Measure Applications Partnership

Clinician Workgroup

NATIONAL QUALITY FORUM

December 15-16, 2014

CENTERS FOR MEDICARE & MEDICAID SERVICES

2015 Physician Fee Schedule Measure Policies

December 15-16, 2014

Measure Policies

- Requirement to report on 1 of 19 “cross-cutting” measures (for EPs with face-to-face encounters)
  - Proposed 2; finalized 1 – signaled in the rule the intent to increase the number of required measures over time
- Groups of 100 or more EPs required to report on CG-CAHPS

PQRS Measures

- Removal of 50 measures
  - "topped out"
  - "low bar"
  - Lost stewardship
  - Evidence change
- Addition of recommended core sets of measures for specialties (and primary care)

Medicare Shared Savings Program (MSSP)

- **Program Type:** Pay for Reporting and Pay for Performance for Accountable Care Organizations (ACOs)

- **Incentive Structure:** Option for one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years).

- **Program Goal**: 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.

Medicare Shared Savings Program (MSSP)

Program Updates (PFS Rule for 2015):

- Quality improvement shown in 30 of 33 quality measures, such as:
  - Patients' ratings of clinicians' communication
  - Beneficiaries' rating of their doctor
  - Health promotion and education
  - Screening for tobacco use and cessation
  - Screening for high blood pressure.

- Controlling spending growth: 53 of 204 organizations slowed spending enough to receive bonus payments; one will face penalties after health spending accelerated.
- In 2013 alone, over 125,000 eligible professionals who were ACO providers or suppliers qualified for their incentive payments for reporting their quality of care through the Physician Quality Reporting System (PQRS).

Source: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html

Medicare Shared Savings Program (MSSP)

Critical Program Objectives

- Improve the overall health for a population of Medicare Fee-For-Service (FFS) beneficiaries
- Improve quality and health outcomes while lowering the rate of growth of healthcare spending
- Encourage coordination and shared accountability by including measures relevant to individuals with multiple chronic conditions, measures in all settings that patients receive care (including ambulatory, acute, and post-acute settings), and measures that span across settings.
- Promote alignment across other quality measurement reporting programs
- Include more high-value measures

MAP approach to MSSP

- MUCs for all three WGs
- Hospital WG referred 14 MUCs to Clinician WG (setting is hospital; level of analysis is clinician)
- Grouped by preliminary analysis results:
  - Support
  - Conditional support
  - Encourage further development
  - Do not support
  - Do not encourage further consideration

Gaps in the clinician quality programs

- Have the MUCs filled any gaps?
- What areas need high-value measures?
  - PROs, appropriate use, composites or process and adverse outcome measures
- What topic areas/conditions need measures?
  - Palliative care/end of life;
- What specialties need measures?
  - Allergy and immunology; oral surgery; pathology; plastic and reconstructive surgery, pulmonary, PAC/LTC professionals
- What non-physician EPs need measures?

Programmatic deliverable

- Feedback from Workgroup

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						

MAP Pre-Rulemaking Timeline 2014-2015

- **November 28**: HHS list of measures under consideration provided to MAP
- **December 1-5**: Pre-meeting public comment period
- **December 9-16**: MAP workgroup meetings to provide input on program measure sets and measures under consideration
- **December 23 – January 13:** Public comment period on Workgroup input on measures under consideration
- **January 26-27**: MAP Coordinating Committee Meeting in-person to finalize MAP's recommendations to HHS
- **February 1-March 15**: Pre-Rulemaking deliverables due to HHS

Summary of Meeting

- Feedback on MAP process improvements
  - Preliminary analysis
  - Discussion Guide
  - Consent calendars and voting
  - Pre-meeting comments
- Suggestions for additional improvements