

MEASURE APPLICATIONS PARTNERSHIP

MAP 2016
Considerations for
Implementing Measures
in Federal Programs:
Clinicians

FINAL REPORT
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NATIONAL
QUALITY FORUM

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GUIDANCE ON CROSS-CUTTING ISSUES

Summary

- The new Merit-based Incentive Payment System (MIPS) aligns all clinician measures into a single program.
- Further alignment of clinician measures with ACOs/APMs and hospital/facility measures is warranted.
- Public reporting of clinician measures on Physician Compare is ramping up.
- Measure gaps in both MIPS and MSSP remain.

In the past four years, the Measure Applications Partnership (MAP) has provided multistakeholder, pre-rulemaking input to the Centers for Medicare & Medicaid Services (CMS) on clinician-level measures for the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VBPM) program, and the EHR Incentive program. This year, MAP reviewed measures under consideration for the following clinician quality reporting programs:

- Merit-based Incentive Payment System (MIPS) – MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program that will adjust eligible providers' Medicare payments based on performance.
- Medicare Shared Savings Program (MSSP) – MSSP is a program 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.

MAP 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 promotion of parsimony and alignment among public and private quality programs.

Scores on clinician measures reported to the MSSP and PQRS/MIPS program are publicly reported and available on the [Physician Compare website](#).

OVERARCHING THEMES

New Merit-based Incentive Payment System (MIPS) Consolidates All Clinician Programs in 2019

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR), the long-standing formula for determining Medicare payments to physicians and other eligible health professionals. To replace that formula, the MACRA legislation created a new framework for clinician payment, moving toward a system of reimbursement based on performance incentives or alternative payment models.

As required under MACRA, CMS will establish a new program through which eligible health professionals' payments will be adjusted based on performance. This program, known as the Merit-based Incentive Payment System (MIPS), will combine the previously separate PQRS, VBPM, and EHR Incentive programs into a single payment system. The previous clinician-level quality programs will sunset after 2018, with the MIPS program taking effect in 2019. Under the MIPS program, each eligible professional or group practice will be assigned a composite performance score based on four categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health record (EHR) technology. Eligible professionals' payments will then be adjusted up or down (or not at all) based on comparison of their composite scores to a performance threshold.

As part of the transition from multiple quality programs to the consolidated MIPS program, clinician-level measures under consideration in the 2015-16 pre-rulemaking cycle were proposed for potential implementation in 2017 to collect data for use in the MIPS program in 2019.

Alignment Within and Across Programs

In pursuit of consistency, parsimony, and reducing the burden of measurement and reporting, MAP has identified alignment of measures across federal programs as one of its most important cross-cutting priorities. Alignment, or use of the same or related measures, is a critical strategy for accelerating improvement in priority areas, reducing duplicative data collection and enhancing comparability and transparency of healthcare information. MAP assesses and promotes alignment of measurement across federal programs and between public- and private-sector initiatives to streamline the costs of measurement and focus improvement efforts. One of the principles guiding MAP's work is that, to the extent possible, the same measures should be used across different programs and should be defined in the same way (unless there are justifiable reasons for differences). MAP continues to take strides toward promoting alignment and gap-filling through development of Families of Measures related to the National Quality Strategy (NQS) priority areas. MAP agreed that there remains a strong need for alignment of clinician-level measures with measures at the system level (e.g., Accountable Care Organizations (ACOs), Alternative Payment Models (APMs), etc.) and facility level (e.g., hospitals, ambulatory care facilities, etc.).

CMS representatives noted that CMS and America's Health Insurance Plans (AHIP) have been working with patients and provider groups to develop consensus around core sets of measures in particular areas, including primary care, liver disease, gastroenterology, medical oncology, and cardiology. MAP members supported these efforts and noted that the development of such core

sets is in line with MAP's goals of consistency and alignment across measurement programs.

