
- Measures addressing patient experience, care coordination, population health, quality of life, or impact on equity
- Appropriateness, overuse, efficiency, and cost-of-care measures
- Composite measures
- Process measures with a strong evidence-based link to patient outcomes

However, MAP acknowledged the potential challenges of moving to higher value measures. In particular, MAP members recognized the associated complexities of developing, testing, and properly attributing outcome measures at the clinician level.

MAP provided input on innovative measurement approaches that could lead to high-value measures for MSSP and MIPS. First, MAP recognized the need for better measures addressing population health. To address this

need, the Centers for Medicare and Medicaid Innovation (CMMI) shared a measure of smoking prevalence. CMMI discussed the concept of having a measure focus on geographically defined populations in order to promote multimodal, evidence-based smoking interventions in a way that a process measure cannot. MAP members acknowledged the importance of incorporating measures that can improve broad impact issues such as smoking. MAP recommended that CMMI continue to work on this measure and specifically address issues of attribution and performance goals. It was recommended that the measure be constructed as a 'delta measure,' which evaluates the change in rate rather than the absolute rate, as certain geographic regions are known to have a higher prevalence of smokers that could skew the interpretation of results from any interventions.

MAP has stressed the need to understand better a person's outcomes across an episode of care. The American College of Surgeons (ACS) introduced its concept of evaluating five phases of surgical care in a combined episode. ACS presented its plan to ultimately develop a composite, patient-centered measure that incorporates weighted process measures and outcome measures where appropriate. Small sample sizes present a challenge to some of the desired outcome measures that ACS evaluated. Additionally, the ACS expressed its desire to incorporate measures into MIPS that would also work in an APM model. MAP appreciated the novel approach to measurement and expressed hope that the measure(s) would come before MAP for consideration for the MIPS program next year after further testing and development.

MAP has repeatedly called for the development of more performance measures based on patient-reported outcomes. MAP believes that these measures could improve patient and family

engagement and drive improvements in the outcomes that matter most to patients. MAP acknowledged complexities with this type of measurement, such as the development of valid and reliable instruments to collect the data. MAP discussed the Patient-Reported Outcomes Measurement Information System (PROMIS®), developed by the National Institutes of Health (NIH). The presentation demonstrated the capabilities of the tool and discussed its use in clinical practice and research. MAP members expressed support for reliable and valid self-reported outcomes using computer-adapted technology and the crosswalk to existing survey tools. MAP concluded that PROMIS® has great potential. Members were pleased at the planned integration into both EPIC and Cerner electronic health records.

MAP also called for the development of additional appropriate use measures. MAP highlighted that the vast majority of measures evaluate a process without consideration of whether the process was, in fact, appropriate. MAP members noted that the programs contain few appropriate use measures and encouraged the inclusion of more of them. MAP members proposed that each specialty or cross-cutting area could potentially identify areas to measure appropriateness. Inclusion of existing recommendations for appropriate use of resources, such as the *Choosing Wisely* initiative, should be considered.

Overall, MAP stressed the need to include more high-value measures in the programs. MAP members requested that CMS and specialty societies work together to create a suite of high-impact measures that are relevant to the individual clinician and demonstrate the ability to improve quality.

MAP received public comments supporting its call for high-value measures. Commenters noted the need to align around measures that will drive improvements in healthcare while minimizing the reporting burden on clinicians. One public commenter cited a need for caution when

removing measures that have high performance and limited variation among providers. The commenter wrote that some of these measures may promote alignment and maintain high performance.

Attribution Considerations

Accurate attribution is a particular concern for clinician-level measurement. A team of clinicians and providers frequently influences the outcomes of a patient's care, but performance measures may assign accountability to only one individual. This can limit the accuracy and perceived fairness of outcome measures at the clinician level.

MAP emphasized that appropriate attribution is essential to ensuring clinician and provider buy-in to the MIPS and MSSP programs. MAP provided guidance on attribution for MIPS. First, MAP noted that an individual clinician should be able to influence the results of a measure. Secondly, the timing of care should be a consideration for the assessment of attribution, as sometimes outcomes of care cannot be fully assessed until years afterwards. MAP cited breast surgery as an example of an outcome that could take 10 to 20 years to fully assess the outcome. For the MSSP, MAP noted that an ACO has more control over outcomes than an individual clinician. However, MAP members stressed that the measures in MSSP must still be actionable for an ACO.

MAP noted the need to encourage shared accountability and improve cooperation and communication across the healthcare system but cautioned that a measure must attribute results to an entity that can influence the outcome.

