Measure Applications Partnership

Clinician Workgroup Pre-Rulemaking In Person Meeting

December 9-10, 2015

NATIONAL QUALITY FORUM

Clinician Workgroup Membership

Workgroup Co-chairs (Voting): Bruce Bagley, MD and Eric B. Whitacre, MD, FACS

Organizational Members (Voting)

The Alliance	Amy Moyer
American Academy of Ophthalmology	Scott Friedman, MD
American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
American Association of Nurse Practitioners	Diane Padden, PhD, CRNP, FAANP
American College of Cardiology	Paul N. Casale, MD, FACC
American College of Radiology	David J. Seidenwurm, MD
Anthem	Stephen Friedhoff, MD
Association of American Medical Colleges	Janis Orlowkski, MD
Carolina's HealthCare System	Scott Furney, MD, FACP
Center for Patient Partnerships	Rachel Grob, PhD
Consumers' CHECKBOOK	Robert Krughoff, JD
Kaiser Permanente	Kate Koplan, MD, MPH
March of Dimes	Cynthia Pellegrini
Minnesota Community Measurement	Beth Averbeck, MD
National Business Coalition on Health	Bruce W. Sherman, MD, FCCP, FACOEM
National Center for Interprofessional Practice and Education	James Pacala, MD, MS
Pacific Business Group on Health	Stephanie Glier, MPH
Patient-Centered Primary Care Collaborative	Marci Nielsen, PhD, MPH
Primary Care Information Project	Winfred Wu, MD, MPH
St. Louis Area Business Health Coalition	Barb Landreth, RN, MBA

Clinician Workgroup Membership

Subject Matter Experts (Voting)

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Constance M. Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN

Federal Government Members (Non-Voting)

Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Kate Goodrich, MD
Health Resources and Services Administration (HRSA)	Girma Alemu, MD, MPH

Duals Workgroup Liaison

Treatment Research Institute	Mady Chalk, MSW, PhD

Meeting Objectives

- Review and provide input on measures under consideration for federal programs applicable to Clinician settings
- Identify high-priority measure gaps for each program measure set
- Finalize input to the MAP Coordinating Committee on measures for use in federal programs

MAP Pre-Rulemaking Approach

MAP Pre-Rulemaking Approach

MAP revised its approach to pre-rulemaking deliberations for 2015/2016. The approach to the analysis and selection of measures is a three-step process:

- Develop program measure set framework
- Evaluate measures under consideration for what they would add to the program measure sets
- Identify and prioritize measure gaps for programs and settings

MAP Decision Categories

- MAP Workgroups must reach a decision about every measure under consideration
  - Decision categories are standardized for consistency
  - Each decision should be accompanied by one or more statements of rationale that explains why each decision was reached

MAP Decision Categories for Fully Developed Measures and Example Rationales

MAP Decision Category	Rationale (Examples)
Support	• Addresses a previously identified measure gap • Core measure not currently included in the program measure set • Promotes alignment across programs and settings
Conditional Support	• Not ready for implementation; should be submitted for and receive NQF endorsement • Not ready for implementation; measure needs further experience or testing before being used in the program.
Do Not Support	• Overlaps with a previously finalized measure • A different NQF-endorsed measure better addresses the needs of the program.

MAP Decision Categories for Measures Under Development and Example Rationales

MAP Decision Category	Rationale (Examples)
Encourage continued development	• Addresses a critical program objective, and the measure is in an earlier stage of development. • Promotes alignment, and the measure is in an earlier stage of development
Do not encourage further consideration	• Overlaps with finalized measure for the program, and the measure is in an earlier stage of development. • Does not address a critical objective for the program, and the measure is in an earlier stage of development.
Insufficient Information	• Measure numerator/denominator not provided

MAP Measure Selection Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2. Program measure set adequately addresses each of the National Quality Strategy's three aims
3. Program measure set is responsive to specific program goals and requirements
4. Program measure set includes an appropriate mix of measure types
5. Program measure set enables measurement of person- and family-centered care and services
6. Program measure set includes considerations for healthcare disparities and cultural competency
7. Program measure set promotes parsimony and alignment

Preliminary Analysis of Measures Under Consideration

To facilitate MAP's consent calendar voting process, NQF staff has conducted a preliminary analysis of each measure under consideration.

The preliminary analysis is an algorithm that asks a series of questions about each measure under consideration. This algorithm was:

- Developed from the MAP Measure Selection Criteria, and approved by the MAP Coordinating Committee, to evaluate each measure
- Intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions

MAP Voting Instructions

Key Voting Principles

- Every measure under consideration will be subject to a vote, either individually or as part of a consent calendar
- Workgroups will be expected to reach a decision on every measure under consideration
  - There will no longer be a category of “split decisions” where the MAP Coordinating Committee makes a decision on a measure under consideration
  - However, the Coordinating Committee may decide to continue discussion on a particularly important matter of program policy or strategy in the context of a measure for a program
- Staff will provide an overview of the process for establishing consensus through voting at the start of each in-person meeting

Key Voting Principles

- After introductory presentations from staff and the Chair to give context to each programmatic discussion, discussion and voting will begin using the electronic Discussion Guide
- A lead discussant will be assigned to each group of measures.
- The Discussion Guide will organize content as follows:
  - The measures under consideration will be divided into a series of related groups for the purposes of discussion and voting
  - Each measure under consideration will have a preliminary staff analysis
  - The discussion guide will note the result of the preliminary analysis (i.e., support, do not support, or conditional support) and provide rationale to explain how that conclusion was reached

Voting Procedure

Step 1. Staff will review a Preliminary Analysis Consent Calendar

- Staff will present each group of measures as a consent calendar reflecting the result of the preliminary analysis using MAP selection criteria and programmatic objectives

Voting Procedure

Step 2. MUCs can be pulled from the Consent Calendar and become regular agenda items