MAP also stressed that alignment within programs remains a priority; this emerged during discussion about specific measure recommendations, including measures of the quality of cardiovascular care. MAP members noted that a composite measure for optimal control of cardiovascular disease (MUC15-275: Ischemic Vascular Disease All or None Outcome Measure [Optimal Control]), under consideration for both the MIPS and MSSP programs, duplicates a set of individual measures (known as the "Million Hearts" measures) currently used in both programs. While addition of the composite measure was recognized as a potential redundancy, MAP members agreed that the value of a composite measure—which can drive and incentivize improvement in ways that are different from individual measures—was sufficient justification for including such a composite in addition to the individual measures for the Million Hearts campaign. MAP was informed that MUC15-275 will be reviewed for NQF endorsement in an upcoming project on cardiovascular care, and that this review will include a side-by-side comparison with another composite measure of optimal vascular care that is already NQF-endorsed (NQF #0076). Recognizing that the NQF review will likely result in a best-in-class decision, MAP conditionally supported MUC15-275 pending the outcome of the NQF evaluation, making it clear that the group supported inclusion of the composite measure that is considered best-in-class by the NQF review. In another instance, MAP members noted that use of the PHQ-9 tool for depression screening is promoted through measurement in private programs as well as the Adult and Child Core Measure Sets for Medicaid. Fostering alignment across these programs was part of MAP's rationale for supporting a similar measure for MIPS and MSSP.

Under the MACRA legislation, clinicians may be exempted from participation in the MIPS program if they participate in an Alternative Payment Model (APM). Examples of APMs may include Accountable Care Organizations (ACOs), patient-centered medical homes (PCMHs), shared savings programs, and bundled payment models. Like the MIPS program, APMs will also involve measurement-based payment, and MAP agreed that it will be important for CMS to pursue alignment of quality measures across the MIPS program and APMs.

Public Reporting of Clinician Measures on Physician Compare

CMS has continued to ramp up public reporting of clinician quality information. Public reporting of eligible professionals' performance on PQRS measures through the Physician Compare website has been phased in over time, with all 2015 PQRS data becoming eligible for public reporting in December of 2016. CMS intends to continue public reporting of performance results through the Physician Compare website based on measures in the MIPS program; all measures that are included in MIPS may be reported on Physician Compare. However, measure results may be reported in one of two ways: through a clinician webpage for measures that are particularly meaningful to consumers, or through a downloadable spreadsheet intended for more technical or specialized audiences.

For the 2015-2016 pre-rulemaking cycle, CMS asked MAP to provide input on which measures would be most suitable for public reporting on the clinician webpages of the Physician Compare site. In general, NQF-endorsed measures are preferred for public reporting, as are measures focused on outcomes (especially patient-reported outcomes), care coordination, population health, and appropriate care. The

MAP Clinician Workgroup's Guiding Principles identify considerations specifically for selecting measures that are meaningful to consumers and purchasers. Applying these principles, MAP gave input on which measures would be most useful to consumers and purchasers on the Physician Compare clinician webpages, in addition to recommending measures for the MIPS program.

Measure Gaps Remain

During both measure-specific deliberations and overarching discussions, MAP continued to highlight measure gaps across clinician-level programs. In particular, MAP members noted the need for patient-centered measures, including patient-reported outcome measures, functional status measures, care coordination measures, and measures that incorporate patient values and preferences. MAP noted that the principle of patient preference could apply not only to new measures, but also to existing measures, which could potentially be modified to include outcomes or processes that reflect patient preferences and shared decisionmaking. Measures concerning end-of-life care, for example, would lend themselves especially well to such considerations. With regard to patient-reported measures, MAP noted that such measures should go beyond patients' experiences with the healthcare system and focus on the impact of healthcare on patients' health and well-being—it was noted that measures sometimes focus on clinical success as defined by providers, while potentially losing sight of what patients regard as success.

MAP expressed appreciation for the increase in measures of appropriate use or overuse that have been submitted for consideration, while

recognizing that this remains a gap area and a priority for development. Many suggested looking to the Choosing Wisely campaign for direction in this area. MAP members also noted that overuse measures should be paired with measures of quality and of the total cost of care so that consumers and purchasers can better understand the value they are getting for their money.

The importance of developing measures of team-based care was also a recurring theme. MAP members suggested that the healthcare system needs to do better at identifying patients who are in need of care, defining what good care looks like for them, and leveraging both team-based approaches and the overall resources of the health system to provide that care.

