NATIONAL QUALITY FORUM

Considerations for Implementing Measures in Federal Programs: Guidance from Measure Applications Partnership

*TECHNICAL REPORT – **DRAFT FOR MAP CLINICIAN WORKGROUP REVIEW***

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Guidance on Cross-Cutting Issues

Summary

- **Progress to include more high-value measures in federal programs is slow. Incentives are needed to promote the development of meaningful and impactful measures, particularly those used for public reporting.**
- **Alignment of measures in programs is essential to reduce burden and improve participation in quality reporting, to avoid confusing audiences of public reports of performance and to synergize quality improvements across providers and settings of care.**
- **Participation in the clinician voluntary reporting programs is growing slowly. Incentives are changing to payment penalties for non-participation. The effect of cumulative incentives and/or penalties is unclear.**

BACKGROUND

Clinician quality reporting began in 2006 as the Physician Quality Reporting Initiative (PQRI) and became the Physician Quality Reporting System (PQRS) in 2007. PQRS is a voluntary reporting program for individual clinicians, practices and groups. The measures reported in PQRS will be publicly reported on CMS's web site Physician Compare beginning in 2014 with large groups and increasing to all professionals in 2016. The PQRS measures will be also used in the quality component of the Physician Value Based Payment Modifier beginning in 2015.

The other major quality reporting programs for clinicians are the Medicare and Medicaid EHR Incentive Programs, also known as "Meaningful Use". The EHR incentive programs encourage adoption and "meaningful use" of electronic health records. These voluntary quality reporting programs use payment incentives to encourage participation by "eligible professionals (EPs)", i.e., Medicare physicians, practitioners and therapists allowed by law to participate in the quality programs.

In the past three years MAP has provided multi-stakeholder, pre-rulemaking input to CMS on measures for both PQRS and the EHR Incentive programs. MAP has created measure selection criteria to identify characteristics that are associated with ideal measure sets used for public reporting and payment programs. MAP's measure selection criteria complement program-specific statutory and regulatory requirements. The measure selection criteria focus on selecting high-quality measures that optimally address the National Quality Strategy's three aims; fill critical measure gaps; and increase alignment among programs. Additionally, the selection criteria emphasize the use of NQF-endorsed measures whenever possible; inclusion of a mix of measures types, i.e., outcome, composite, efficiency, patient reported outcomes, etc.; enabling measurement of person- and family-centered care and services; consideration of healthcare disparities and cultural competency; and promotes parsimony and alignment among public and private quality programs.

Overarching Themes

Include more high-value measures in federal programs

The multi-stakeholder MAP Clinician Workgroup has identified "high-value" measures as more meaningful and useable for various stakeholders and more likely to drive improvements in quality. High-value measures include outcome measures; patient-reported outcomes (PROs); composite measures; intermediate outcome measures; process measures that are closely linked by empiric evidence to outcomes; cost and resource use measures; appropriate use measures; care coordination measures and patient safety measures. Additional measures of value to patients and consumers for public reporting include patient experience and population health. Similarly, the MAP Dual Eligible Beneficiaries Workgroup emphasized that new and improved measures are needed to evaluate goal-directed, person-centered care planning and implementation; shared decision-making; systems to coordinate acute care, long-term services and supports, and nonmedical community resources; beneficiary sense of control/autonomy/self-determination; psychosocial needs; community integration/inclusion and participation; and optimal functioning (e.g., improving when possible, maintaining, managing decline).

The MAP Clinician Workgroup is concerned that progress to the high-value measures is too slow, particularly now that public reporting of performance measure results for PQRS is imminent. In past years MAP has noticed that some condition/topic areas have more high-value measures and requested a "scorecard" to judge progress toward high-value measures. Table 1 presents a tally of the high-value measures by condition/topic area for the 2015 PQRS measures and the measures under consideration for the 2014-2015 pre-rulemaking MAP process. Some topic areas have significantly more high-value measures for PQRS 2015 including cardiac care, eye care, renal disease and surgery.

MAP Clinician Workgroup noted that clinicians that report on more high-value measures receive the same incentive payments even though they are reporting more challenging measures. Greater incentives for those that report on high-value measures might prompt faster development of high-value measures in other condition/topic areas.

To identify potential measures to be considered for included in PQRS CMS issues an "Open Call for Measures". CMS requests measures that are outcome-based rather than clinical process measures; measures that identify appropriate use of diagnostics and therapeutics; address the National Quality Strategy domains of care coordination, communication, patient experience, patient-reported outcomes; and measures that address efficiency, cost and resource use. Of the 96 measures under consideration for PQRS for 2014-2015, 27 are high-value measures including two composite measures, three patient-reported outcome measures and seven are appropriate use/efficiency measures.