- The co-chairs will ask the Workgroup members to identify any MUCs they would like to pull off the consent calendar. Any Workgroup member can ask that one or more MUCs on the consent calendar be removed for individual discussion
- Once all of the measures the Workgroup would like to discuss are removed from the consent calendar, the co-chair will ask if there is any objection to accepting the preliminary analysis and recommendation of the MUCs remaining on the consent calendar
- If no objections are made for the remaining measures, the consent calendar and the associated recommendations will be accepted (no formal vote will be taken)

Voting Procedure
Step 3. Voting on Individual Measures

- Workgroup member(s) who identified measures for discussion will describe their perspective on the measure and how it differs from the preliminary analysis and recommendation in the Discussion Guide.
- Workgroup member(s) assigned as lead discussant(s) for the group of measures will respond to the individual(s) who requested discussion. Lead discussant(s) should state their own point of view, whether or not it is in agreement with the preliminary recommendation or the divergent opinion.
- Other Workgroup members should participate in the discussion to make their opinions known. However, in the interests of time, one should refrain from repeating points already presented by others.
- After discussion of each MUC, the Workgroup will vote on the measure with three options:
  - Support
  - Support with conditions
  - Do not support

Voting Procedure
Step 4: Tallying the Votes

- If a MUC receives ≥ 60% for Support -- the recommendation is Support
- If a MUC receives ≥ 60% for the SUM of Support and Conditional support – the recommendation is Conditional support. Staff will clarify and announce the conditions at the conclusion of the vote
- If a MUC receives < 60% for the SUM of Support and Conditional support - the recommendation is “Do not support”
- Abstentions are discouraged but will not count in the denominator

Voting Procedure
Step 4: Tallying the Votes

DO NOT SUPPORT	CONDITIONAL SUPPORT	SUPPORT
> 60% consensus of do not support	≥ 60% consensus of conditional support	≥60% consensus of support
< 60% consensus for the combined total of conditional support and support	≥ 60% consensus of both conditional support and support	N/A

Voting Procedure
Step 4: Tallying the Votes

25 Committee Members
2 members abstain from voting

Voting Results	
Support	10
Conditional Support	4
Do Not Support	9
Total:	23

10+4 = 14/23 = 61%
The measure passes with Conditional Support

Commenting Guidelines

- Comments from the early public comment period have been incorporated into the discussion guide.
- There will be an opportunity for public comment before the discussion on each consent calendar.
  - Commenters are asked to limit their comments to only MUCs on that consent calendar and limit comments to two minutes.
- There will be a global public comment period at the end of each day.
- Public comment on the Workgroup recommendations will run from December 23-January 12.
  - These comments will be considered by the Coordinating Committee and submitted to CMS.

Medicare Shared Savings Program

Medicare Shared Savings Program

Rabia Khan, MPH

December 9, 2015

Agenda

- Statutory Authority
- Shared Savings Program Overview
  - Promising Results
- Overview of Quality Measurement Approach
- Quality Measures
- Data Collection
- Quality Performance Scoring
  - Pay-for-Performance Phase-in
  - Sliding Scale Measure Scoring Approach
  - 2015 Reporting Year Scoring
- Quality Reporting Alignment
- Public Reporting
- Future Measure Considerations

Statutory Authority

Medicare Shared Savings Program (Shared Savings Program):

- Mandated by Section 3022 of the Affordable Care Act
- Shared Savings Program Rules
  - November 2011
  - June 2015
- Physician Fee Schedule
  - Annual updates for quality and assignment

Shared Savings Program Overview

- Participation in an Accountable Care Organization (ACO) creates incentives for health care providers to work together voluntarily to coordinate care and improve quality for their patient population.
- ACOs submit an application to join the Shared Savings program and, if accepted, voluntarily enter a 3-year agreement with CMS.
- ACOs may enter 1 of 3 program tracks:
  - Track 1 – one-sided risk model (savings only)
  - Track 2 – two-sided risk model
  - Track 3* – two-sided risk model with prospective assignment

*Track 3 was finalized in the 2015 Shared Savings Program Final Rule and will be effective beginning 1/1/16

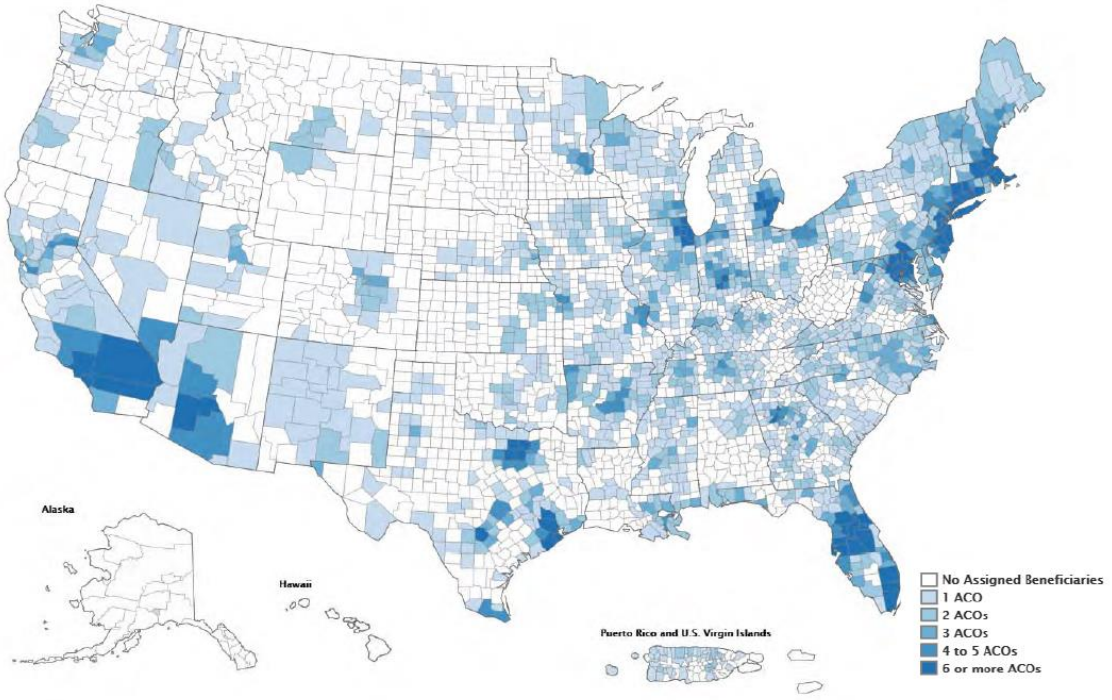
Shared Savings Program Overview (continued)

- CMS assesses ACO performance annually on quality performance and against a financial benchmark to determine shared savings or losses.
- ACOs must meet the quality performance standard to be eligible to share in savings, if earned.

