NATIONAL QUALITY FORUM

Welcome to Today's Virtual Review!

- **Housekeeping reminders:**
  - Please mute your computer or line when you are not speaking
  - Please ensure your name is displayed correctly (right click on your picture and select "Rename" to edit)
  - We encourage you to turn on your video, especially during the measure discussions and when speaking
  - To switch your display, right click "View" in the upper-right hand corner and select "Speaker" or "Gallery."
  - Please use the 'hand raised' feature if you wish to provide a point or raise a question.
    - »*To raise your hand, click on the "participants" icon on the bottom of your screen. At the bottom of the list of participants you will see a button that says, 'Raise Hand'*
  - Feel free to use the chat feature to communicate with the NQF Host or IT Support
  - For this meeting, we will be using Zoom for presentations and discussion, and will use Poll Everywhere for voting. Please ensure you have access to both platforms.

If you are experiencing technical issues, please contact us at
MAPClinician@qualityforum.org

Measure Application Partnership (MAP)

Clinician Workgroup Virtual Review Meeting

January 12, 2021

Welcome, Introductions, Disclosure of Interest, and Review of Meeting Objectives

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Agenda

- Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives
- CMS Opening Remarks
- Overview of Pre-Rulemaking Approach
- Merit-Based Incentive Payment System (MIPS) Measures
- Medicare Shared Savings Program (SSP) Measures
- Opportunity for Public Comment
- Summary of Day and Next Steps
- Adjourn

Clinician Workgroup Membership

Workgroup Co-Chairs: Rob Fields, MD; Diane Padden, PhD, CRNP, FAANP

Organizational Members (Voting)

- American Academy of Family Physicians
- American College of Cardiology
- American College of Radiology
- American Occupational Therapy Association
- Atrium Health
- Blue Cross Blue Shield of Massachusetts
- Consumers' Checkbook
- Council of Medical Specialty Societies
- Genentech
- HealthPartners, Inc.
- Kaiser Permanente
- Louise Batz Patient Safety Foundation
- Magellan Health, Inc.
- OCHIN, Inc.
- Pacific Business Group on Health
- Patient Safety Action Network
- Pharmacy Quality Alliance
- St. Louis Area Business Health Coalition

Individual Subject Matter Experts (Voting)

- Amy Nguyen Howell, MD, MBA
- Nishant Anand, MD
- Stephanie Fry
- William Fleischman, MD, MHS

Federal Government Liaisons (Nonvoting)

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Health Resources and Service Administration (HRSA)

Workgroup Staff

- **Samuel Stolpe, PharmD, MPH,** Senior Director
- **Katie Berryman, MPAP,** Project Manager
- **Chris Dawson, MHA,** Manager
- **Carolee Lantigua, MPA,** Manager
- **Michael Haynie**, Managing Director

CMS Opening Remarks

CMS Quality Action Plan

Draft – Do Not Distribute

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Disclaimer

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations.

This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulation.

We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

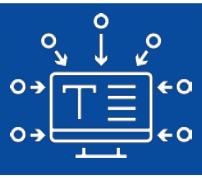
Our Vision

Use impactful quality measures to improve health outcomes and deliver value by empowering patients to make informed care decisions while reducing burden to clinicians.

Goals of the CMS Quality Action Plan

Use Meaningful Measures to Streamline Quality Measurement

Leverage Measures to Drive Value and Outcome Improvement



Improve Quality Measures Efficiency by a Transition to Digital Measures and Use of Advanced Data Analytics

Empower Patients to Make Best Healthcare Choices Through Person-Centered Quality Measures and Public Transparency

Meaningful Measures 1.0

Promote Effective Communication & Coordination of Care

Meaningful Measure Areas:

- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease

Meaningful Measure Areas:

- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Work with Communities to Promote Best Practices of Healthy Living

Meaningful Measure Areas:

- Equity of Care
- Community Engagement

Make Care Affordable

Meaningful Measure Areas:

- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

Make Care Safer by Reducing Harm Caused in the Delivery of Care

Meaningful Measure Areas:

- Healthcare-associated Infections
- Preventable Healthcare Harm

Strengthen Person & Family Engagement as Partners in their Care

Meaningful Measure Areas:

- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Functional Outcomes

Meaningful Measures 1.0 Accomplishments

- Since its inception in 2017, the Meaningful Measures Framework 1.0 has been utilized to review, reduce, and align measures.
- Meaningful Measures 1.0 highlighted 6 strategic domains and 17 strategic focus areas.
- This has resulted in a 15% reduction of the overall number of measures in the CMS Medicare FFS programs (from 534 to 460 measures).
- Overall, the measures portfolio has demonstrated a 25% increase in percentage of outcome measures; the percentage of process measures has dropped from 52% in 2017 to 37% in 2021.
- Streamlining measures has a projected savings of an estimated $128M and a reduction of 3.3M burden hours through 2020.*

