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Measure Applications Partnership (MAP)

Clinician Workgroup Orientation Web Meeting

September 23, 2020

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Agenda

- Welcome and Review of Meeting Objectives
- CMS Welcoming Remarks
- MAP Pre-Rulemaking Approach
- Overview of Programs Under Consideration
- CMS Presentations
- Opportunity for Public Comment
- Next Steps
- Adjourn

Welcome, Introductions, and Review of Meeting Objectives

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Workgroup Staff

- **Samuel Stolpe, PharmD, MPH,** Senior Director
- **Katie Berryman, MPAP,** Project Manager
- **Chris Dawson, MHA, CPHQ, CPPS, LSSBB,** Manager
- **Carolee Lantigua, MPA,** Manager
- **Teja Vemuganti, MPH,** Analyst

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)

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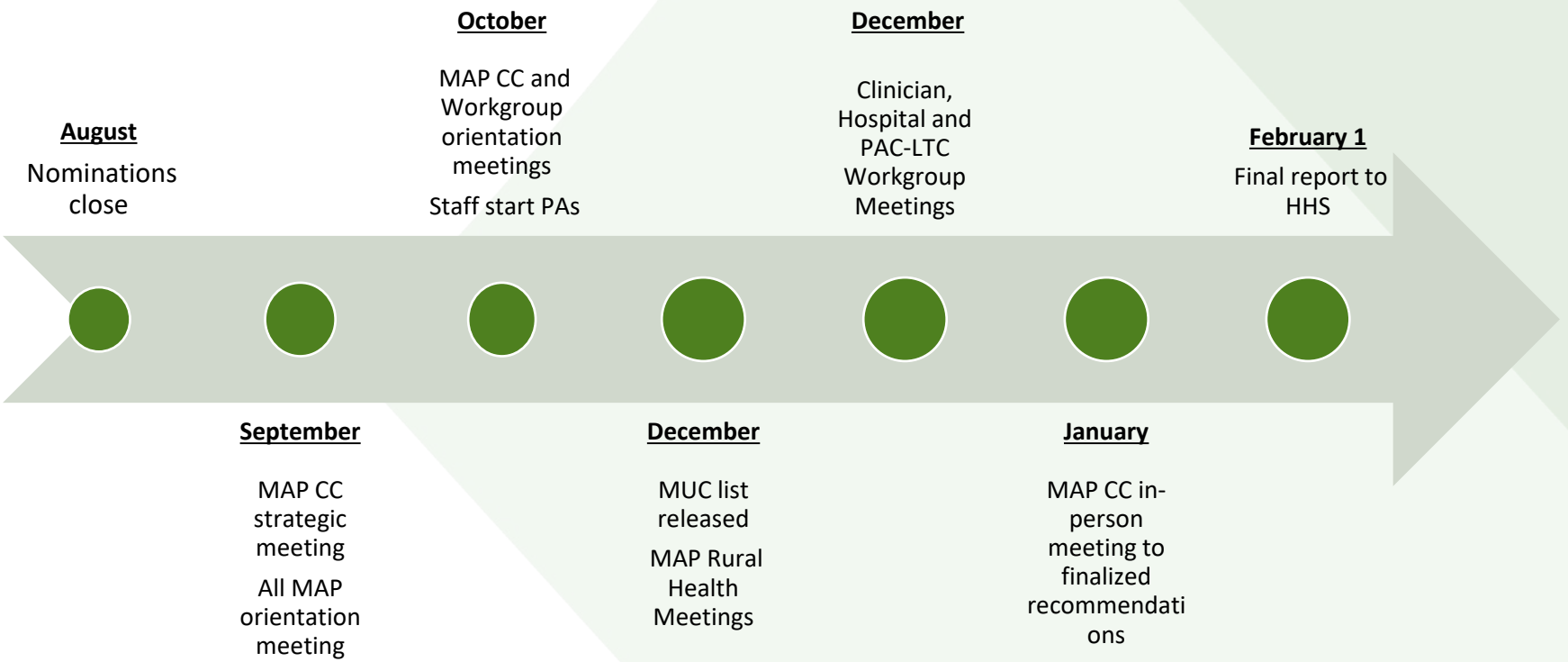
Goals for Today's Meeting

- Review the goals and structure of each program
- Review the critical objectives of each program
- Identify measurement gap areas

CMS Welcoming Remarks

MAP Pre-Rulemaking Approach

Timeline of MAP Activities



Overview of Clinician Programs Under Consideration

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Programs to be Considered by the Clinician Workgroup

Merit-based Incentive Payment System (MIPS)

Medicare Shared Savings Program (SSP)

Medicare Part C and D Star Ratings

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Merit-based Incentive Payment System (MIPS)

- **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 finalized 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.

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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**

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MIPS – CMS High-Priority for Future Measure Consideration

- **Person and Caregiver-centered Experience and Outcomes**: The measure should address the experience of each person and their family; and the extent to which they are engaged as partners in their care.
- **Communication and Care Coordination**: The measure must address the promotion of effective communication and coordination of care; and coordination of care and treatment with other providers.
- **Efficiency/Cost Reduction**: The measure must address the affordability of health care including unnecessary health services, inefficiencies in health care delivery, high prices, or fraud. Measures should cause change in efficiency and reward value over volume.
- **Patient Safety**: The measure must address either an explicit structure or process intended to make care safer, or the outcome of the presence or absence of such a structure or process; and harm caused in the delivery of care. This means that the structure, process or outcome must occur as a part of or as a result of the delivery of care.
- **Appropriate Use**: CMS wants to specifically focus on appropriate use measures. This means that the measure must address appropriate use of services, including measures of overuse.
- **Opioid Related Measures:** Opioid-related measures of opioid use, overuse, risks, monitoring, and education

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Workgroup Discussion

- Does the Workgroup have suggestions for refinement or additions to these high-priority domains for future measurement?

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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.

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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

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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

SSP – CMS Measure Requirements

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 the Quality Payment Program.

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Workgroup Discussion

- Does the Workgroup have suggestions for refinement or additions to these measure requirements?