Sociodemographic Status Adjustment

MAP suggested that the impact of patients' sociodemographic status (SDS) on measure results should continue to be explored and expressed support for NQF's two-year trial period examining the impact of SDS adjustment. MAP members noted that taking account of whether providers are caring for high-risk populations is important to providers—from both a clinical and a sociodemographic standpoint. It is important for providers who want to ensure a level playing field for performance measurement, and it also is important to patients who want to know which providers are taking good care of high-risk populations. MAP observed that these considerations may become increasingly important in the context of patient-reported outcomes.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

Merit-based Incentive Payment System (MIPS)

CMS has identified key **program needs and priorities** for the MIPS program, including outcome measures, measures relevant to specialty providers, domains of person and caregiver experience and outcomes, communication and care coordination, and appropriate use and resource use. CMS also noted a preference for electronic clinical quality measures (eCQMs or eMeasures), measures that do not duplicate existing clinician measures, and measures with an opportunity for improvement, i.e., those that are not “topped out.” The measures under consideration addressed these CMS needs and priorities.

MEASURES UNDER CONSIDERATION FOR USE IN FEDERAL PROGRAMS, 2015-2016

Measure Descriptor	Number of Measures
Outcome measures	24
Patient-reported outcome measures	2
Fully developed measures	5
NQF-endorsed measures	2
eCQMs/eMeasures	2
Measures relevant for specialty providers	52
Identified opportunity for improvement	11

MAP has also identified priorities for clinician measures, including outcomes and PROs, composite measures, cost and resource use measures, appropriate use measures, care coordination measures, and patient safety measures. Although many of the measures under consideration address key program needs identified by MAP, measure gaps in priority areas remain. Currently, outcome measures represent

approximately 25 percent of the measures available for reporting under the PQRS program. While the proportion of outcome measures under consideration for the 2015-2016 pre-rulemaking cycle has increased (roughly 37 percent of proposed measures are outcomes), the large majority of measures available for clinician quality programs remain process measures.

Specificity Versus Generalizability in Measurement

Many of the measures under consideration for the MIPS program narrowly focus on specific procedures or conditions, and apply only to particular specialty or subspecialty providers. MAP discussed the relative benefits and drawbacks of a large array of specialized measures compared to a smaller set of generalizable measures that can be applied across a wide range of conditions and providers.

MAP members agreed that having a limited set of broadly applicable measures is an important goal for federal programs, because such a measure set should help to ensure alignment, reduce measurement burden for providers, and increase the comparability of performance across contexts (e.g., different providers and settings). However, MAP members acknowledged that the practices of some physicians (e.g., ophthalmologists, oncologists) can be very highly specialized, and that correspondingly specialized measures are needed to evaluate the quality of care appropriately. This tension was highlighted, for example, during discussion of a measure of biopsy reporting time for non-melanoma skin cancer. MAP members questioned why the measure was limited only to non-melanoma skin cancer, noting that patients should expect a timely report on the results of any biopsy or critical laboratory test.

MAP members also recognized that consumers of healthcare can benefit from both highly specific and more general measures. While measures of broader aspects of care may help patients select their primary care physicians or other clinicians they will be seeing for routine care, more granular measures of performance for specific procedures or treatment of specific conditions may help patients select providers when they need more specialized services. MAP recognizes a need for balance on this issue, while noting that the goals of parsimony and alignment should be pursued unless there is a compelling reason for multiple similar or narrowly focused measures.

Opportunity for Improvement

MAP agreed that an important consideration in recommending measures for use in federal programs is whether there is an opportunity for improvement—i.e., variation in performance or overall low performance—warranting measurement in a given area. It was noted that, particularly for measures still under development, MAP had very limited information on gaps in care or performance in general. This made it challenging for MAP members to make truly informed decisions on the appropriateness of some measures for use in accountability programs such as MIPS.