Public commenters supported MAP's focus on attribution. Commenters noted that attribution is a particular challenge for the cost domain of MIPS and supported MAP's call for fair and accurate attribution methodologies.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

Merit-Based Incentive Payment System (MIPS)

The Merit-Based Incentive Payment System (MIPS) was established by H.R. 2 Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MIPS consolidates Medicare's existing incentive and quality reporting programs for clinicians. 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 2016-2017 pre-rulemaking deliberations, MAP reviewed 18 measures for the MIPS program. MAP supported two measures: Otitis Media with Effusion: Systemic Antimicrobials – Avoidance of Inappropriate Use (MUC 16-269) and Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey (S-CAHPS) (MUC16-291). MAP stressed the need for more measures addressing appropriate use and patient and family engagement. Commenters supported MAP's decision for MUC 16-269, citing that the incorporation of this measure would add value to the MIPS program by identifying and reducing the inappropriate, ineffective, and

potentially harmful use of systemic antimicrobials for otitis media with effusion. One public commenter did not agree with MAP's decision for MUC16-291. The commenter expressed concern with the use of patient experience and satisfaction for accountability purposes due to its perceived subjectivity.

MAP conditionally supported three patient-reported outcome-based performance measures pending NQF endorsement and testing that supports variation in performance at the individual clinician level. MAP noted that these measures address important outcomes of surgery and would provide valuable information for patients and consumers when selecting healthcare providers.

MAP conditionally supported four other measures addressing gaps in febrile neutropenia, management of HIV, prevention of post-operative vomiting in children, and safety concerns for patients with dementia. MAP noted the need for more information about how these measures would be implemented and perform in the MIPS program. To address these concerns, MAP recommended that measures be submitted for NQF review and endorsement and electronic clinical quality measures (eCQMs) be successfully tested. One of these measures, HIV Medical Visit Frequency (MUC16-073), was pulled by the Coordinating Committee for further review. The Coordinating Committee concluded that while this measure is not fully tested as an eCQM, it adds another measure to this important topic and supports alignment with the Core Measures Collaborative. MAP determined that it should be conditionally supported pending successful testing as an eCQM and completion of NQF endorsement review to ensure that the performance gap continues to exist.

MAP received public comments on its conditional support recommendations. Two public

commenters recommended that MAP fully support Febrile Neutropenia Risk Assessment Prior to Chemotherapy (MUC16-151) noting the emergent nature of febrile neutropenia and evidence that the measure can be feasibly implemented. Two commenters agreed with MAP's recommendation about Safety Concern Screening and Follow-Up for Patients with Dementia (MUC16-317). Two commenters also supported MAP's recommendation about Prevention of Post-Operative Vomiting (POV) - Combination Therapy (Pediatrics) (MUC16-317).

MAP recommended that eight measures under consideration be refined and resubmitted prior to rulemaking. MAP noted that these measures addressed promising concepts in population health, appropriate use, cancer care, cardiology, HIV care, and treatment of uterine fibroids. However, MAP stressed the need for testing to be completed prior to implementation in the MIPS program. MAP discussed some of these measures at length. These deliberations are outlined below.

MAP deliberated over Appropriate Use Criteria - Electrophysiology (MUC16-398) at length. MAP members noted support for the concept of this measure, and asked the measure developer to further specify the attributable population. Additionally, MAP commented on the need to ensure that new appropriate use measures align with practice guidelines. Commenters agreed with MAP's decision stating that there is insufficient information to evaluate whether the measure fully aligns with appropriate use criteria and questioned the feasibility and meaningfulness of the measure.

MAP had extensive discussion on measure Fixed-Dose Combination of Hydralazine and Isosorbide Dinitrate Therapy for Self-identified Black or African American Patients with Heart Failure and Left Ventricular Ejection Fraction (LVEF) <40% on ACEI or ARB and Beta-Blocker Therapy (MUC16-074). MAP noted that this measure could address both effective clinical care and potential disparities in heart failure as it would track use of a therapy that can reduce morbidity and mortality

in patients who self-identify as African American. This eMeasure has been approved for trial use. Ultimately, MAP recommended that the measure be resubmitted for consideration after review of testing results by the NQF Cardiovascular Standing Committee. While many commenters agreed with MAP's decision, several comments suggested that MAP reconsider the decision to recommend "refine and resubmit" for this measure and instead fully support it for inclusion, citing results that demonstrated the efficacy of the therapy and the opportunity to close the disparity gap and improve outcomes for African American heart failure patients. The Coordinating Committee agreed with the Clinician Workgroup's decision and did not pull the measure for reconsideration.

MAP also had an in-depth discussion on Adult Local Current Smoking Prevalence (MUC16-069). This measure is under consideration for both MIPS and MSSP. MAP members noted the need to engage clinicians in important public health initiatives such as smoking cessation but raised concerns about the actionability of this measure, as a clinician would be held accountable for the county-level smoking rate. MAP encouraged continued refinement of this measure, citing concerns around attribution and the accuracy of the underlying data. Commenters supported MAP's decision.