Participation in Medicare ACOs Growing

- **423 ACOs** have been established in the Shared Savings Program and Pioneer ACO Model*
- **7.9 million assigned beneficiaries**
- This includes **89 new ACOS** covering **1.6 million beneficiaries** assigned to the Shared Saving Program in 2015
- Continued **strong i**nterest from new and renewing ACOs

Medicare ACO-Assigned Beneficiaries by County



* Source: Medicare Shared Savings Program Fast Facts, April 2015 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Promising Results

Quality Results

- ACOs that reported in both 2013 and 2014 **improved average performance on 27 of 33 quality measures.**
- Achieved higher performance than other FFS providers on **18 of the 22** Group Practice Reporting Option Web Interface measures.
- Quality improvement was shown in such measures as patients' ratings of clinicians' communication, beneficiaries' rating of their doctor, screening for tobacco use and cessation, and screening for high blood pressure.
- Eligible professionals participating in ACOs also qualify for their Physician Quality Reporting System (PQRS) incentive payments and avoid the PQRS payment adjustment in 2016 because their ACO satisfactorily reported quality measures on their behalf for the 2014 reporting year.

Promising Results (continued)

Financial Results

- Performance Year 2014: Total net savings **$383 million**
  - 92 ACOs (28%) **held spending $806 million below their targets and earned performance payments of more than $341 million.**
  - An additional 89 ACOs reduced health care costs compared to their benchmark, but did not meet the minimum savings threshold.
  - ACOs with more experience in the program were more likely to generate shared savings: 37 percent of 2012 starters, compared to 27 percent of those that entered in 2013, and 19 percent of those that entered in 2014.
- Performance Year 1: 58 ACOs (26%) **held spending $705 million below their targets and earned performance payments of more than $315 million.**

Overview of Quality Measurement Approach

- The quality measurement approach in the Shared Savings Program is intended to:
  1. Improve individual health and the health of populations
  2. Address quality aims such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement, and care coordination
  3. Support the Shared Savings Program goals of better care, better health, and lower growth in expenditures
  4. Align with other quality reporting and incentive programs like PQRS, VM and Medicare EHR Incentive Program

Overview of Quality Measurement Approach (continued)

- 33 quality measures are separated into the following four key domains that serve as the basis for assessing, benchmarking, rewarding, and improving ACO quality performance:
  - Better Care for Individuals
    1. Patient/Caregiver Experience
    2. Care Coordination/Patient Safety
  - Better Health for Populations
    3. Preventive Health
    4. At-Risk Population

Note: 34 quality measures for 2016 and subsequent performance years (80 Fed. Reg. 71263)

Quality Measures:
Aim 1: Better Care for Individuals

1. PATIENT/CARE GIVER EXPERIENCE
Clinician/Group CAHPS
ACO-1 Getting Timely Care, Appointments, and Information
ACO-2 How Well Your Providers Communicate
ACO-3 Patients' Rating of Provider
ACO-4 Access to Specialists
ACO-5 Health Promotion and Education
ACO-6 Shared Decision Making
ACO-7 Health Status/Functional Status
ACO-34 Stewardship of Patient Resources

Quality Measures:
Aim 1: Better Care for Individuals (continued)

2. CARE COORDINATION/PATIENT SAFETY
ACO-8 Risk-Standardized All Condition Readmission
ACO-35 Skilled Nursing Facility 30-Day All-Cause Readmission Measure
ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes
ACO-37 All-Cause Unplanned Admissions for Patients with Heart Failure
ACO-38 All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
ACO-9 Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults
ACO-10 Ambulatory Sensitive Condition Admissions: Heart Failure
ACO-11 Percent of Primary Care Physicians (PCPs) who Successfully Meet Meaningful Use Requirements
ACO-39 Documentation of Current Medications in the Medical Record
ACO-13 Screening for Future Fall Risk

Quality Measures: Aim 2: Better Health for Populations

3. PREVENTIVE HEALTH
ACO-14 Influenza Immunization
ACO-15 Pneumococcal Vaccination
ACO-16 Body Mass Index (BMI) Screening and Follow-Up
ACO-17 Tobacco Use: Screening and Cessation Intervention
ACO-18 Screening for Clinical Depression and Follow-Up Plan
ACO-19 Colorectal Cancer Screening
ACO-20 Breast Cancer Screening
ACO-21 Screening for High Blood Pressure and Follow-Up Documented

Note: ACO-42 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease is a new measure in the Preventive Health domain beginning with the 2016 performance year.

Quality Measures: Aim 2: Better Health for Populations (cont.)

4. Clinical Care for At-Risk Population
Depression
ACO-40 Depression Remission at 12 Months
Diabetes
ACO-27 Diabetes Mellitus: HbA1c Poor Control*
ACO-41 Diabetes: Eye Exam*
Hypertension
ACO-28 Controlling High Blood Pressure
Ischemic Vascular Disease
ACO-30 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
Heart Failure
ACO-31 Beta-Blocker Therapy for LVSD
Coronary Artery Disease
ACO-33 ACEI or ARB Therapy

*The Diabetes Composite includes ACO-27 and ACO-41

Data Collection

- Quality data collected via:
  - Patient Survey (CAHPS for ACOs)
  - Claims
  - EHR Incentive Program data
  - Group Practice Reporting Option (GPRO) Web Interface

Quality Performance Scoring: Pay-for-Performance Phase-In

- CMS designates the quality performance standard depending on how long the ACO has been in the program.