*Seema Verma's Speech at the 2020 CMS Quality Conference: https://www.cms.gov/newsroom/press-releases/speech-remarks-cms-administrator-seema-verma-2020-cms-quality-conference

Meaningful Measures 2.0

Goals of MM 2.0
Utilize only quality measures of highest value and impact focused on key quality domains
Align measures across value-based programs and across partners, including CMS, federal, and private entities
Prioritize outcome and patient reported measures
Transform measures to fully digital by 2025, and incorporate all-payer data
Develop and implement measures that reflect social and economic determinants

Use Meaningful Measures to Streamline Quality Measurement

Objective

Align measures across CMS, federal programs, and private payers

Reduce number and burden of measures

- Leverage Meaningful Measures 2.0 framework to reduce burden and align measures across the Agency and federal government
- Develop (as needed), prioritize, and utilize measures for high priority targeted areas, such as socioeconomic status, maternal mortality, and kidney care
- Align quality measures to quality improvement activities
- Increase the proportion of outcome measures by 50% by 2022
- Continue work of the Core Quality Measures Collaborative to align measures across all payers

Leverage Measures to Drive Value and Outcome Improvement

Objective
Accelerate ongoing efforts to streamline and modernize value-based programs, reducing burden and promoting strategically important focus areas

- Introduce 5-10 MIPS Value Pathways (MVPs)
- Continue to examine programs across CMS for modernization and alignment, as appropriate
- Provide additional confidential feedback reports on measure performance
- Incorporate robust quality measurement into all value-based payment models

Improve Quality Measures Efficiency by a Transition to Digital Measures and Use of Advanced Data Analytics

Objective

Use data and information as essential aspects of a healthy, robust healthcare infrastructure to allow for payment and management of accountable, value-based care and development of learning health organizations

- Transform to all digital quality measures by 2025
- Accelerate development and testing eCQMs using FHIR API technology for transmitting and receiving quality measurement
- Transform data collection to use FHIR API technology and all CMS data (all-payer data)
- Accelerate expanded and timely performance feedback reports
- Leverage centralized data analytic tools to examine programs and measures, and develop capacity for using all CMS (or all-payer) data
- Evaluate new technologies of AI and machine learning to innovate new concepts in quality measures

Empower Patients to Make Best Healthcare Choices through Patient-Directed Quality Measures and Public Transparency

Objective
Empower patients through transparency of data and public reporting, so that patients can make the best-informed decisions about their healthcare

- Expand and prioritize patient and caregiver engagement during the measure development process
- Increase Patient Reported Outcome Measures (PROMs) by 50%
- Continue to modernize Compare Sites
- Advance use of FHIR API to allow patients to receive their health information electronically
- Expand the availability of public use files for CMS data by 2021
- Leverage quality measures to identify health disparities

Leverage Quality Measures to Highlight Disparities and Close Performance Gaps

Objective
Commit to a patient-centered approach in quality measure and value-based incentives programs to ensure that quality and safety measures address healthcare equity

- Expand confidential feedback reports stratified by dual eligibility in all CMS value-based incentive programs as appropriate by the end of 2021.
- Introduce plans to close equity gaps through leveraging the pay-for-performance incentive programs by 2022.
- Ensure equity by supporting development of Socioeconomic Status (SES) measures and stratifying measures and programs by SES or dual eligibility as appropriate. Partner with OMH regarding HESS measures (health equity).

Expanding the CMS Disparity Methods to Include Stratified Reporting Using Indirect Estimation of Race and Ethnicity

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Health Equity: Stratified Reporting

The National Academy of Medicine[1] and Assistant Secretary for Planning and Evaluation[2] have recommended stratified reporting of health care quality measures by social factors

CMS confidentially reports stratified results for 6 condition hospital readmission measures using dual eligibility

Limitations in the accuracy[3] of demographic information in CMS data has hindered stratification by race and ethnicity:

	White	Black	Hispanic	API	AI/AN
Sensitivity	97.1	93.8	30.1	56.7	17.6
Specificity	91.5	99.7	99.9	99.9	99.9

1- The National Academies of Science, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment. Washington DC: The National Academies Press; 2017
2- Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. 2016
3- Zaslavsky AM, Ayanian JZ, Zaborski LB. The validity of race and ethnicity in enrollment data for Medicare beneficiaries.. Health Serv Res. 2012 Jun;47(3 Pt 2):1300-21. doi: 10.1111/j.1475-6773.2012.01411.x. Epub 2012 Apr 19.