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Part C and D Star Ratings

- **Program Type:** Quality Payment Program & Public Reporting
- **Incentive Structure:**
  - Medicare Advantage: Public reporting and quality bonus payments
  - Stand-alone Prescription Drug Plans: Public reporting
- **Program Goal:**
  - Provide information about plan quality and performance indicators to beneficiaries to help them make informed plan choices
  - Incentivize high performing plans (Part C)

The April 2018 final rule (CMS-4282-F) codified the methodology for the Part C and D Star Ratings

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2021 Star Ratings Measure List
Divided by Meaningful Measure Area

Healthcare Priority	Meaningful Measure Title	# of Measures
Effective Prevention and Treatment	Management of Chronic Conditions	12
	Preventive Care	7
	Prevention, Treatment, and Management of Mental Health	1
Making Care Safer	Preventable Healthcare Harm	1
Communication/Care Coordination	Medication Management	3
	Transfer of Health Information and Interoperability	2
Making Care Affordable	Appropriate Use of Healthcare	4
	Patient Focused Episode of Care	2
Person and Family Engagement	Patient's Experience of Care	13
	Patient's Reported Functional Outcomes	1
Total		**46***

*44 unique meaningful measure areas

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Summary of 2021 Part C & D Star Rating Changes

- Due to COVID-19, CMS replaced the 2021 Star Ratings measures based on HEDIS and CAHPS data collections with earlier values from the 2020 Star Ratings (CMS-1744-IFC).
- The weight of Patients' Experience and Complaints Measures and Access measures have been increased to 2 (CMS-4182-F).
- The weight of Statin Use in Persons with Diabetes (SUPD) has been increased to 3 (CMS-4182-F).
- The Plan All-Cause Readmissions measure is being temporarily moved to the display page for 2021 and 2022 Star Ratings because NCQA made substantive changes to the measure specifications (CMS-4185-F).

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Part C and D – CMS High-Priority for Future Measure Consideration

The Medicare population includes a large number of individuals and older adults with high-risk multiple chronic conditions (MCC) who often receive care from multiple providers and settings and, as a result, are more likely to experience fragmented care and adverse healthcare outcomes.

- **Promote Effective Communication and Coordination of Care.** A primary goal is to coordinate care for beneficiaries in the effort to provide quality care.
- **Promote Effective Prevention and Treatment of Chronic Disease.** It is important to focus attention on preventing and treating chronic disease.

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Workgroup Discussion

- Does the Workgroup have suggestions for refinement or additions to these high-priority domains for future measurement?

2019- 2020 MAP Clinician Overarching Themes

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Overarching Themes

- Emphasizing care coordination and attribution
- Appropriate opioid measurement
- Meaningful measure initiative considerations for clinicians

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Care Coordination and Attribution

- Measures of patient outcomes require balancing the goals of shared accountability of clinicians and health systems, and appropriate attribution of outcomes that can be influenced by each entity.
- While process measures may be appropriate in early stages of transition toward truly coordinated, holistic, and individualized care, they do not measure if all care is coordinated through a centralized and shared care plan for the patient.
- Addressing social determinants is critical, but data limitations and data collection burden may limit risk adjustment. Clinicians and health systems need information to understand differences in outcomes among patient cohorts to drive improvement, but caution is important when performance assessments involve social determinants.

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Appropriate Opioid Measurement

- There is a shared responsibility for individual providers, health systems, and health plans to address issues of pain management and function as well as to identify and address issues associated with opioid use disorder (OUD).
- There is a need for better initial prescribing measures to balance appropriate use of opioids for pain management with associated risks.
- There is a need to include measures assessing patient-centered analgesia treatment planning, including appropriate tapering strategies to measures of long-term recovery from OUD, and measures of physical and mental health comorbidities with OUD.

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Meaningful Measures Initiative Considerations for Clinicians

- Efforts to optimize predictive analytics and artificial intelligence to understand opportunities for quality improvement should prioritize increased feedback to providers through actionable quality measurement and clinical decision support.
- Ensuring appropriate interpretation of publicly reported measures is critical to driving toward goals of health system improvement. Focus should be placed on patient safety in public reporting.
- There is a need for electronic clinical quality measures (eCQMs). Measures that draw on other electronic sources beyond the electronic health record (EHR) should be considered, including the use of all-payor data.
- Wellness measures represent an opportunity to align payment and quality initiatives across healthcare settings.

MAP Rural Workgroup Review of MUC

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

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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 discussion guide
    - » 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
  - In-person attendance of a Rural Health Workgroup liaison at the pre-rulemaking meeting in December

CMS Presentations

Overview of Medicare Shared Savings Program

For the Measures Application Partnership

Fiona Larbi, MS, RN

Division of Program Alignment and Communications

Agenda

- Medicare Shared Savings Program Overview
- Overview of Quality Measurement Approach
- Quality Measures
- Quality Performance Assessment
- Physician Fee Schedule Proposals
- Future Measure Considerations

Shared Savings Program Overview

- Medicare Shared Savings Program (Shared Savings Program) is mandated by Section 3022 of the Affordable Care Act.
- Accountable Care Organizations (ACOs) create incentives for health care providers to work together voluntarily to coordinate care and improve quality for their patient population.
- CMS assesses ACO performance annually based on quality and financial performance to determine shared savings or losses.

Overview of Quality Measurement Approach

- The quality measurement approach in SSP is intended to:
  - Improve individual health and the health of populations
  - Address quality aims such as prevention, care of chronic illness and high prevalence conditions, patient safety, patient and caregiver engagement, and care coordination
  - Align with the Quality Payment Program
- In Performance Year 2020, there are 23 quality measures separated into the following four key domains
  - Patient/Caregiver Experience
  - Care Coordination/Patient Safety
  - Preventive Health
  - At-Risk Population
- Quality data is collected via patient surveys (CAHPS), claims, and CMS web interface

Quality Performance Assessment

- CMS designates the quality performance standard for each ACO based on its performance year. It does not vary based on track.
- ACOs earn points based on individual measure performance and up to 4 quality improvement points per domain. All domains are weighted equally and an overall quality score is determined.
- Performance benchmarks are set for 2 years to support ACO quality improvement efforts.
- New measures added to the quality measure set are 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).