Performance Year	Pay-for-Reporting or Pay-for-Performance	To be eligible to share in savings, if earned, the ACO must:
1	Pay-for-Reporting	Completely and accurately **report** all quality measures. This qualifies the ACO to share in the maximum available sharing rate for payment.
2 and 3*	Pay-for-Performance	Completely and accurately report all quality measures and meet minimum attainment on at least one **pay-for-performance** measure in each domain.**

*ACOs in their second agreement period will be assessed under the same pay-for-performance requirements as ACOs in the 3rd performance year of their first agreement.

**Minimum attainment = performance at 30 percent or the 30th percentile of the performance benchmark.

Quality Performance Scoring: Pay-for-Performance Phase-In (continued)

- When CMS introduces new measures for the quality measure set, they will be set as pay-for-reporting for two years before being phased into pay-for-performance, unless finalized as pay-for-reporting for all performance years.
- Under Pay-for-Performance (i.e., ACO's second and subsequent performance years)…
  - Increasing number of measures are phased into pay-for-performance each year.
  - ACOs must meet minimum attainment level to receive points for pay-for-performance measures.
    - Minimum attainment = performance at 30 percent or the 30th percentile of the performance benchmark
  - Shared savings payments are linked to quality performance as compared to benchmarks based on a sliding scale for scoring. Benchmarks are set for 2 years to support ACO quality improvement efforts.
  - High performing ACOs receive higher sharing rates for payment.

	2015 starters	2014 starters	2012/2013 starters
Pay-for-Reporting Measures in 2015	33	16	10
Pay-for-Performance Measures in 2015	0	17	23
Total Measures in 2015	33	33	33

Quality Performance Scoring: Sliding Scale Measure Scoring Approach

ACO Performance Level*	Quality Points (all measures except ACO-11 EHR measure)	ACO-11 EHR Measure quality points
90th percentile benchmark	2 points	4 points
80th percentile benchmark	1.85 points	3.7 points
70th percentile benchmark	1.7 points	3.4 points
60th percentile benchmark	1.55 points	3.1 points
50th percentile benchmark	1.4 points	2.8 points
40th percentile benchmark	1.25 points	2.5 points
30th percentile benchmark	1.10 point	2.2 points
<30th percentile benchmark	No points	No points

* For some measures, these will be flat percentages (from 30% to 90%)

2015 Performance Year Scoring

Domain	Total Individual Measures	Total Measures for Scoring Purposes	Total Potential Points per Domain	Domain weight (percent)
Patient/Caregiver Experience	8	8 measures	16	25
Care Coordination/ Patient Safety	10	10 measures; ACO-11 EHR measure double-weighted (4 points)	22	25
Preventive Health	8	8 measures	16	25
At-Risk Population	7	5 individually-scored measures, and one 2-component Diabetes Composite*	12	25
Total	**33**	**32**	**66**	**100**

- Beginning with the 2015 performance year, ACOs can earn up to 4 quality improvement points in each domain. The total number of points an ACO earns for a domain cannot exceed the total possible points in that domain.

Quality Reporting Alignment

- When the ACO meets the Shared Savings Program's requirements for quality reporting and performance, eligible professionals (EPs) participating in an ACO, will meet quality reporting requirements for the following CMS programs:
  - PQRS
  - Value-based Payment Modifier (VM)
  - Medicare EHR Incentive Program

Quality Reporting Alignment (continued)

- PQRS:
  - If the ACO satisfactorily reports measures via the GPRO web interface for the 2015 performance year, then its ACO participant TINs with PQRS eligible professionals will not be subject to the 2017 PQRS payment adjustment.
- VM:
  - Beginning in 2017, CMS is applying the VM to physicians in group practices with 2 or more EPs and to physician solo practitioners. Groups and solo practitioners (as identified by their Taxpayer Identification Number (TIN)) participating in a Shared Savings Program ACO in 2015 will be subject to the 2017 VM based on their performance in calendar year 2015.
  - The VM is determined by calculating a cost composite and a quality composite.
    - For TINs participating in a Shared Savings Program ACO, the cost composite will be classified as "Average," but the quality composite will be calculated using ACO-level data reported by the ACO through the GPRO Web Interface and the ACO's All-Cause Readmission measure.
    - ACOs participants may be eligible for an upward adjustment based on their ACO's quality performance
    - If an ACO fails to successfully report on quality measures, then the participant TINs under the ACO who are subject to the VM will be subject to an automatic downward adjustment under the VM. In 2017, the automatic downward adjustment is -4.0% for physicians in groups with 10 or more EPs and -2.0% for physicians in groups with between 2 to 9 EPs and physician solo practitioners.

Quality Reporting Alignment (continued)

- Medicare EHR Incentive Program:
  - EPs participating in the Shared Savings Program can satisfy their CQM reporting for the Medicare EHR Incentive Program if EPs use Certified EHR Technology (CEHRT) and the ACO satisfactorily reports via the GPRO web interface.
  - EPs must separately attest to the other requirements for the Medicare EHR Incentive Program to successfully demonstrate meaningful use.