Health Equity: Indirect Estimation

CMS is considering confidential, hospital-level, stratified reporting by race and ethnicity using *indirect estimation*

> Statistical method for inferring race and ethnicity from names and census data when directly reported information is missing or incorrect

National Quality Forum[4] and Institute Of Medicine[5] have supported indirect estimation for population-based equity measurement when self-reported data are not available

Validation testing suggests high correlation with self-report among White, Black, Hispanic and API patients[6]:

	White	Black	Hispanic	API	AI/AN
Correlation	90.2	94.6	87.6	91.6	53.8

4- NQF. 2008. National voluntary consensus standards for ambulatory care—measuring healthcare disparities. Washington, DC: National Quality Forum.
5- IOM. 2009. Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Washington, DC: The National Academies Press.
6- Haas A, Elliott MN, Dembosky JW, et al. Imputation of race/ethnicity to enable measurement of HEDIS performance by race/ethnicity. Health Serv Res. 2019;54(1):13-23.

Health Equity: Indirect Estimation

Systematic initiatives to improve data collection across the health care system are often lengthy and resource-intensive

Use of indirect estimation of race and ethnicity has potential to support more timely reporting and quality improvement

Medicare Bayesian Improved Surname Geocoding developed by RAND is currently in use for reporting contract-level Part C & D performance data (HEDIS) stratified by race and ethnicity[7]

No previous use in risk-adjusted quality outcome measures

National confidential reporting and stakeholder engagement would be necessary to monitor usage and acceptability

7- https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting

Break

Overview of Pre-Rulemaking Approach

Preliminary Analyses

Preliminary Analysis of Measures Under Considerations

- The preliminary analysis is intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions.
- Staff use an algorithm developed from the MAP Measure Selection Criteria to evaluate each measure in light of MAP's previous guidance.
  - This algorithm was approved by the MAP Coordinating Committee.

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MAP Preliminary Analysis Algorithm

Assessment	Definition	Outcome
1)The measure addresses a critical quality objective not adequately addressed by the measures in the program set.	• The measure addresses key healthcare improvement priorities such as CMS's Meaningful Measures Framework; or • The measure is responsive to specific program goals and statutory or regulatory requirements; or • The measure can distinguish differences in quality, is meaningful to patients/consumers and providers, and/or addresses a high-impact area or health condition.	Yes: Review can continue. No: Measure will receive a Do Not Support. MAP may provide a rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.
2) The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.	• For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented can lead to the desired outcome(s). • For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is influenced by healthcare processes or structures.	Yes: Review can continue No: Measure will receive a Do Not Support MAP may provide a rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.
3) The measure addresses a quality challenge.	• The measure addresses a topic with a performance gap or addresses a serious reportable event (i.e., a safety event that should never happen); or • The measure addresses unwarranted or significant variation in care that is evidence of a quality challenge.	Yes: Review can continue No: Measure will receive a Do Not Support. MAP may provide a rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.

MAP Preliminary Analysis Algorithm

Assessment	Definition	Outcome
4) The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.	• The measure is either not duplicative of an existing measure or measure under consideration in the program or is a superior measure to an existing measure in the program; or • The measure captures a broad population; or • The measure contributes to alignment between measures in a particular program set (e.g., the measure could be used across programs or is included in a MAP "family of measures"); or • The value to patients/consumers outweighs any burden of implementation.	Yes: Review can continue No: Highest rating can be Do Not Support with potential for mitigation. MAP may provide a rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.
5) The measure can be feasibly reported.	• The measure can be operationalized (e.g., the measure is fully specified, specifications use data are found in structured data fields, and data are captured before, during, or after the course of care).	Yes: Review can continue No: Highest rating can be Do Not Support with potential for mitigation. MAP may provide a rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.

MAP Preliminary Analysis Algorithm

Assessment	Definition	Outcome
6) The measure is applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s).	• The measure is NQF-endorsed; or • The measure is fully developed, and full specifications are provided; and • Measure testing has demonstrated reliability and validity for the level of analysis, program, and/or setting(s) for which it is being considered.	Yes: Measure could be supported or conditionally supported. No: Highest rating can be Conditional support MAP may provide a rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.
7) If a measure is in current use, no negative unintended issues to the patient have been identified.	• Feedback from implementers or end users has not identified any negative unintended consequences to patients (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and • Feedback is supported by empirical evidence.	If no implementation issues have been identified: Measure can be supported or conditionally supported. If implementation issues are identified: The highest rating can be Conditional Support. MAP can also choose to not support the measure, with or without the potential for mitigation. MAP may provide a rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.