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.
2, 3, 4, and 5 and subsequent agreement periods	Pay-for-Performance	Completely and accurately report all quality measures and meet minimum attainment on at least one measure in each domain.

2020 Quality Measures

Aim 1: Better Care for Individuals

1. Patient/Caregiver Experience CAHPS for ACOs
ACO-1 CAHPS: Getting Timely Care, Appointments, and Information
ACO-2 CAHPS: How Well Your Providers Communicate
ACO-3 CAHPS: Patients' Rating of Provider
ACO-4 CAHPS: Access to Specialists
ACO-5 CAHPS: Health Promotion and Education
ACO-6 CAHPS: Shared Decision Making
ACO-7 CAHPS: Health Status/Functional Status*
ACO-34 CAHPS: Stewardship of Patient Resources
ACO-45 CAHPS: Courteous and Helpful Office Staff*
ACO-46 CAHPS: Care Coordination*

* Measures that are pay-for-reporting for 2020

2020 Quality Measures

Aim 1: Better Care for Individuals (continued)

2. Care Coordination/Patient Safety
ACO-8 Risk-Standardized, All Condition Readmission
ACO-38 Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions
ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91) (version with additional Risk Adjustment)*
ACO-13 Falls: Screening for Future Falls

*Measure is pay-for-reporting for 2020

2020 Quality Measures

- Aim 2: Better Health for Populations

3. Preventive Health
ACO-14 Preventive Care and Screening: Influenza Immunization
ACO-17 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
ACO-18 Preventive Care and Screening: Screening for Depression and Follow-Up Plan*
ACO-19 Colorectal Cancer Screening
ACO-20 Breast Cancer Screening
ACO-42 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*

*Measures that are pay-for-reporting for 2020.

2020 Quality Measures

- Aim 2: Better Health for Populations (continued)

4. Clinical Care for At-Risk Populations
Depression
ACO-40 Depression Remission at Twelve Months*
Diabetes
ACO-27 Diabetes Mellitus: Hemoglobin A1c Poor Control
Hypertension
ACO-28 Hypertension (HTN): Controlling High Blood Pressure

*Measure is pay-for-reporting all years of the agreement period

Physician Fee Schedule Shared Savings Proposals

For performance year 2020, all ACOs are considered to be affected by the Public Health Emergency for the COVID-19 pandemic and the Shared Savings Program extreme and uncontrollable circumstances policy applies. In addition:

- CMS is proposing to waive the requirement for ACOs to field a CAHPS for ACOs survey and provide automatic full credit for the patient experience measures.
- CMS is seeking comment on an alternative scoring methodology approach under the extreme and uncontrollable circumstances policy.

Physician Fee Schedule Shared Savings Proposals

- For performance year 2021, ACOs would report quality measure data via the proposed Alternative Payment Model (APM) Performance Pathway (APP).
  - ACOs would only need to report one set of quality metrics
  - Meets requirements under both MIPS and SSP
  - This would reduce the measure set from 23 to 6 measures; measures on which ACOs are required to actively report would be reduced from 10 to 3
- ACOs would need a quality performance score ≥ 40th percentile across all MIPS Quality performance category scores to share savings
- CMS may terminate an ACO's participation agreement when an ACO demonstrates a pattern of failure to meet the quality performance standard

Future Measure Considerations

- Consider how best to align Shared Savings Program measures and scoring methodology with other value-based payment programs, including MIPS

Overview of the Part C and D Star Ratings Program

The Part C & D Star Ratings Program

A quality and performance measures program whose participants include:

- Medicare Advantage-Prescription Drug Plans (MA-PD plans) – offering both health (Part C) and drug (Part D) benefits;
- Medicare Advantage Only Health Plans (MA-only plans) – offering only health benefits; and
- Standalone Prescription Drug Plans (PDPs) – offering only drug benefits to supplement benefits received through Original Medicare.

The Part C & D Star Ratings Program

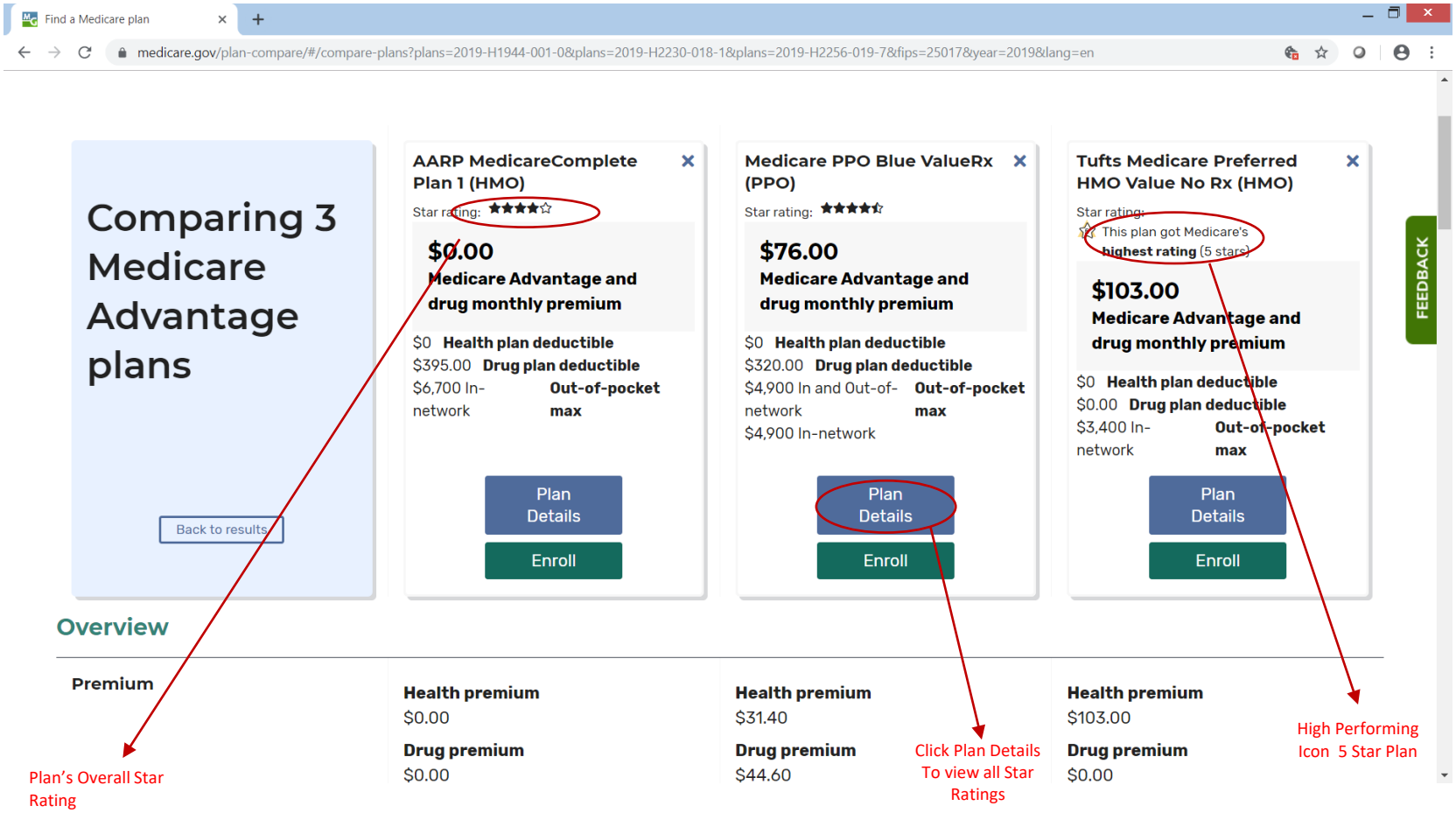
Approximately 66 million Americans are enrolled in Medicare.