Notable Measure Discussions

MAP held extensive discussion on measure MUC15-1019, Non-Recommended PSA-Based Screening, which is intended to reduce the use of prostate-specific antigen (PSA)-based screening for prostate cancer. A 2012 recommendation from the United States Preventive Services Task Force (USPSTF) discouraged the use of PSA screening due to a lack of evidence supporting its benefits, giving the service a **grade D recommendation**. The urology community has heavily criticized the USPSTF recommendation, and more than 33 public comments to MAP on this measure strongly opposed its adoption as part of the MIPS program, citing concern about the measure's

potential to inhibit shared decisionmaking by dissuading providers from informing patients of PSA screening as an option.

MAP noted that overtreatment in this area is a legitimate concern and that measurement could address more narrow aspects of screening or treatment specifically until the controversy over general PSA screening has been resolved and an evidence-based standard of care is established.

Two composite measures under consideration, MUC15-577 and MUC15-576 (PQI 91: Prevention Quality Acute Composite and PQI 92: Prevention Quality Chronic Composite, respectively) were also the subjects of MAP discussion. PQI 91, the acute composite, measures the number of people per 100,000 who are admitted to the hospital for selected acute conditions, including dehydration, bacterial pneumonia, and urinary tract infection. PQI 92, the chronic composite, measures the number of people per 100,000 who are admitted to the hospital for selected chronic conditions, including diabetes with short- or long-term complications, chronic obstructive pulmonary disease, asthma, and heart failure. Both composite measures are intended to encourage care coordination and efficient use of healthcare services. MAP members discussed the limitations and potential unintended consequences of these measures, noting, for example, that the acute composite's measurement of hospital admissions for urinary tract infections could result in providers misusing or overusing antibiotics to achieve higher performance on the measure. With regard to the chronic composite measure, MAP members suggested that sociodemographic factors may have a significant impact on outcomes addressed by this measure, and that adjustment for these factors should be considered.

MAP also noted that these measures were designed to be applied at a population level, and discussed whether use of the measures at the clinician level would be appropriate, given the much smaller number of patients treated by individual clinicians or practice groups.

Medicare Shared Savings Program (MSSP)

MAP considered five measures for addition to the Medicare Shared Savings Program (MSSP); discussion centered on several composite measures proposed for use in MSSP. Each of these measures (Ischemic Vascular Disease All or None Outcome Measure (Optimal Control), PQI 91: Prevention Quality Acute Composite and PQI 92: Prevention Quality Chronic Composite) was proposed for use in both the MIPS program and the MSSP, and MAP addressed similar issues across both programs.

As noted above, discussion of the IVD Optimal Control composite focused on concerns around alignment and duplication of measures.

Discussion of the acute and chronic population health composites mirrored the discussion of these measures for the MIPS program, with similar concerns raised about incentives for overuse of antibiotics and the potential need for sociodemographic status adjustment. While MSSP applies to Accountable Care Organizations (ACOs), which may serve larger patient populations than individual clinicians or group practices, MAP members suggested that there are similar concerns about population-level measures being applied at the ACO level.

Alignment of measures both within MSSP and between MSSP and other programs was also recognized by MAP as a remaining need.

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 May 2015.

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 (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 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 two 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) and (2) two-sided risk model (sharing of savings and losses for all three years).

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,
- 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 PQRS. Quality measure data for the Shared Savings Program are collected via claims and administrative data, CG-CAHPS, and the PQRS GPRO 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 PQRS and the VM;
4. Measures that support improved individual and population health.

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 in 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

In the CY 2016 PFS Rule, 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 to specifically 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

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.

- 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.”

Physician Compare

Program History and Structure

Section 10331 of the 2010 Patient Protection & Affordable Care Act (ACA) requires CMS to establish the Physician Compare website to publicly report physician performance data. The goal of the Physician Compare website is to provide reliable information for consumers to encourage informed healthcare decisions and to create explicit incentives for physicians to maximize performance. To meet the statutory mandate, CMS repurposed the Medicare.gov Healthcare Provider Directory into Physician Compare. On December 30, 2010, CMS officially launched the Physician Compare website using the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) as its underlying data source. Based on stakeholder feedback and understanding the Affordable Care Act (ACA) requirements for the site, CMS redesigned Physician Compare in June 2013. Since that time, CMS has been working continually to enhance the site and its functionality, improve the information available, and include more and increasingly

useful information about the physicians and other healthcare professionals.