MAP Voting Decision Categories

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MAP Decision Categories 2020-2021

Decision Category	Definition	Evaluation Criteria
Support for Rulemaking	MAP supports implementation with the measure as specified.	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP Preliminary Analysis Algorithm. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	MAP supports implementation of the measure as specified but has identified certain conditions or modifications that would ideally be addressed prior to implementation.	The measure meets assessments 1-3, but may need modifications. A designation of this decision category assumes at least one assessment 4-7 is not met. Ideally, the modifications suggested by MAP would be made before the measure is proposed for use.
Do Not Support for Rulemaking with Potential for Mitigation	MAP does not support implementation of the measure as specified. MAP agrees with the importance of the measure and has suggested material changes to the measure specifications.	The measure meets assessments 1-3 but cannot be supported as currently specified. A designation of this decision category assumes at least one assessment 4-7 is not met.
Do Not Support for Rulemaking	MAP does not support the measure.	The measure under consideration does not meet one or more of assessments 1-3.

MAP Voting Process

Key Voting Principles

- Quorum is defined as 66 percent of the voting members of the Committee present in person or by phone for the meeting to commence.
  - Quorum must be established prior to voting. The process to establish quorum has two steps: 1) taking roll call and 2) determining if a quorum is present. At this time, only if a member of the Committee questions the presence of a quorum is it necessary to reassess the presence of the quorum.
  - If quorum is not established during the meeting, MAP will vote via electronic ballot after the meeting.
- MAP has established a consensus threshold of greater than or equal to 60 percent of voting participants voting positively AND a minimum of 60 percent of the quorum figure voting positively.
  - Abstentions do not count in the denominator.
- Every measure under consideration will receive a decision.

Workgroup Voting Procedure

- **Step 1.** Staff will review the preliminary analysis for each MUC using the MAP selection criteria and programmatic objectives.
  - Co-chairs may choose to present methodologically or clinically similar measures as a group in the interest of time or to prevent redundant conversations.
  - Workgroup members can request any item to be removed from the group and discussed individually.
- **Step 2.** The co-chairs will ask for clarifying questions or concerns from the workgroup. The chairs will compile all workgroup questions and concerns.
  - Measure developers will respond to the clarifying questions and concerns on the specifications of the measure.
  - NQF staff will respond to clarifying questions and concerns on the preliminary analysis.
- **Step 3.** Voting on acceptance of the preliminary analysis decision.
  - After clarifying questions and concerns have been resolved, the co-chair will open for a vote on accepting the preliminary analysis assessment. This vote will be framed as a yes or no vote to accept the result.
  - If greater than or equal to 60 percent of the workgroup members vote to accept the preliminary analysis assessment, then the preliminary analysis assessment will become the workgroup recommendation. If less than 60 percent of the workgroup votes to accept the preliminary analysis assessment, discussion will open on the measure.

Workgroup Voting Procedure

- **Step 4.** Discussion and Voting on the MUC
  - Lead discussants will review and present their findings.
    - Workgroup member(s) assigned as lead discussant(s) for the measure will be asked to respond to the staff preliminary assessment. 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.
  - MAP Rural Health liaisons add a summary of their workgroup's discussion.
  - The co-chair will then open for discussion among the workgroup. Other workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
  - After the discussion, the co-chair will open the MUC for a vote.
    - Co-chairs will summarize the major themes of the workgroup's discussion, supported by NQF staff.
    - The co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions. If the co-chairs do not feel there is a consensus position to use to begin voting, the workgroup will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with the potential for mitigation, then do not support.

Workgroup Voting Procedure

- **Step 5.** Tallying the Votes:
  - If a decision category put forward by the co-chairs receives greater than or equal to 60 percent of the votes, the motion will pass and the measure will receive that decision.
  - If a no decision category achieves greater than 60 percent to overturn the preliminary analysis, the preliminary analysis decision will stand. This will be marked by staff and noted for the Coordinating Committee's consideration.

MAP Rural Health Workgroup Charge

MAP Rural Health Workgroup Charge

- To provide timely input on measurement issues to other MAP Workgroups and committees and to provide rural perspectives on the selection of quality measures in MAP
- To help address priority rural health issues, including the challenge of low case-volume
- Rural liaison for Clinician Workgroup: Kimberly Rask, Alliant Health

Rural Health Workgroup Review of MUCs

- The Rural Health Workgroup will review the MUCs and provide the following feedback to the setting-specific Workgroups:
  - Relative priority/utility of MUC measures in terms of access, cost, or quality issues encountered by rural residents
  - Data collection and/or reporting challenges for rural providers
  - Methodological problems of calculating performance measures for small rural facilities
  - Potential unintended consequences of inclusion in specific programs
  - Gap areas in measurement relevant to rural residents/providers for specific programs

Rural Health Workgroup Review (cont.)