Public Reporting

- Performance year results, which include financial results, are publicly reported on data.cms.gov.*
- A subset of measures aligned with PQRS are displayed on Physician Compare.
- ACOs must publicly report their quality performance results on their website according to our Shared Savings Program ACO public reporting guidance.**

*The 2014 Shared Savings Program performance year results are available online at: https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/ucce-hhpu

**The ACO public reporting guidance is available online at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes-Regulations-Guidance.html

Future Measure Considerations

- We would appreciate MAP recommendations for measures that:
  - Address National Quality Strategy and CMS Quality Strategy goals and priorities
  - Align with other value-based purchasing initiatives (e.g. MIPS, SNF VBP)
  - Address population health across settings of care
  - Focus on patient outcomes
    - Balance of process, intermediate outcome, and outcome measures
  - Sensitive to administrative burden for reporting

Clinician Workgroup feedback on MSSP last year

- **Measures for MSSP should focus on:**
  - Composite measures for clinical conditions
  - Measures that promote care coordination
  - Outcome measures
  - Measures using patient-reported data
  - Prevention and population health

Measures under consideration for MSSP

- Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
- Advanced Care Plan
- PQI 91 Prevention Quality Acute Composite
- PQI 92 Prevention Quality Chronic Composite
- Ischemic Vascular Disease All or None Outcome Measure (Optimal Control)

Merit-based Incentive Payment System

The Merit-Based Incentive Payment System (MIPS)

MIPS Principles

- Use a patient-centered approach to program development that leads to better, smarter, and healthier care
- Focus on policies that remove as much administrative burden as possible from eligible professionals (EPs) and their offices.
- Develop a program that is meaningful, understandable and flexible for participating clinicians
- Design Incentivizes that drive movement toward delivery system reform principles and APMs
- Ensure close attention to excellence in Implementation, operational feasibility, and effective communication with stakeholders.

Overview of MIPS

- The MIPS is a new program designed to link providers' performance on quality and cost measures to their payment.
- The MIPS combines parts of PQRS, VM, and the Medicare EHR Incentive Program into one single program based on four categories:
  - Quality
  - Resource use
  - Clinical practice improvement
  - Meaningful use of certified EHR technology

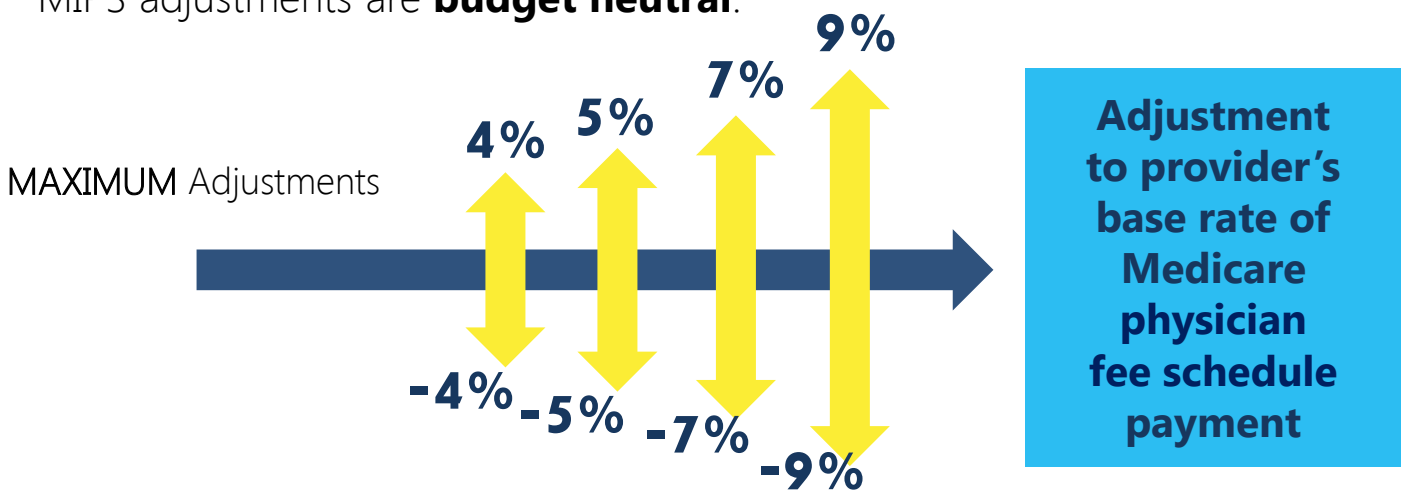
MIPS Eligible Professionals

Applies to individual EPs, groups of EPs, or virtual groups

2019-2020 (first two years)	• Physicians, Physician assistants • Nurse practitioners, Clinical nurse specialists • Nurse anesthetists
2021-Onward	• Physical or occupational therapists, Speech-language pathologists • Audiologists, Nurse midwives • Clinical social workers, Clinical psychologists • Dietitians or nutrition professionals
Excluded EPs	• Qualifying APM participants • Partial Qualifying APM participants • Low volume threshold exclusions

MIPS Adjustments to Part B Payments

- Based on the MIPS **composite performance score** across **four** domains of performance, physicians and practitioners will receive positive, negative, or neutral adjustments.
  - Clinical quality
  - Resource use
  - Clinical practice improvement activities
  - Meaningful use of certified EHR technology
- MIPS adjustments are **budget neutral**.