- 34% of Medicare beneficiaries are enrolled in Part C Plans (MA-only or MA-PD Plans).
  - 88% are in MA-PDs and, thus, receive drug coverage through Part D.
- 39% of Medicare beneficiaries are enrolled in stand-alone Part D Plans (PDPs).

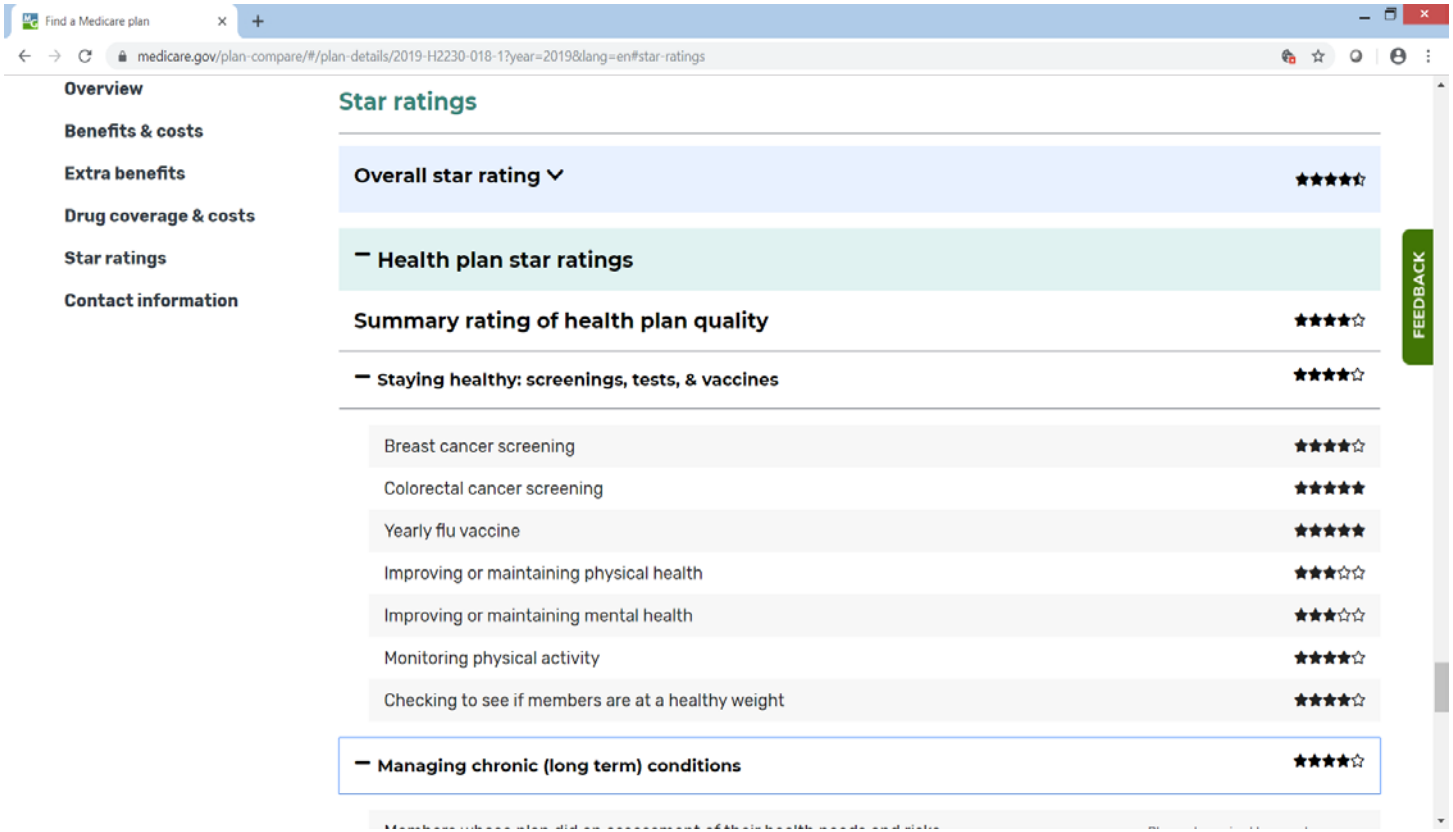
Goals of the Star Ratings Program

- Public Reporting on Medicare Plan Finder (MPF)
- Quality Improvement
- Marketing/Enrollment
- Financial Incentives

Medicare Plan Finder: Your Results Page



Medicare Plan Finder: Your Star Ratings Page

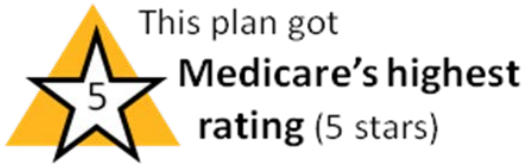


Quality Improvement

- The Star Ratings Program is consistent with CMS's Quality Strategy of optimizing health outcomes by improving quality and transforming the health care system.
- The CMS Quality Strategy goals reflect the six priorities set out in the National Quality Strategy:
  - Safety, person and caregiver-centered experience and outcomes, care coordination, clinical care, population/community health, efficiency and cost reduction.