- Rural Health Workgroup feedback will be provided to the setting-specific Workgroups through the following mechanisms:
  - **Measure Preliminary Analysis**
    - » A qualitative summary of Rural Health Workgroup's discussion of the MUCs
    - » Voting results that quantify the Rural Health Workgroup's perception of suitability of the MUCs for various programs
  - Attendance of a Rural Health Workgroup liaison at each setting-specific MAP Workgroup pre-rulemaking meeting in January

Merit-Based Incentive Payment System (MIPS) Measures

Merit-Based Incentive Payment System (MIPS) Measures

- **Program Type:** Quality Payment Program
- **Incentive Structure:**
  - Pay-for-performance
  - There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight.
  - The MIPS performance categories and proposed 2020 weights:
    - Quality (45%)
    - Promoting Interoperability (25%)
    - Improvement Activities (15%)
    - Cost (15%)
    - The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.
- **Program Goals:**
  - Improve quality of patient care and outcomes for Medicare FFS.
  - Reward clinicians for innovative patient care.
  - Drive fundamental movement toward value in healthcare.

Public Comment: MIPS Measures Under Consideration

MIPS Cost Measures

CMS Presentation

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MIPS Cost Measures

MUC 20-0015: Asthma/COPD
MUC 20-0016: Colon and Rectal Resection
MUC 20-0017: Diabetes
MUC 20-0018: Melanoma Resection
MUC 20-0019: Sepsis

Measure Applications Partnership
Clinician Workgroup Meeting

January 12, 2021

Cost Measures Address Needs in MIPS

- Currently, MIPS has 20 cost measures:
  - 18 episode-based cost measures for specific procedures and acute conditions
  - 2 population-based cost measures that assess the overall cost of care
- As required by statute, CMS has developed 5 novel cost measures
  - These were selected to address measurement gaps and Meaningful Measures priorities
  - Development process has included extensive expert stakeholder input through TEP, clinician subject matter expert panels, patient and family voice, and national field testing
- These 5 new measures would allow more clinicians to be assessed by episode-based measures and support MIPS Value Pathway (MVP) development

Measure Framework Focuses on Capturing Clinician Role in Care

- Measures are constructed using the same framework as other cost measures reviewed by MAP in previous years
  - Procedure: Melanoma Resection, and Colon and Rectal Resection
  - Acute inpatient medical condition: Sepsis
- Chronic condition measures use a familiar framework
  - Shares elements from other episode-based measures and NQF #3575 TPCC
    - » Attribution requires 2 visits to identify start of clinician-patient relationship
  - Features to account for chronic condition management were developed with stakeholder input through multiple meetings over 18 month period
    - » Costs measured for at least one year to reflect ongoing nature of care and encourage care coordination
  - Tailored to capture care specific to the management of Diabetes and Asthma/COPD
    - » Stratifies patient cohort into smaller groups, includes only clinically related costs, accounts for risk factors specific to that condition

Thank You

MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost Measure

Description: The Asthma/COPD Episode-Based Cost measure evaluates a clinician or clinician group's risk-adjusted cost to Medicare for patients receiving medical care to manage asthma or COPD. The measure score is a clinician or clinician group's weighted average of risk-adjusted cost for each episode attributed to the clinician/clinician group, where each episode is weighted by the number of assigned days during the episode. This chronic measure includes services that are clinically related and under the reasonable influence of the attributed clinician/clinician group. Services are assigned during an Asthma/COPD episode, which is a portion of the overall time period of a clinician or clinician group's responsibility for managing a patient's asthma or COPD. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

LoA: Clinician: Individual and Clinician: Group/Practice

NQF Recommendation: Conditional Support for Rulemaking

Lead Discussant: Wendolyn Gozansky, Kaiser Permanente and Stephani Fry, SME

MUC20-0016: Colon and Rectal Resection Episode-Based Cost Measure

Description: The Colon and Rectal Resection Episode-Based Cost measure evaluates clinician or clinician group's risk-adjusted cost to Medicare for patients who receive colon or rectal resections for either benign or malignant indications. The measure score is a clinician or clinician group's average risk-adjusted cost for the episode group across all attributed episodes. This inpatient procedural measure includes services that are clinically related and under the reasonable influence of the attributed clinician or clinician group during the 15 days prior to the clinical event that opens or "triggers" the episode through 90 days after. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

LoA: Clinician: Individual and Clinician: Group/Practice

NQF Recommendation: Conditional Support for Rulemaking

Lead Discussant: Helen Burstin, Council of Medical Specialty Societies and Robert Krughoff, Consumer's Checkbook