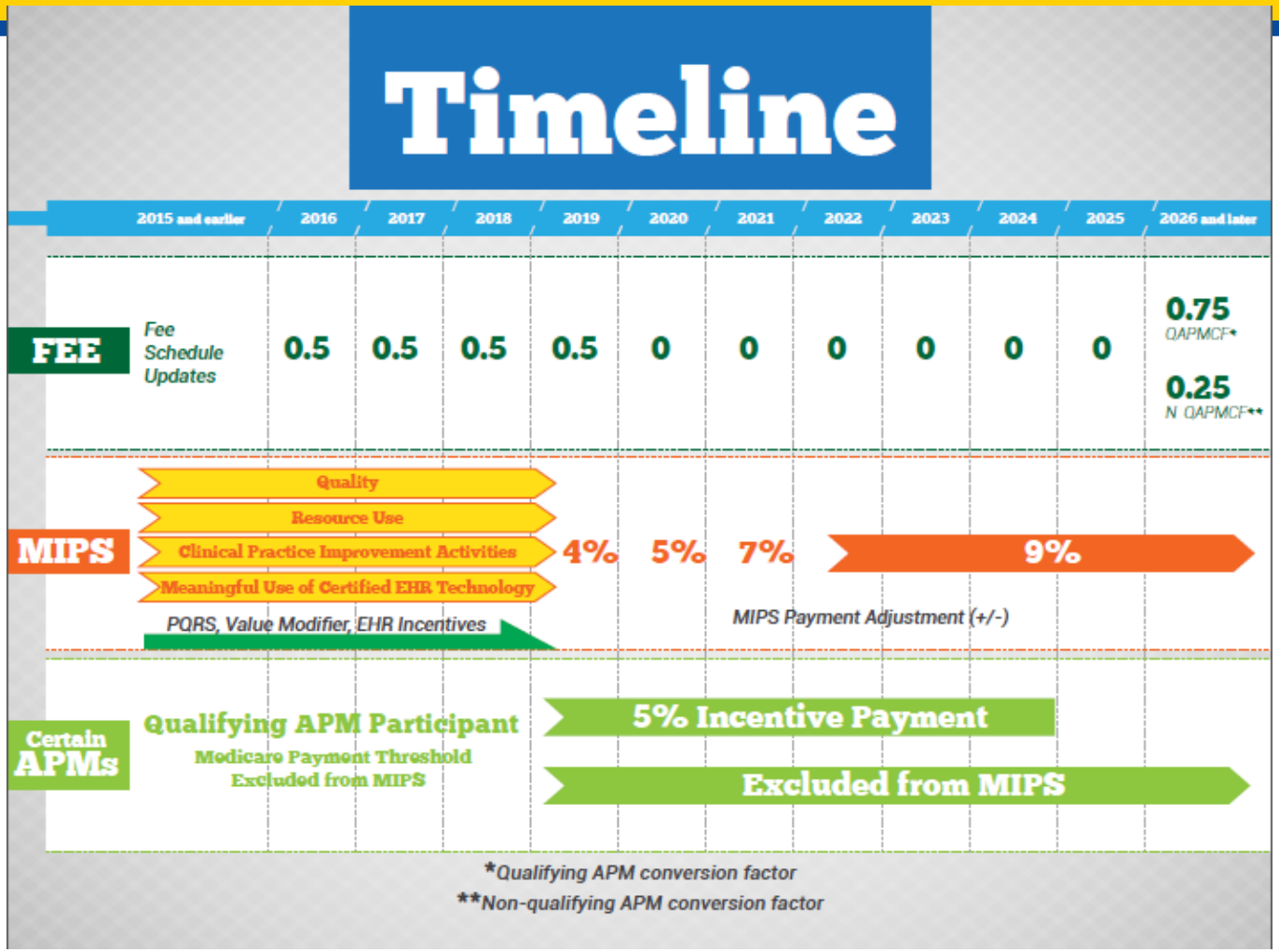


Merit-Based Incentive Payment System **(MIPS)**

MIPS Performance Score

- Beginning Jan 1, 2019, CMS must assess EP performance during a performance period for measures and activities in four weighted performance categories.
- A composite or total performance score will be developed using a scale of 0 to 100.
- The performance threshold is based on the mean or median of composite scores during prior period.
- The score will assess achievement and improvement (if data is available).

Physician Fee Schedule and Timeline



CMS Priority and Needs for Measures for MIPS

- Outcome measures
- Measures relevant for specialty providers
- High priority domains:
  - Person and caregiver-centered Experience and Outcomes (PROMs)
  - Communication and Care coordination
  - Appropriate Use and Resource Use
- Address one of the following quality domains:
  - Clinical care
  - Safety
  - Care coordination
  - Patient and caregiver experience
  - Population health and prevention
- Preference for eCQMs – electronic clinical quality measures
- Not duplicative of measures in set
- Identify opportunities for improvement – avoid “topped out” measures

Measures under consideration for MIPS – 58 measures

CMS priority and needs for measures for MIPS

- Outcome measures - 24 (41%)
  - Patient-reported outcome measures - 2
- Fully developed measures - 5
- NQF-endorsed measures - 2
- eCQMs (eMeasures) - 2
- Measures relevant for specialty providers - 51 (88%)
- Identified opportunity for improvement – 11 (19%)

CMS priority and needs for measures for MIPS (con't)

Measures relevant for specialty providers:

Dermatology	5 measures
Eye care	12 measures
GYN oncology	8 measures
Interventional Radiology	7 measures
Urogynecology	5 measures
Gastroenterology/liver	10 measures

How well do MUCs address gaps identified by Clinician Workgroup last year

- Palliative/end of life care - 1 measure
- Cancer outcomes
- Multiple chronic conditions and complex conditions
- Patient-centered measures using patient-reported data:
  - Patient experience
  - Shared decision-making
  - Care coordination – 2 measures
  - Patient-reported outcomes – 3 measures
- Trauma care
- Geriatrics and frailty
- Measures of diagnostic accuracy
- Measures for specialties with few measures – 51 measures
- EHR measures that promote interoperability