MAP also provided feedback on the measures previously finalized for MIPS. MAP noted a desire to include more high-value measures in the MIPS measure set. The group noted the need for more outcome measures as the set is predominantly process measures. However, MAP members recognized the challenges in using outcome measures at the individual clinician level, such as adequacy of sample size to ensure reliability. MAP called for continued partnership between CMS, NQF, and specialty societies to drive toward the continued adoption of outcome measures. MAP also recommended that CMS and other developers pursue ways to improve process measures when outcome measures are not possible, such as the

development of composites and use of process measures more closely tied to outcomes that are most important to patients. The group also noted a gap in measures of appropriate use and a need for more cross-cutting measures.

Although MAP did not recommend any specific measures for removal, MAP suggested that topped out measures be considered for removal from the program. However, MAP also recognized that a number of factors must be balanced in the MIPS measure set. First, MAP acknowledged the tension between removing topped out measures and the need to ensure that the measure set includes measures that allow all ECs to participate in the program.

Some MAP members also expressed concerns that performance could regress if measures are removed. Members noted that there are inadequate data to determine if the rates would slip if a topped out accountability measure was removed. MAP noted that clinicians choose which quality measures to report in MIPS. This raised the question of whether clinicians who are high performers can raise current rates of performance by selecting which measures to report. CMS responded that it considers measures for removal by using an internal process that evaluates the measures. However, MIPS is an exception to this rule and presents unique challenges. MAP suggested this measurement science issue for further investigation.

Public commenters shared both MAP's desire for higher value measures for MIPS and MAP's concern regarding when it is reasonable to remove measures from the program.

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 one measure for the Medicare Shared Savings Program (MSSP): Adult Local Current Smoking Prevalence (MUC16-69). This measure was also under consideration for MIPS. MAP recognized the importance of this measure, noting its potential to address a crucial public health concern and encourage collaboration between ACOs and their communities. While MAP noted that this measure might be more actionable for an ACO than for a clinician, the group still expressed concerns. MAP noted that the measure needs to be properly risk-adjusted. The group also raised concerns about how this measure could affect ACOs located in areas with higher smoking prevalence and whether these ACOs would be compared to ACOs in areas where smoking is less common. One strategy MAP suggested to mitigate these concerns was to measure change in the rates rather than comparing rates across the country.

Public comments were mixed on this measure. One commenter stressed the importance of smoking cessation as a public health priority. However, another commenter raised attribution concerns, noting that many factors can affect a patient's ability to quit smoking successfully and that this measure may not truly reflect the quality of care delivered by the measured entity.

MAP also reviewed the measures currently in the MSSP set. MAP noted that the measure set needed more outcome measures. The group pointed out a need for measures that can help ensure care coordination within the ACO with a focus on communication and timeliness of care. To help improve the care coordination domain, the group suggested adding measures of

avoidable emergency department use in addition to avoidable hospitalizations to provide a more complete picture of a patient's need for acute care. MAP emphasized the need for more measures of person and family engagement, especially measures addressing the creation of person-centered goals. MAP discussed the importance

of cross-cutting measures, rather than disease-specific measures, given the high number of clinical areas not addressed by the current MSSP measures. Finally, MAP emphasized that cost savings should not prevent patients from getting needed care and suggested the need to balance quality and appropriate use measures.

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 2016.

Medicare Shared Savings 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 (MSSP) 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 healthcare costs. Eligible providers, hospitals, and suppliers may 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.

Current Program Measure Information

The Affordable Care Act specifies appropriate measures of clinical processes and outcomes; patient, and, wherever practicable, caregiver

experience of care; and utilization (such as rates of hospital admission for ambulatory sensitive conditions) and that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
- Hospitals employing ACO professionals, and
- Other Medicare providers and suppliers as determined by the Secretary.

The Shared Savings Program quality reporting requirements are aligned with the Merit-Based Incentive Payment System (MIPS). Quality measure data for the MSSP is collected via claims and administrative data, CG-CAHPS, and the CMS web interface.

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 MIPS.
4. Measures that support improved individual and population health.
5. Measures that align with recommendations from the Core Quality Measures Collaborative.

Merit-Based Incentive Payment System (MIPS)

Program History and Structure

The Merit-Based Incentive Payment System (MIPS) is established by H.R. 2 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 2019. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2021, 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 Domains for Future Measure 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 domains as high-priority for future measure consideration:

1. Person and caregiver-centered experience and outcomes
 - a. CMS wants specifically to focus on patient-reported outcome measures (PROMs)
2. Communication and care coordination
 - a. Measures addressing coordination of care and treatment with other providers
3. Appropriate use and resource use
4. Patient safety

In addition, CMS identified the following measure types as high-priority for future measure consideration:

5. Outcome measures
6. Appropriate use of services measures
7. Patient experience measures
8. Care coordination measures

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: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. 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 the future MIPS regulation.
 - The data collection mechanisms must be able to transmit and receive requirements as identified in future MIPS regulation. For example, eCQMs must meet QRDA standards.
- Measures must be fully developed and tested.
 - Reliability and validity testing must be conducted for measures.
 - Feasibility testing must be conducted for eCQMs.
- 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, i.e., measures that are “topped out.”

APPENDIX B: MAP Clinician Workgroup Roster and NQF Staff

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