High Performing Plans

- CMS highlights contracts receiving an overall rating of 5 stars:



- Beneficiaries may enroll in a 5-Star PDP, MA-PD, or MA-only plan through a Special Election Period (SEP).
- 5-star plans may market year-round.

Consistently Low Performing Plans

- Icon displayed for contracts rated less than 3 stars for at least the last 3 years in a row for their Part C or D summary rating.
- Beneficiaries may not enroll online via the MPF in a Low Performing Icon (LPI) plan. Beneficiaries must contact the plan directly.
- Beneficiaries in LPI plans are eligible for a Special Enrollment Period (SEP) to move to a higher quality plan.

MA Quality Bonus Payments

- Per the Affordable Care Act, CMS makes Quality Bonus Payments (QBPs) to MA organizations that meet quality standards measured using a five-star quality rating.
- The QBP percentage for each Star Rating for 2020 payments:

Star Rating	QBP Percentage
3.5 stars or below	0%
4 stars or more	5%

- The MA rebate level for plans is tied to the contract's Star Rating.

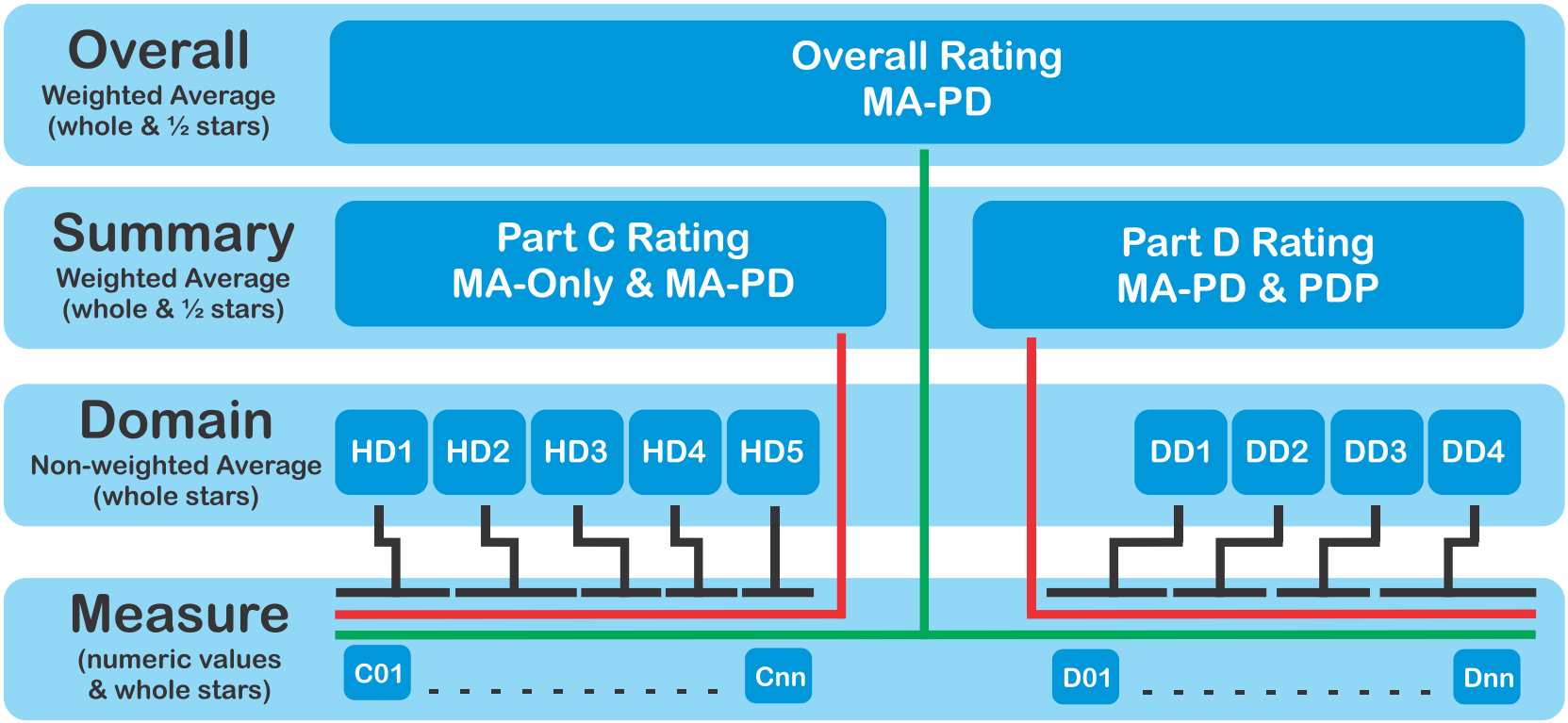
Overview of Star Ratings Methodology

Measure Development

- CMS looks to consensus-building entities such as National Committee for Quality Assurance and Pharmacy Quality Alliance for measure concept development, specifications, and endorsement.
- Measure set reviewed each year; move towards more outcome measures.
- Measures moved from the Star Ratings to CMS's display page are still used for compliance and monitoring.

2021 Star Ratings measures listed in Appendix

Structure of the Star Ratings



Star Ratings Cover 9 Domains (44 unique measures across Parts C & D)

Ratings of Health Plans (Part C)
Staying healthy: screenings, tests and vaccines
Managing chronic (long-term) conditions
Member experience with health plan
Member complaints and changes in the health plan's performance
Health plan customer service

Ratings of Drug Plans (Part D)
Drug plan customer service
Member complaints and changes in the drug plan's performance
Member experience with the drug plan
Drug safety and accuracy of drug pricing

Part C and Part D Improvement Measures

- The improvement measures are derived through the comparison of a contract's current and prior year measure scores.
- The Part C improvement measure includes only Part C measure scores; the Part D improvement measure includes only Part D measure scores.
- For high performing contracts/sponsors, due to limited opportunities for improvement, CMS has a Hold Harmless Provision.