Physician Compare

Physician Compare:
Public Reporting and Consumer Engagement

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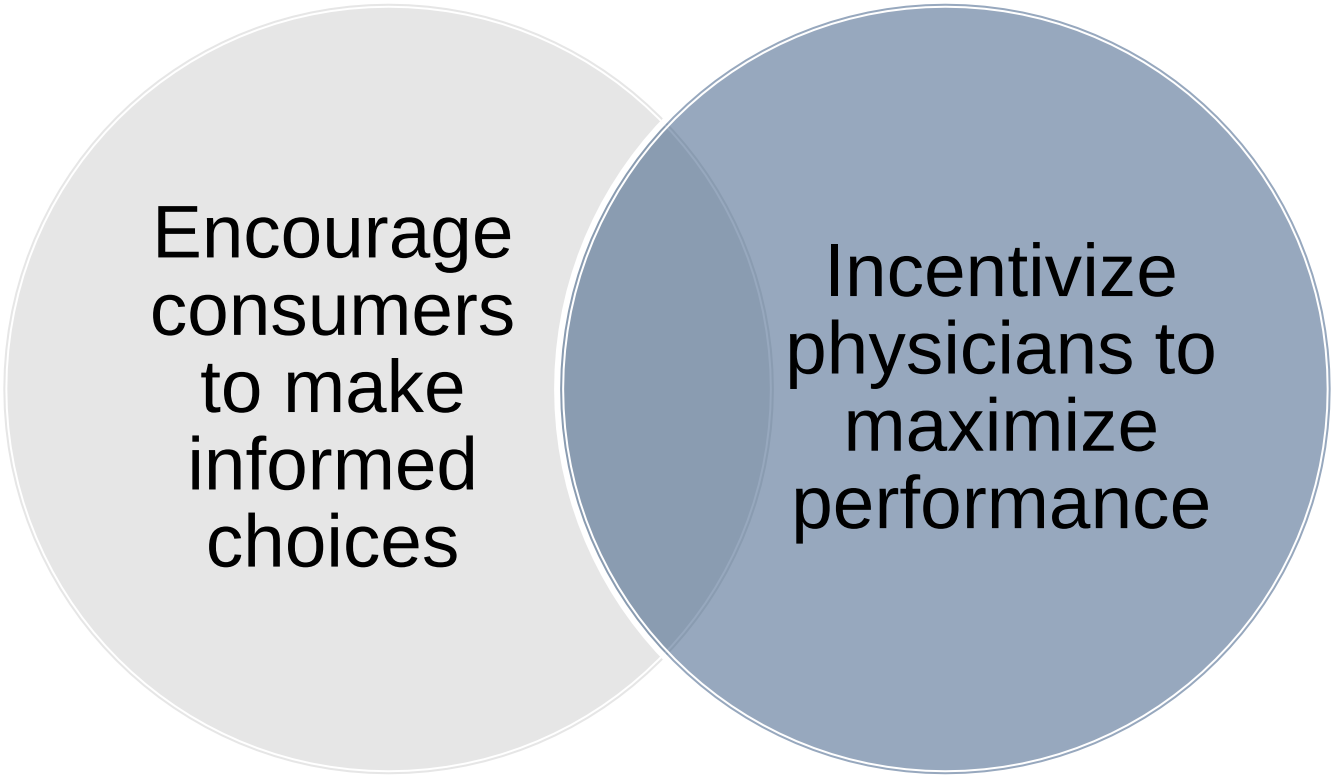
Physician Compare

Two-Fold Purpose



Physician Compare

Public Reporting By Year

Date of Publication	Rule	PQRS GPROs	ACOs	Patient Experience of Care Measures	Individual Eligible Professionals (EPs)
February 2014	2012 Physician Fee Schedule (PFS) Final Rule 2012 Medicare Shared Savings Program (SSP) Final Rule	2012 PQRS GPRO measures collected via the Web Interface ❖ Diabetes Mellitus (DM) and Coronary Artery Disease (CAD) measures only	2012 ACO measures collected via the Web Interface for Medicare Shared Savings Program (SSP) & Pioneer ACOs ❖ Diabetes Mellitus (DM) and Coronary Artery Disease (CAD) measures only	N/A	N/A

Public Reporting By Year

Date of Publication	Rule	PQRS GPROs	ACOs	Patient Experience of Care Measures	Individual Eligible Professionals (EPs)
December 2014	2013 Physician Fee Schedule (PFS) Final Rule	2013 PQRS GPRO measures collected via the Web Interface ❖ DM and CAD ❖ 139 Group Practices	2013 ACO measures collected via the Web Interface ❖ DM and CAD ❖ 214 Shared Savings Program ACOs ❖ 23 Pioneer ACOs	2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs	N/A

Public Reporting By Year

Date of Publication	Rule	PQRS GPROs	ACOs	Patient Experience of Care Measures	Individual Eligible Professionals (EPs)
Late 2015	2014 Physician Fee Schedule (PFS) Final Rule	2014 PQRS GPRO measures collected via the Web Interface ❖ A sub-set of 14 measures	2014 ACO measures collected via the Web Interface ❖ Matching sub-set of group practice 14 measures	2014 CAHPS for PQRS and CAHPS for ACOs ❖ Group practices of 25 or more EPs reporting via a CMS-approved certified survey vendor	2014 PQRS measures collected via claims ❖ A sub-set of 6 measures

MACRA

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Enacted on April 16, 2015
  - Repeals the Sustainable Growth Rate (SGR)
  - Creates the Merit-based Incentive Payment System (MIPS), a new reimbursement rate system for physicians and other eligible providers
  - Establishes incentives for Alternative Payment Models (APM)
  - Increases the data available for public reporting on Physician Compare

Public Reporting Challenges

- Data Attribution
  - It is important that public reporting accurately reflects individual health care professionals' performance
- Public Reporting Standards
  - Physician Compare will only publicly report valid, reliable, and comparable quality data that resonates with consumers

Engaging Consumers

- Critical to keep the “public” in “public reporting”
  - Consumers want data from other consumers
  - Consumers would like narrative reviews
  - Value CAHPS data, and regularly request this type of patient experience data at the individual EP level
  - Consumers also greatly value clinical quality of care measures that they can relate to

Engaging Consumers

- Engagement starts with measure development
  - Working with the Measure Development Contractor to further update the Measures Blueprint to help developers build measures with consumers in mind
- Engagement should also be a criteria for selecting measures for program inclusion
  - Important to think about which measures can help consumers make informed decisions about their health care

For More Information…

- Please direct inquiries regarding Physician Compare to PhysicianCompare@Westat.com

- CMS Lead – Alesia Hovatter (CMS/CCSQ) Alesia.Hovatter@cms.hhs.gov

MAP Clinician Workgroup Guiding Principles for Physician Compare

- **Staff used the guiding principles to propose web page reporting for measure under consideration that are:**
  - Meaningful to consumers and purchasers
  - Outcome measures
  - Patient experience
  - Patient-reported outcomes
  - Care coordination
  - Population health
  - Appropriate care
  - Composite measures

Workgroup Discussions

Gaps in Clinician Measures

- Currently approximately 300 measures
- 58 measures on MUC list

- What is missing?
- Are there other measures available?