Cost and resource use measures with quality measures provide an assessment of efficiency. Development of cost measures has lagged behind quality measures. Last year the MAP Clinician Workgroup considered a number of clinical episode based payment measures that were still in development. Six additional clinical episode based payment measures are included for consideration the current year. [update with CMS briefing on status of cost measures at the meeting]

TABLE 1. PROGRESS to HIGH-VALUE MEASURES

	PQRS 2015							Measures Under Consideration for PQRS						
Condition/topic area	Total measures	Outcomes	PROs	Composites	Intermediate outcomes	Patient Experience	Efficiency/ Appropriate Use	Total measures	Outcomes	PROs	Composites	Intermediate outcomes	Patient Experience	Efficiency/ Appropriate Use
Asthma	3		1					1			1			
CAHPS/ Patient Experience	2		2					0						
Cancer	23							0						
Cardiovascular conditions	15	3		1	1			2			1			
Care Coordination	3	1						4						
CKD/ESRD	9				4			2						
COPD	2							0						
Cognitive Impairment/Dementia	9							2						
Diabetes	11			1	2			1						
Emergency care	2							4						2
Ear, Nose, Throat/Head and Neck	7							0						
Eye care	12	7			1	1		1						
Geriatric care	2							0						
Gastrointestinal	6							2						
Genitourinary	1							11	3					
Hepatitis	7							1						
HIV/AIDS	7				1			0						
Hypertension	2	2						1				1		
Imaging	12						3	6	1					2
Interventional Radiology	0							3	2					
Medication Management	4							6						
Mental Health	10	1						2		1				
Multiple chronic conditions	1							0						
Musculoskeletal	22	5						3						
Neurologic conditions	8							17		1				
Oral Health	2	1						0						
Pain Management	1							0						

	PQRS 2015							Measures Under Consideration for PQRS						
Condition/topic area	Total measures	Outcomes	PROs	Composites	Intermediate outcomes	Patient Experience	Efficiency/ Appropriate Use	Total measures	Outcomes	PROs	Composites	Intermediate outcomes	Patient Experience	Efficiency/ Appropriate Use
Palliative care/End of Life	2		1					0						
Perinatal	5	1						2	2					
Population Health	20				2			10						2
Respiratory Infections	3							0						
Skin conditions	5							2	1					
Sleep Apnea	4							0						
Stroke/TIA	3							2	2					
Substance Use	1							0						
Perioperative and anesthesia	8	2						6	1					
Surgery - cardiac	7	5						0						
Surgery - colorectal	1	1						0						
Surgery - orthopedic	4							2		2				
Surgery - vascular	8	4			3			2	1					

Alignment across programs

Various legislative mandates have created multiple programs requiring clinicians and providers to report on quality and performance. Calls for alignment of the measures in federal programs recognize the benefits of reducing data collection and reporting burdens on clinicians and providers, avoiding confusion for audiences of the publicly reported information and promoting synergies among providers across settings.

The MAP Measure Selection Criteria and the critical program objectives for the clinician programs used to make recommendation on the measure under consideration emphasize the importance of alignment among the programs. The MAP Coordinating Committee continues to identify alignment of measures across federal programs, and across public and private programs as a cross-cutting priority. The Coordinating Committee encouraged the three workgroups to consider alignment of similar measures under consideration from different settings or levels of analysis.

Clinicians must coordinate the reporting for overlapping programs sometimes with different implementation rules. In October 2014 the American Medical Association outlined the growing burden on clinicians and requested that CMS "synchronize and simplify" the requirements of the programs. The 2015 Physician Fee Schedule (PFS) final rule reflects a growing effort by CMS to align the federal quality programs for clinicians by using PQRS measures reported on by clinicians for public reporting on Physician Compare and for use in the quality component of the Physician Value-Based Payment Modifier. Additionally, EPs that satisfactorily report to PQRS using the EHR-based reporting option will also satisfy the Clinical Quality Measurement (CQM) component of the EHR Incentive program.

The measures under consideration for the 2014-2015 pre-rulemaking activities include many measures under consideration for multiple programs. Most of the measures under consideration for the EHR Incentive programs are also under consideration for PQRS or are already in PQRS. Significant progress is being made aligning the measures within the federal clinician quality programs. Additionally, some measures are also in private programs.

Participation and Incentives

The PQRS and EHR Incentive programs are voluntary. Growth in participation has been slow despite the payment incentives in 2014 of up to 2% of Medicare billings for participation in PQRS and $4-12,000 for meaningful use of EHRs. In 2012, 36% of 1,201,362 eligible professionals participated in PQRS for all reporting methods including individuals, practices, groups or Accountable Care Organizations (ACOs). PQRS participation is highest among EPs who see the most Medicare patients -- participation is at 53% among those who treat more than 200 Medicare beneficiaries a year.

The potential reasons for non-participation in these voluntary programs are many:

- lack of meaningful measures appropriate to the EP's practice;
- administrative costs and burden required to report electronically;

- payment incentives are not sufficient to promote quality reporting;
- lack of awareness of the programs, particularly for small practices and individual professionals;
- reluctance to share performance information; and
- lack of awareness of upcoming payment penalties.