Measure Weights

- The Star Ratings measures span five broad categories:
  - Improvement – 5
  - Outcomes/Intermediate Outcomes – 3
  - Patient Experience and Complaints – 2
  - Access – 2
  - Process – 1
- Each measure is assigned a weight using category definitions included in the Star Ratings Technical Notes.
- New measures are given a weight of 1 for their first year in the ratings.

Goals for Star Ratings Enhancements

CMS continuously reviews the Star Ratings methodology and seeks to enhance it to:

- Improve the process and transparency surrounding the calculations,
- Incentivize plans to foster continuous quality improvement in the MA and Part D programs, and
- Provide information that is a true reflection of the quality of care provided.

One recent enhancement was to codify the Star Ratings methodology in regulation starting with the 2021 Star Ratings (2019 measurement year) [CMS-4182-F].

High Performing Contracts

- Tend to focus on the needs of each enrollee rather than focusing on particular Star Ratings measures.
- When a contract targets the needs of each enrollee, they tend to do well in the Star Ratings program.

Additional Resources

Part C & D Star Ratings and Display Measure data, Technical Notes, and other key information posted on CMS website:

https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata

Mailbox for questions:

PartCandDStarRatings@cms.hhs.gov

Appendix – 2021 Star Ratings measures

Part C Domain: Staying Healthy: Screenings, Tests and Vaccines

- Breast Cancer Screening
- Colorectal Cancer Screening
- Annual Flu Vaccine
- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Monitoring Physical Activity
- Adult BMI Assessment

Part C Domain: Managing Chronic (Long Term) Conditions

- Special Needs Plan (SNP) Care Management
- Care for Older Adults – Medication Review
- Care for Older Adults – Functional Status Assessment
- Care for Older Adults – Pain Assessment
- Osteoporosis Management in Women who had a Fracture
- Diabetes Care – Eye Exam
- Diabetes Care – Kidney Disease Monitoring
- Diabetes Care – Blood Sugar Controlled
- Rheumatoid Arthritis Management
- Reducing the Risk of Falling
- Improving Bladder Control
- Medication Reconciliation Post-Discharge
- Statin Therapy for Patients with Cardiovascular Disease

Part C Domain: Member Experience with Health Plan

- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Rating of Health Care Quality
- Rating of Health Plan
- Care Coordination

Part C Domain: Member Complaints and Changes in the Health Plan's Performance

- Complaints about the Health Plan
- Members Choosing to Leave the Plan
- Health Plan Quality Improvement

Part C Domain: Health Plan Customer Service

- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions
- Call Center - Foreign Language Interpreter and TTY Availability

Part D Domain: Drug Plan Customer Service

- Call Center – Foreign Language Interpreter and TTY Availability
- Appeals Auto-Forward
- Appeals Upheld

Part D Domain: Member Complaints and Changes in the Drug Plan's Performance

- Complaints about the Drug Plan
- Members Choosing to Leave the Plan
- Drug Plan Quality Improvement

Part D Domain: Member Experience with Drug Plan

- Rating of Drug Plan
- Getting Needed Prescription Drugs

Part D Domain: Drug Safety and Accuracy of Drug Pricing

- MPF Price Accuracy
- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS Antagonists)
- Medication Adherence for Cholesterol (Statins)
- MTM Program Completion Rate for CMR
- Statin Use in Persons with Diabetes (SUPD)

Quality Payment Program

Quality Payment Program Year 4 (2020)

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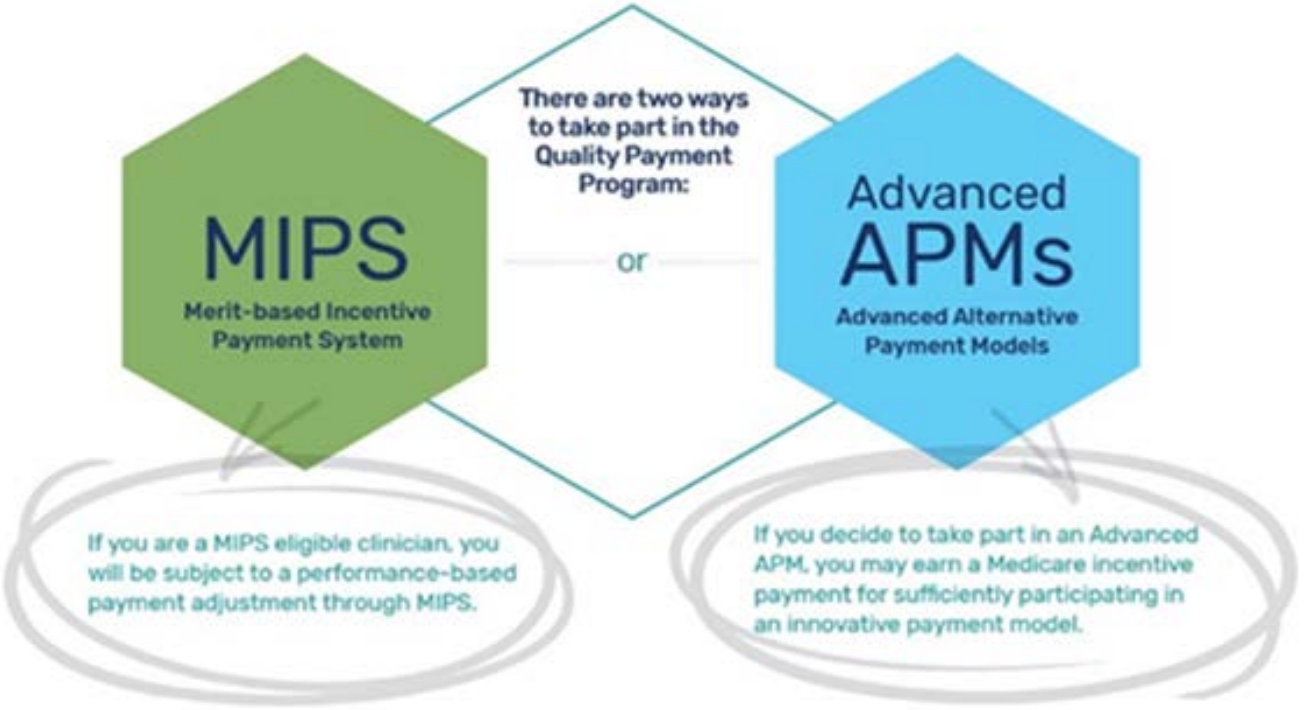
- The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

Resource Library

- Information on the Quality Payment Program can be found in the library of QPP resources.
  - QPP Resource Library: https://qpp.cms.gov/about/resource-library

Quality Payment Programs
MIPS and Advanced APMs

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:



Quality Payment Program Considerations

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit https://qpp.cms.gov.