How well do MUCs address gaps identified by Clinician Workgroup last year

- Palliative/end of life care - 1 measure
- Cancer outcomes
- Multiple chronic conditions and complex conditions
- Patient-centered measures using patient-reported data:
  - Patient experience
  - Shared decision-making
  - Care coordination – 2 measures
  - Patient-reported outcomes – 3 measures
- Trauma care
- Geriatrics and frailty
- Measures of diagnostic accuracy
- Measures for specialties with few measures – 51 measures
- EHR measures that promote interoperability

Alignment of measures

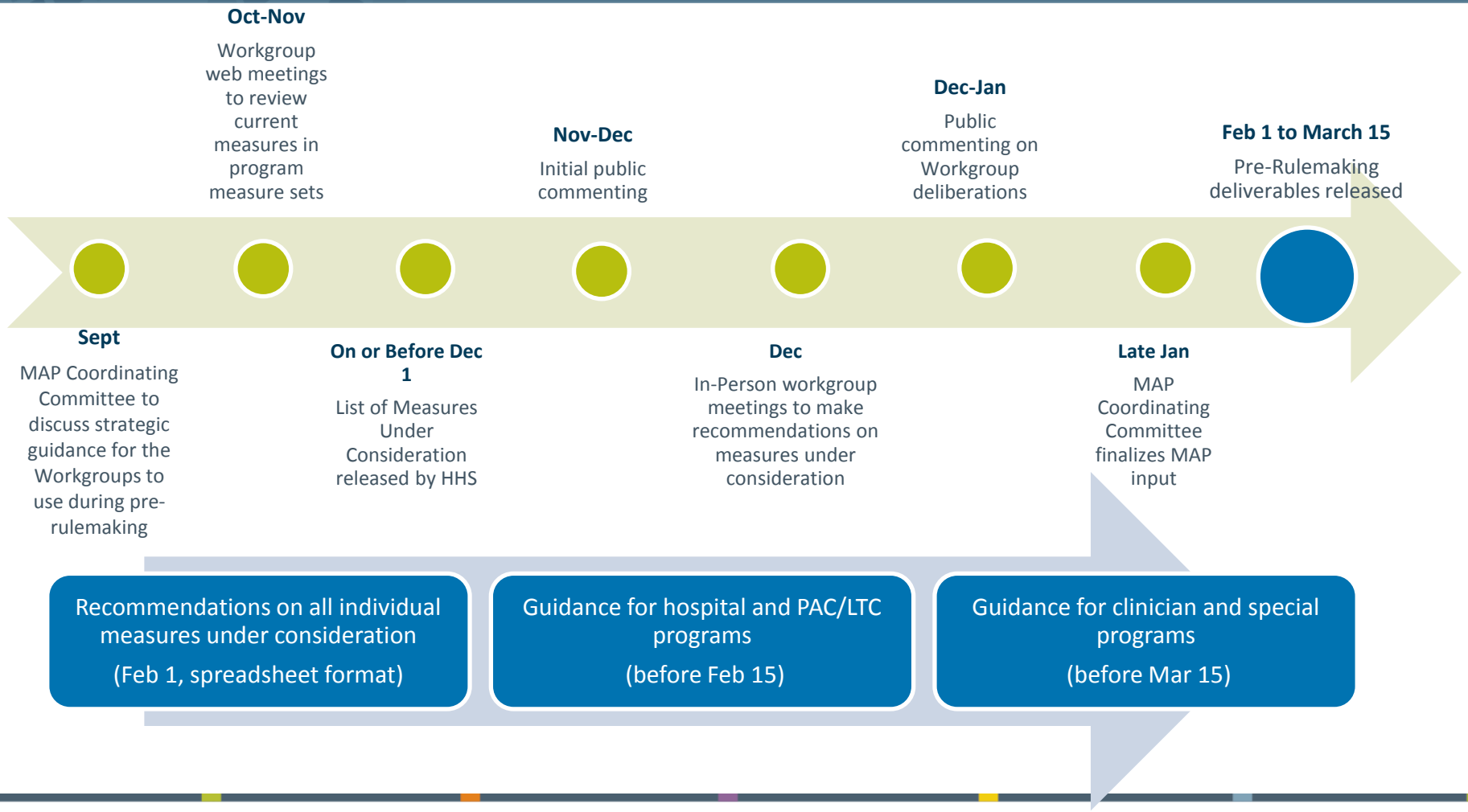
- Alignment of measures across clinician programs
  - Are there measures in PQRS/MIPS that would be appropriate for MSSP?
  - Alignment of clinician measures with hospital and PAC/LTC measures

Clinician measure issues

- Parsimony vs granularity
- Broadening the scope of measures
- Including patient preferences in composites
- Other?

Workgroup Discussions:
Public reporting of clinician measures

Next Steps


Sept
MAP Coordinating Committee to discuss strategic guidance for the Workgroups to use during pre-rulemaking
Oct-Nov
Workgroup web meetings to review current measures in program measure sets
On or Before Dec 1
List of Measures Under Consideration released by HHS
Nov-Dec
Initial public commenting
Dec
In-Person workgroup meetings to make recommendations on measures under consideration
Dec-Jan
Public commenting on Workgroup deliberations
Late Jan
MAP Coordinating Committee finalizes MAP input
Feb 1 to March 15
Pre-Rulemaking deliverables released
Recommendations on all individual measures under consideration
(Feb 1, spreadsheet format)
Guidance for hospital and PAC/LTC programs
(before Feb 15)
Guidance for clinician and special programs
(before Mar 15)

Next Steps

Member and Public Comment	December 23, 2015-January 12, 2016
Coordinating Committee Review of Recommendations	January 26, 2016
Spreadsheet of Recommendations on All Individual Measures Under Consideration Released	February 1, 2016
Guidance For Hospital And PAC/LTC Programs	February 15, 2016
Guidance For Clinician And Special Programs	March 15, 2016

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Thank You!