The 2012 Physician Fee Schedule final rule indicated that the first measures available for public reporting on Physician Compare would be a subset of the 2012 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) measures collected via the Web Interface. CMS publicly reported this first set of measure data in February 2014 for the 66 group practices and 141 ACOs. In December 2014, the next phase of public reporting was accomplished with the posting of a subset of the 2013 PQRS GPRO Diabetes Mellitus (DM) and Coronary Artery Disease (CAD) measures collected via the Web Interface for 139 group practices and 214 Shared Savings Program and 23 Pioneer ACOs. In addition, CAHPS for ACO summary survey measures were added to Physician Compare. The following quality measures were publicly reported in December 2014:

2013 PQRS GPRO and ACO measures

- A subset of three DM and one CAD Web Interface measures
 - Diabetes: High Blood Pressure Control
 - Diabetes: Hemoglobin A1c Control (<8%)
 - Diabetes: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease
 - Coronary Artery Disease (CAD): ACE-I/ARB Therapy - Diabetes or LVSD

2013 CAHPS for ACOs measures

- Four CAHPS for ACOs summary survey measures
 - Getting Timely Care, Appointments, and Information
 - How Well Providers Communicate
 - Patient's Rating of Provider
 - Health Promotion & Education

For 2014 data, all PQRS GPRO measures collected via the Web Interface, as well as a subset of measures reported via registry and EHR are available for public reporting on Physician Compare. All measures reported by the Shared Savings Program and Pioneer ACOs are also available for public reporting. CMS will continue to publicly report 2014 CAHPS for ACOs and will publish the first set of CAHPS for PQRS measures for groups of 100 or more Eligible Professionals (EPs) who participate in PQRS GPRO and for group practices of 25-99 EPs reporting via a certified CAHPS vendor. In addition, 20 individual measures reported by EPs under the 2014 PQRS via claims, EHR, or registry are available for public reporting. All 2014 data are targeted for publication in late 2015.

For 2015 data, at the group practice level, all 2015 PQRS GPRO measures reported via the Web Interface, registry, or EHR are available for public reporting. In addition, the 12 summary survey 2015

CAHPS for PQRS and CAHPS for ACO measures are available for public reporting for group practices of two or more EPs and ACOs reporting via a CMS-approved certified survey vendor. At the individual EP level, all 2015 PQRS measures reported via registry, EHR, or claims are available for public reporting. In addition, individual EP-level 2015 Qualified Clinical Data Registry (QCDR) measures, which include PQRS and non-PQRS data, will be available for public reporting on Physician Compare in late 2016.

Current Program Measure Information

Table A1 below provides the number of quality measures under each domain of measurement from the National Quality Strategy (NQS) priorities that were finalized in the 2012, 2013, 2014 and 2015 PFS final rules as available for public reporting. Only those measures that are comparable, valid, reliable, and suitable for public reporting will be publicly reported on Physician Compare (see “Measure Requirements” below).

TABLE A1. NUMBER OF QUALITY MEASURES FINALIZED FOR POTENTIAL PUBLIC REPORTING ON PHYSICIAN COMPARE BY THE 2012, 2013, 2014, AND 2015 PFS FINAL RULES

NQS Priority Domains	2012 PFS Final Rule		2013 PFS Final Rule		2014 PFS Final Rule			2015 PFS Final Rule		
	Groups	ACOs	Groups	ACOs	EPs	Groups	ACOs	EPs	Groups	ACOs
Effective Clinical Care	27	20	20	20	13	14	14	110	138	8
Patient Safety	1	1	1	1	2	2	2	26	34	2
Communication/Care Coordination	1	1	1	1	0	0	29	37	0	
Community/Population Health	0	0	0	0	5	5	5	14	15	5
Efficiency and Cost Reduction	0	0	0	0	0	0	0	15	16	0
Person- and Caregiver-Centered Experience and Outcomes	0	0	25	35	0	12	12	12	14	12
Effective Clinical Care	27	20	20	20	13	14	14	110	138	8

High Priority Domains for Future Measure Consideration

As public reporting expands, it is critical to include consumer friendly measures. This means that measure development needs to focus on creating measures that look at the types of information consumers need to know to make informed healthcare decisions. PQRS was originally a pay-for-reporting program without explicit intent to publicly report quality measures. However, starting with 2015 data, all PQRS measures are available for public reporting on Physician Compare. Based on this expansion of public reporting and the changing use of PQRS measures, it is critical to consider public reporting and the consumer perspective during measure development. CMS identified the key areas to consider when developing consumer friendly measures.