MUC20-0017: Diabetes Episode-Based Cost Measure

Description: The Diabetes Episode-Based Cost Measure evaluates a clinician or clinician group's risk-adjusted cost to Medicare for patients receiving medical care to manage type 1 or type 2 diabetes. The measure score is a clinician or clinician group's weighted average of risk-adjusted cost for each episode attributed to the clinician group, where each episode is weighted by the number of assigned days during the episode. This chronic measure includes services that are clinically related and under the reasonable influence of the attributed clinician group. Services are assigned during a Diabetes episode, which is a portion of the overall time period of a clinician or clinician group's responsibility for managing a patient's diabetes. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

LoA: Clinician: Individual and Clinician: Group/Practice

NQF Recommendation: Conditional Support for Rulemaking

Lead Discussant: Joy Bland, Magellan Health, Inc. and Amy Mullins, American Academy of Family Physicians

MUC20-0018: Melanoma Resection Episode-Based Cost Measure

Description: The Melanoma Resection Episode-Based Cost measure evaluates clinician or clinician group's risk-adjusted cost to Medicare for patients who undergo an excision procedure to remove a cutaneous melanoma. The measure score is a clinician's average risk-adjusted cost for the episode group across all episodes attributed to the clinician or clinician group. This procedural measure includes services that are clinically related and under the reasonable influence of the attributed clinician during the 30 days prior to the clinical event that opens or "triggers" the episode through 90 days after. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

LoA: Clinician: Individual and Clinician: Group/Practice

NQF Recommendation: Conditional Support for Rulemaking

Lead Discussant: Donald Nichols, Genentech and Caroline Reinke, Atrium Health

MUC20-0019: Sepsis Episode-Based Cost Measure

Description: The Sepsis Episode-Based Cost measure evaluates clinician or clinician group's risk-adjusted cost to Medicare for patients who receive inpatient medical treatment for sepsis. The measure score is a clinician or clinician group's average risk-adjusted cost for the episode group across all attributed episodes. This acute inpatient medical condition measure includes services that are clinically related and under the reasonable influence of the attributed clinician's role in managing care during each episode from the clinical event that opens or "triggers" the episode through 45 days after. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure

LoA: Clinician: Individual and Clinician: Group/Practice

NQF Recommendation: Conditional Support for Rulemaking

Lead Discussant: Nishant Anand, SME and Scott Fields, OCHIN, Inc.

Lunch

MIPS Quality Measures

MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System

Description: Annual risk-standardized rate of acute, unplanned cardiovascular-related admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with heart failure (HF) or cardiomyopathy.

LoA: Clinician: Individual and Clinician: Group/Practice

NQF Recommendation: Conditional Support for Rulemaking

Lead Discussant:

- J. Chad Teeters, American College of Cardiology
- Wei Ying, Blue Cross Blue Shield of Massachusetts

MUC20-0040: Intervention for Prediabetes

Description: Percentage of patients aged 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period who were provided an intervention.

LoA: Clinician: Individual and Clinician: Group/Practice

NQF Recommendation: Do Not Support with Potential for Mitigation

Lead Discussant:

- Amy Mullins, American Academy of Family Physicians
- Karen Roth, St. Louis Area Business Health Coalition

MUC20-0042 Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure

Description: The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM PROM (a comprehensive and parsimonious set of 11 patient-reported items) to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the provider or practice. Patients identify the PCPCM PROM as meaningful and able to communicate the quality of their care to their clinicians and/or care team. The items within the PCPCM PROM are based on extensive stakeholder engagement and comprehensive reviews of the literature.

LoA: Clinician: Individual and Clinician: Group/Practice

NQF Recommendation: Conditional Support for Rulemaking

Lead Discussant: Rachel Brodie, Pacific Business Group on Health and Kathleen Stevens, Lousie Batz Patient Safety Foundation

MUC20-0043: Preventive Care and Wellness (composite)

Description: Percentage of patients who received age- and sex-appropriate preventive screenings and wellness services. This measure is a composite of seven component measures that are based on recommendations for preventive care by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), and American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE).

LoA: Clinician: Individual and Clinician: Group/Practice

NQF Recommendation: Conditional Support for Rulemaking

Lead Discussant:

- Yanling Yu, Patient Safety Action Network
- David Seidenwurm, American College of Radiology

Break

NQF Remarks on COVID-19 Measures

CMS Presentation

SARS-CoV-2 Vaccination by Clinicians

Measure Applications Partnership

Centers for Medicare & Medicaid Services
Mathematica
National Committee for Quality Assurance

January 12, 2021

SARS-CoV-2 Vaccination by Clinicians

- **Denominator: All patients aged 18 years and older seen for a visit during the measurement period.**
- **Exclusions/exceptions:**
  - Exclusion: Patient received hospice services any time during the measurement period
  - Exceptions: 1) patient contraindication, 2) patient refusal, or 3) vaccine unavailable
- **Numerator: Patients who have ever received or reported having ever received a SARS-CoV-2 vaccination dose OR who have ever received or reported having ever received a full SARS-CoV-2 vaccination course**