The role of payment incentives and penalties to influence participation in PQRS and the EHR Incentive Program are unclear. In 2015 payment penalties for non-participation begin. Participation in the programs can lead to as much as a 4% increase in payment in 2017 for high quality and low cost performance in 2015 for the value modifier. An additional upward payment adjustment is available for EPs that care for high-risk beneficiaries. Conversely, non-participation in PQRS by small groups of 2-9 EPs and solo practitioners in 2017 can result in a 2% reduction in Medicare payments in the Value Modifier. For groups with 10 or more EPs the payment penalty under the Value Modifier is 4% for non-participants.

Considerations for Specific Programs

Physician Quality Reporting System (PQRS), Physician Compare, Physician Value-Based Payment Modifier

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). Now in its eighth year PQRS has finalized 285 measures in the 2015 Physician Fee Schedule final rule. All PQRS measures will be used for public reporting on Physician Compare and for the quality component of the Value-Based Payment Modifier. As noted above, MAP encourages a focus on high-value measures that vary greatly by condition/topic (Table 1). CMS has identified 19 “cross-cutting measures” on the recommendation of the MAP for a core set of measures that can be reported on by most EPs.

MAP Clinician Workgroup noted three significant issues for PQRS:

- Encourage greater participation by including measures that allow more EPs to participate by reporting measures that are meaningful to their practice.
- The effect of measure turnover in PQRS (20 measures added and 50 measures removed from PQRS for 2015) disruption of participating EPs quality reporting and creating new gaps in measures for EPs.
- All PQRS measures will be used for accountability purposes , i.e., public reporting and payment.

[Include any updates from meeting discussion]

MAP’s critical program objectives for PQRS are:

- Include more high value measures, e.g., outcomes, patient-reported outcomes, composites, intermediate outcomes, process measures close to outcomes, cost and resource use measures, appropriate use measures, care coordination measures, patient safety, etc.
- To encourage widespread participation many measures are needed for the variety of EPs specialties and sub-specialties.

- The measures chosen by EPs to submit for PQRS will be reported on Physician Compare and used to determine the Value Based Payment Modifier, therefore all PQRS measures will be used for accountability purposes.
- Include NQF-endorsed measures relevant to clinician reporting to encourage engagement Measures selected for the program that are not NQF-endorsed should be submitted for endorsement.
- For measures that are not endorsed, include measures under consideration that are fully specified and that:
    - Support alignment (e.g., measures used in other programs, registries)
    - Are outcome measures that are not already addressed by outcome measures included in the program
    - Are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures

Specific to public reporting:

- Include measures that focus on outcomes and are meaningful to consumers (i.e., have face validity) and purchasers.
- Focus on patient experience, patient-reported outcomes (e.g., functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care measures.
- To generate a comprehensive picture of quality, measure results should be aggregated (e.g., composite measures), with drill-down capability for specific measure results

Specific to payment:

- Include measures that have been reported in a national program for at least one year (e.g., PQRS) and ideally can be linked with particular cost or resource use measures to capture value.
- Focus on outcomes, composites, process measures that are proximal to outcomes, appropriate care (e.g., overuse), and care coordination measures (measures included in the MAP Families of Measures generally reflect these characteristics).
- Monitor for unintended consequences to vulnerable populations (e.g., through stratification).

Medicare and Medicaid EHR Incentive Programs

The Medicare and Medicaid Electronic Health Care Record (EHR) Incentive Programs provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The programs promote widespread adoption of certified EHR technology by providers and incentivize "meaningful use" of EHRs to improve quality, safety, efficiency, and reduce health disparities; engage patients and family; improve care coordination, and population and public health; and maintain privacy and security of patient health information. As of September 2014, more than 414,000 health care providers received

payment for participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The incentive structure varies by program:

- Medicare: The last year to begin the program is 2014. Penalties take effect in 2015 and in each year hereafter where EPs are eligible but do not participate.
- Medicaid: The last year to begin the program is in 2016. Payment adjustments do not apply to Medicaid.

The programs align with the PQRS program to allow individual EPs and groups to report electronic clinical quality measures or " eCQMs" through PQRS portal. The programs also allow groups to report eCQMs through Pioneer ACO participation or Comprehensive Primary Care Initiative participation.

EHR measures under consideration for the current pre-rulemaking cycle are for Meaningful Use Stage 3. CMS has determined that the measures under consideration for the EHR Incentive Programs have been appropriately specified as eCQMs or "eMeasures" but all eCQMs are being revised to reflect recently revised standards. CMS indicates that the eCQMs under consideration for pre-rulemaking should be considered as "Measures Under Development".

[include any meeting discussion items]

Critical program objectives for the EHR Incentive Programs include:

- Include endorsed measures that have eMeasure specifications available.
- Alignment with other federal programs, particularly PQRS.
- Over time, as health IT becomes more effective and interoperable, focus on:
    - Measures that reflect efficiency in data collection and reporting through the use of health IT
    - Measures that leverage health IT capabilities (e.g., measures that require data from multiple settings/providers, patient-reported data, or connectivity across platforms to be fully operational)
    - Innovative measures made possible by the use of health IT

Appendix A: Public Comments

Appendix B: MAP Rosters

Appendix C: Glossary