- Outcome measures
- Composite measures
- Risk-adjusted measures

Consumer testing has also shown that users prefer outcome measures over process measures. In order for quality measures to be meaningful to consumers, they must resonate with consumers. Consumers want to understand if patients like them have better outcomes or if a procedure was successful. This is the information that will help them make informed decisions.

Composite measures can help consumers accurately interpret measures in a way that is meaningful to them while also removing the burden of interpretation from them. Composite measures help make data more digestible. It is much easier for a consumer to understand that a doctor is good at diabetes care, for instance, than it is to understand why it is important for a doctor to perform well across a series of technical measures about glucose levels and treatment best practices. Similarly, risk adjustment can ensure that consumers are more accurately comparing healthcare professionals and group practices.

Consumers can provide valuable feedback when engaged early in the measure development process. They can determine if measures are understandable and useful in decisionmaking. Not all measures are intended for public reporting. However, the continued growth of public reporting makes the consumer perspective increasingly important. Moving towards more consumer friendly measures, specifically outcome measures, composite measures, and risk-adjusted measures, will be instrumental in achieving Physician Compare's goal, as defined by the Affordable Care Act, of providing consumers useful quality data to inform healthcare decisions.

Measure Requirements

Although CMS has finalized the quality measures listed in Table A1 for public reporting, not all of these quality measures may ultimately be suitable for public reporting. Only comparable, valid, reliable, and accurate data will be publicly reported. For example, the performance results for certain measures may not be statistically reliable if the total number of patients reported on is low. Hence, to select a subset of quality measures finalized for public reporting, CMS will need to analyze the actual measure performance results collected for each program year. At minimum, any quality measures selected for public reporting must meet the following criteria:

- As statutorily mandated, quality measures must be statistically valid and reliable, and risk adjustment should be considered for outcome measures as appropriate.
- They must be readily comprehensible to users so that users can leverage the performance information to inform their healthcare decisions.
- They should enable users to make meaningful and valid comparisons of performance results across healthcare professionals and group practices by having the following properties:

- There should be sufficient variation in the performance rates, since comparisons would be difficult if the majority of providers are clustered at one or two performance rates.
- There should be room for improvement in the measure performance.
- There should be a sufficient number of cases in the measure denominator, since performance rates that are based only on a handful of cases may result in unreliable rates and make statistically valid comparisons difficult.

- There should be a sufficient number of healthcare professionals or group practices in each peer group comparison.

In addition, CMS will not publish any measures that are in their first year and only those measures that prove to resonate with consumers and are deemed to be relevant to consumers will be included on the profile pages of the website. All other comparable, valid, reliable, and accurate measures would be included in a publicly available downloadable database, similar to the databases currently available on <http://data.medicare.gov>.

APPENDIX B: MAP Clinician Workgroup Roster and NQF Staff

COMMITTEE CHAIRS (VOTING)

Bruce Bagley, MD (Chair)

Eric Whitacre, MD, FACS (Vice-Chair)

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 Orlowski, 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 Averbek, 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

INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

Luther T. Clark, MD

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

FEDERAL GOVERNMENT LIAISONS (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

NATIONAL QUALITY FORUM STAFF

Helen Burstin, MD, MPH

Chief Scientific Officer

Marcia Wilson, PhD, MBA

Senior Vice Present, Quality Measurement

Elisa Munthali, MPH

Vice President, Quality Measurement

Reva Winkler

Senior Director

Andrew Lyzenga

Senior Director

Poonam Bal

Project Manager

Severa Chavez

Project Analyst

NATIONAL QUALITY FORUM
1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005

www.qualityforum.org