Measure development process

- **CMS identified concept as a priority in response to current public health crisis**
- **CMS convened an expert work group to inform development and to provide guidance on how the measure can maximize reach while minimizing the potential for harm**
- **CMS is not seeking NQF endorsement prior to submitting this measure for consideration because this measure has been developed in response to the public health emergency that requires a rapid response**

Rationale for measure development

- **CMS wants a measure in place as soon as possible after vaccine approval and publication of guidelines**
- **CMS already includes several vaccination measures in the Merit-based Incentive Payment System (MIPS); this measure is part of larger federal efforts to promote and track vaccine uptake**
- **CMS has taken into consideration how list of approved vaccines might change between now and implementation, and designed a flexible measure**

Implementation

/ How can the measure be utilized in the program?

- The earliest CMS would be able to propose this measure for implementation in MIPS would be performance year 2022
- CMS is still discussing best way to incorporate the measure into MIPS to promote patient well-being and balance clinician burden
- CMS is considering the appropriate approach for using this measure to inform future policy making; welcomes MAP feedback on the implications of measure implementation

Pathway to implementation

/ What is a reasonable pathway to implementing measures around emergent healthcare issues?

- Measure has been designed to be flexible, to mitigate potential unintended consequences of implementation and to maximize data attained from measure reporting
  - Measure assesses administration of full course of vaccine or at least one dose
  - Measure allows for patient self-report of vaccine so reporting clinician does not have to be the one administering the vaccine
  - Measure has exception for patient contraindication; this allows measure to flex as contraindications become known or specific to a given vaccine
- CMS can revise the measure in future years to be consistent with available data and evidence as it develops

MUC20-0045: CoV-2 Vaccination by Clinicians

Description: Percentage of patients aged 18 years and older seen for a visit during the measurement period who have ever received or reported having ever received a SARS-CoV-2 vaccination dose OR who have ever received or reported having ever received a full SARS-CoV-2 vaccination course.

LoA: Specifications are incomplete

NQF Recommendation: Do Not Support with Potential for Mitigation

Lead Discussant:

- Lisa Hines, Pharmacy Quality Alliance
- Trudy Mallison, American Occupational Therapy Association

MIPS Discussion

- What are the gaps in the program measure set that CMS should consider addressing (Program measure summary on next slide)?

NATIONAL QUALITY FORUM

2020 MIPS Current Measures
Divided by Meaningful Measure Area

Healthcare Priority	# of Measures
Effective Prevention and Treatment	98
Making Care Safer	22
Communication/Care Coordination	26
Best Practices of Healthy Living	0
Making Care Affordable	38
Person and Family Engagement	34
Total	**218**

Medicare Shared Savings Program (SSP) Measures

Medicare Shared Savings Program (SSP)

- **Program Type:** Mandated by section 3022 of the ACA
- **Incentive Structure:**
  - Pay-for-performance
  - Voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an Accountable Care Organization (ACO) to give coordinated, high quality care to their Medicare beneficiaries.
    - » CMS assess ACO performance annually based on quality and financial performance to determine share savings and losses
    - » ACOs reports MIPS measures on behalf of clinicians and are scored under MIPS Alternative Payment Model (APM) Scoring Standard.
    - » Eligible clinicians in Advanced APMS may qualify for the 5% APM incentive payment
- **Program Goals:**
  - Promote accountability for a patient population.
  - Coordinate items and services for Medicare FFS beneficiaries.
  - Encourage investment in high quality and efficient services.

Public Comment: SSP Measures Under Consideration

MUC20-0033 ACO-Level Days at Home for Patients with Complex, Chronic Conditions

Description: This is a measure of days at home or in community settings (that is, not in unplanned acute or emergent care settings) for patients with complex, chronic conditions in Shared Savings Program (SSP) Accountable Care Organizations (ACOs). The measure includes risk adjustment for differences in patient mix across ACOs, with an additional adjustment based on the mortality risk at each ACO.

LoA: Accountable Care Organization

NQF Recommendation: Conditional Support for Rulemaking

Lead Discussant:

- William Fleischeman, SME
- Susan Knudson, HealthPartners

SSP Discussion

- What are the gaps in the program measure set that CMS should consider addressing (Program measure set on next slides)?