Merit-based Incentive Payment System (MIPS) Quick Overview

- Combined legacy programs into a single, improved program.

Merit-based Incentive Payment System (MIPS) Quick Overview

MIPS Performance Categories for Year 4 (2020)

- In the CY 2020 PFS Final Rule, it was finalized that the weight of the quality performance category will remain at 45, and the weight of the cost performance category at 15.
- All performance categories are calculated for MIPS Final Score.
- *The points from each performance category are added together to give you a MIPS Final Score.*

MIPS Year 4 (2020)
Who is Included?

MIPS eligible clinicians include:

Physicians+

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

+ *The definition of Physicians includes: Doctors of Medicine; Doctors of Osteopathy (including Osteopathic Practitioners); Doctors of Dental Surgery; Doctors of Dental Medicine; Doctors of Podiatric Medicine; Doctors of Optometry; Chiropractors*

Finalized for Year 3 (2019 with no change for 2020):

- Physical Therapists
- Occupational Therapists
- Qualified Speech-Language Pathologists
- Qualified Audiologists
- Clinical Psychologists
- Registered Dieticians
- Nutrition Professionals

MIPS Year 4 (2020) Who is Included?

No Change to the Low-Volume Threshold for 2020.

- Include MIPS eligible clinicians billing more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule **AND** furnishing covered professional services to more than 200 Medicare beneficiaries a year **AND** providing more than 200 covered professional services under the PFS.

Year 4 (2020) Finalized

Note: For MIPS APMs participants, the low-volume threshold determination will continue to be calculated at the APM Entity level.

MIPS Year 4 (2020)
Who is Exempt?

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to **$90,000** a year for professional covered services

OR

- Provided covered professional services to **200** or fewer Medicare Part B patients a year.

Advanced APMs

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

MIPS Year 4 (2020) Opt-In Policy

- **Opt-in** policy for MIPS eligible clinicians who are excluded from MIPS based on the low-volume threshold determination.
  - MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria may choose to participate in MIPS.

MIPS Opt-in Scenarios

Dollars	Beneficiaries	Covered Professional Services (New for MIPS Year3)	Eligible for Opt-in?
≤ 90K	≤ 200	≤ 200	No – excluded
≤ 90K	≤ 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	≤ 200	Yes (may also voluntarily report or not participate)
≤ 90K	> 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate

MIPS Year 4 (2020) Performance Period

Year 4 (2020) Finalized

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Inter-operability	90-days

MIPS Year 4 (2020)
Virtual Groups

What is a virtual group?

– A virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period of a year.

- To be eligible to join or form a virtual group, you would need to be a:
  - **Solo practitioners** who exceed the low-volume threshold individually, and are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
  - **Group** that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

MIPS Year 4 (2020) Quality

Basics:

- ***No Change***: **45%** of Final Score in 2020
- You select 6 individual measures
  - 1 must be an Outcome measure
    - OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Component	Year 3 (2019) Final	Year 4 (2020) Final
Weight to Final Score	• 45%	• 45%
Data Complete-ness	• 60% for submission mechanisms except for Web Interface and CAHPS. • Measures that do not meet the data completeness criteria earn 1 point. • Small practices that do not meet data completeness will receive 3 points.	• 70% for submission mechanisms except for Web Interface and CAHPS. • Data submitted on each measure is expected to be representative of the clinician's or group's performance. If quality data is submitted selectively such that data are unrepresentative of a MIPS eligible clinician or group's performance, any such data would not be true, accurate, or complete.

MIPS Year 4 (2020) Quality

Basics:

- ***No Change***: **45%** of Final Score in 2020
- You select 6 individual measures
  - 1 must be an Outcome measure
    - OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Component	Year 3 (2019) Final	Year 4 (2020) Final
Scoring	• 3-point floor for measures scored against a benchmark. • 3 points for measures that do not have a benchmark or do not meet case minimum. • Bonus points: Two for outcome or patient experience measures. One for other high-priority measures. One for each measure submitted using electronic end-to-end reporting. • Cap bonus points at 10% of category denominator. • Small practice bonus of 3 points for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure	Same requirements as Year 3, with the following change: • Benchmarks based on flat percentages in specific cases where it is determined that the measure's otherwise applicable benchmark could potentially incentivize inappropriate treatment

MIPS Year 4 (2020) Quality

Basics:

- ***No Change***: **45%** of Final Score in 2020
- You select 6 individual measures
  - 1 must be an Outcome measure
    - OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure
- You may also select a specialty-specific set of measures

Topped Out Measures:

- Finalized four year lifecycle to identify and remove topped out measures.
- Scoring cap of 7 points for topped out measures.
- Topped out policies **do not apply** to CMS Web Interface measures, but this will be monitored for differences with other submission options.
- Topped Out policy does not apply to CAHPS for MIPS Summary Survey Measures (SSMs).
- Once a measure has reached extremely topped out status (average mean performance in the 98th to 100th percentile range), CMS may propose the measure for removal in the next rulemaking cycle.
- QCDR measures will not qualify for the topped out measure cycle and special scoring.

MIPS Year 4 (2020) Cost

Basics:

- ***No Change: 15%*** Counted toward Final Score in 2020

- *No Change*: Cost performance category weight is **15% for 2020.**
- Proposing modifications to the Medicare Spending per Beneficiary (MSPB) and Total per Capita Cost measures based on stakeholder input and recommendations from the TEP.
- Proposing to change the approach to proposing attribution methodologies by including the attribution methodology in the measure specifications.
- The eight existing episode-based measures added for the 2019 performance period will be retained; proposing to add ten new episode-based measures for 2020.
- We will propose new cost measures in future rulemaking and provide feedback on episode-based measures prior to potential inclusion in MIPS to increase clinician familiarity with them.

MIPS Year 4 (2020)
MIPS: Scoring Improvements

MIPS Scoring Improvement for Quality and Cost

- For Quality:
  - Eligible clinicians must fully participate (i.e. submit all required measures and have met data completeness criteria) for the performance period.
  - If the eligible clinician has a previous year Quality performance category score less than or equal to 30%, we would compare 2020 performance to an assumed 2019 Quality performance category score of 30%.

- For Cost:
  - There will be no cost improvement scoring for MIPS Year 4.
  - The cost performance category percent score will not take into account improvement until the 2024 MIPS payment year.

MIPS Year 4 (2020) Improvement Activities

Basics:

- **15%** of Final Score in 2020
- Select Improvement Activities and attest "yes" to completing
  - Activity Weights remain the same from Year 3
  - Medium = 10 points
  - High = 20 points
- Small practices, non-patient facing clinicians, and/or clinicians located in rural or HPSAs continue to receive double-weight and report on no more than 2 activities to receive the highest score

Number of Activities:

- Adding 2 new Improvement Activities
- Modifying 7 existing Improvement Activities
- Removing 15 existing Improvement Activities

Finalized Changes for 2020:

- Modify the MIPS rural area definition by changing the file name to reference FORHP
- Remove references to specific accreditation organizations for PCMH
- Increase the group reporting threshold to 50%. The minimum number of clinicians in a group/virtual group required to perform and improvement activity would increase to 50%.
- Establish factors for removing improvement activities from the inventory through notice-and-comment rulemaking
- Conclude and remove the CMS Study on Factors Associated with Reporting Quality Measures and remove the incentive under the Improvement Activity performance category for study participants.
- *IA_ERP_3 "COVID-19 Clinical Trials" was added to the CY 2020 inventory mid-year.

MIPS Year 4 (2020)
Prompting Interoperability

Basics:

- **25%** of Final Score in 2020
- Must use 2015 Edition Certified EHR Technology (CEHRT) in 2020
- 100 total category points.

CEHRT Requirements:

- Must use the 2015 Edition Certified EHR Technology in 2020

Measure and Objectives:

- 10 measures across 4 objectives, based on the 2015 Edition CEHRT

Finalized Changes for 2020:

- Query of Prescription Drug Monitoring Program (PDMP) measure is optional and eligible for five bonus points; making the e-Prescribing measure worth up to 10 points
- Beginning with PY 2019, changed the Query of Prescription Drug Monitoring Program (PDMP) measure to a “yes” or “no” response
- Removed the Verify Opioid Treatment Agreement measure
- Beginning with PY 2019, points will be re-distributed for the Support Electronic Referral Loops by Sending Health Information measure to the Provide Patients Access to Their Health Information measure if an exclusion is claimed
- Revised the description of the exclusion for the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure.

MIPS Year 4 (2020)
MIPS: performance Threshold & Payment Adjustment

- **Change:** Increase in Performance Threshold and Payment Adjustment

Year 3 (2019) Final

- 30 point performance threshold
- Exceptional performance bonus set at 75 points
- Payment adjustment set at +/- 7%

Year 4 (2020) Final

- 45 point performance threshold
- Exceptional performance bonus set at 85 points
- Payment adjustment set at +/- 9%

- The payment adjustment and the exceptional performance bonus are based on comparing the clinician's final score to the performance threshold and the additional performance threshold for exceptional performance.

MIPS Year 4 (2020)
Extreme and Uncontrollable Circumstances

- CMS knows that areas affected by hurricanes and the wildfires have experienced devastating disruptions in infrastructure, and that clinicians face challenges in submitting data under the Quality Payment Program.

- Starting with the 2018 MIPS performance period, if a MIPS eligible clinician is affected by extreme and uncontrollable circumstances (e.g., a hurricane, natural disaster, or public health emergency), the MIPS eligible clinician, group or virtual group may qualify for reweighting of any, or all, of the 4 performance categories (Quality, Cost, Promoting Interoperability, Improvement Activities).

- **New for 2020:**
  - Proposing to extend this to MIPS eligible clinicians participating in MIPS APMs who are subject to the APM scoring standard and would report on MIPS quality performance category measures.
  - Proposing a new policy to allow reweighing for any performance category if, based on information learned prior to the beginning of a MIPS payment year, it is determined data for that performance category are inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the MIPS eligible clinician or its agents.

Opportunity for NQF Member and Public Comment

Next Steps

NATIONAL QUALITY FORUM

Timeline of Upcoming Activities

- **Release of the MUC List** – by December 1
- **Public Comment Period 1** – Timing based on MUC List release
- **Rural Workgroup Web Meetings**
  - December 4, 7, 9
- **Virtual In-Person Meeting**
  - PAC/LTC, Hospital, Clinician Workgroup – **December 17**
  - Coordinating Committee – **January 19**
- **Public Comment Period 2** – December 28, 2020 – January 13, 2020

NATIONAL QUALITY FORUM

Resources

- CMS Measurement Needs and Priorities Document: https://www.cms.gov/files/document/cms-measurement-priorities-and-needs.pdf
- Pre-Rulemaking URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html
- MAP Member Guidebook: http://share.qualityforum.org/Projects/MAP%20Clinician%20Workgroup/SitePages/Home.aspx

Questions

NATIONAL QUALITY FORUM

Contact Information

- **Project Page:** http://www.qualityforum.org/MAP_Clinician_Workgroup.aspx
- **Workgroup SharePoint Site:** http://share.qualityforum.org/Projects/MAP%20Clinician%20Workgroup/SitePages/Home.aspx
- **Email: MAP Clinician Project Team** MAPClinician@qualityforum.org

THANK YOU.

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