SSP Program Measure Set

Type	NQF #	Measure Title	NQF Status
PRO-PM	0005	CG CAHPS: Getting Timely Care, Appointments, and Information	Endorsed
PRO-PM	0005	CG CAHPS: How Well Your Providers Communicate	Endorsed
PRO-PM	0005	CG CAHPS: Patients' Rating of Provider	Endorsed
PRO-PM	0005	CG CAHPS: Access to Specialists	Endorsed
PRO-PM	0005	CG CAHPS: Health Promotion and Education	Endorsed
PRO-PM	0005	CG CAHPS: Shared Decision Making	Endorsed
PRO-PM	0005	CG CAHPS: Stewardship of Patient Resources	Endorsed
PRO-PM	0005	CG CAHPS: Courteous and Helpful Office Staff	Endorsed
PRO-PM	0005	CG CAHPS: Care Coordination	Endorsed
PRO-PM	0006	HP CAHPS: Health Status/Functional Status	Endorsed
Outcome	Based on 1789	Risk-Standardized, All Condition Readmission	Not Endorsed
Outcome	2888	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Endorsed

NATIONAL QUALITY FORUM

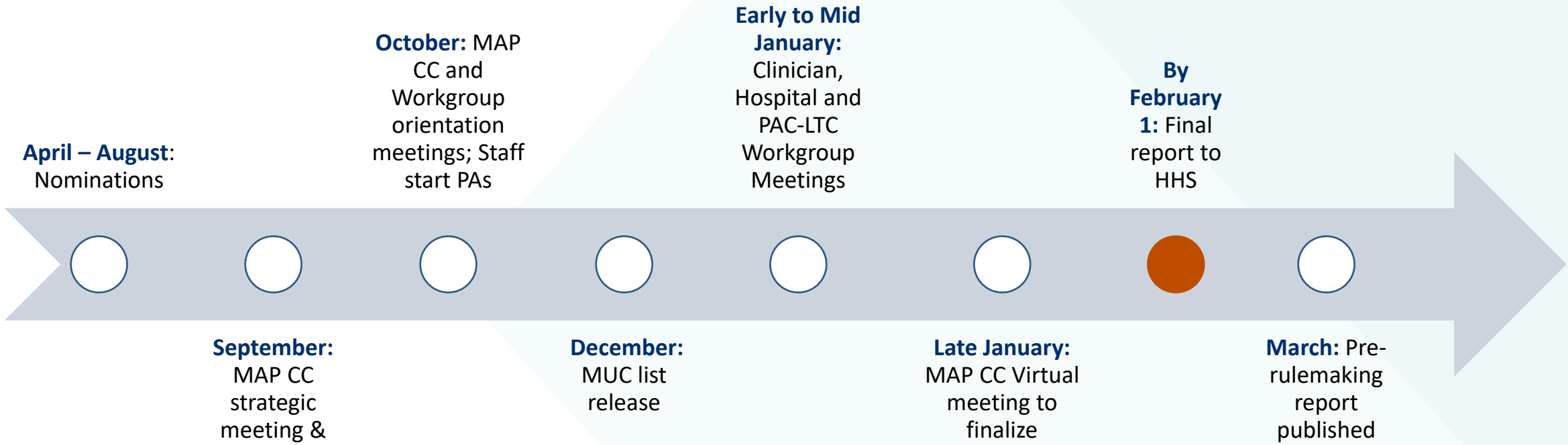
SSP Program Measure Set

Type	NQF #	Measure Title	NQF Status
Outcome	N/A	Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91)	Not Endorsed
Process	0101	Falls: Screening for Future Falls	Endorsed
Process	0041	Preventive Care and Screening: Influenza Immunization	Endorsed
Process	0028	Tobacco Use: Screening and Cessation Intervention	Endorsed
Process	0418	Screening for Depression and Follow-up Plan	Endorsed
Process	0034	Colorectal Cancer Screening	Endorsed
Process	2372	Breast Cancer Screening	Endorsed
Process	N/A	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Not Endorsed
Process	0710	Depression Remission at Twelve Months	Endorsed
Interm. Outcome	0059	Diabetes Hemoglobin A1c (HbA1c) Poor Control (>9%)	Endorsed
Outcome	0018	Hypertension : Controlling High Blood Pressure	Endorsed

Opportunity for Public Comment

Summary of Day and Next Steps

MAP Pre-Rulemaking Approach



Timeline of Upcoming Activities

- **Public commenting period on Workgroup recommendations:** January 15 – January 20, 2021
- **Coordinating Committee Virtual Review Meeting:** January 25, 2021
- **Final recommendations to CMS:** by February 1, 2021

Contact Information

- Project page
  - http://www.qualityforum.org/MAP_Clinician_Workgroup.aspx
- Workgroup SharePoint site
  - https://share.qualityforum.org/portfolio/MAPClinicianWorkgroup/SitePages/Home.aspx
- Email: MAP Clinician Project Team
  - MAPClinician@qualityforum.org

THANK YOU.

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