NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Clinician Workgroup Orientation Web Meeting

October 24, 2019

Welcome, Introductions, and Review of Meeting Objectives

Agenda

- Welcome and Review of Meeting Objectives
- CMS Opening Remarks
- MAP Pre-Rulemaking Approach
- Overview of Programs Under Consideration
- CMS Presentations
  - *Quality Payment Program Year 4 (2020)*
  - *Overview of Medicare Shared Savings Program*
  - *Part C and D Star Ratings*
- Opportunity for Public Comment
- Next Steps

Workgroup Staff

- Samuel Stolpe, PharmD, MPH, Senior Director
- Kate Buchanan, MPH, Senior Project Manager
- Jordan Hirsch, MHA, Project Analyst

Clinician Workgroup Membership

Workgroup Co-chairs: Bruce Bagley, MD; Robert Fields, MD (acting)

Organizational Members (voting)	
The Alliance	Council of Medical Specialty Societies
American Academy of Family Physicians	Genentech
American Academy of Pediatrics	HealthPartners, Inc.
American Association of Nurse Practitioners	Kaiser Permanente
American College of Cardiology	Louise Batz Patient Safety Foundation
American College of Radiology	Magellan Health, Inc.
American Occupational Therapy Association	Pacific Business Group on Health
America's Physician Groups	Patient-Centered Primary Care Collaborative
Anthem	Patient Safety Action Network
Atrium Health	St. Louis Area Business Health Coalition
Consumers' Checkbook/Center for the Study of Services	

Clinician Workgroup Membership

Individual Subject Matter Experts (Voting)
Nishant “Shaun” Anand, MD, FACEP
William Fleischman, MD, MHS
Stephanie Fry, MS

Federal Government Liaisons (Nonvoting)
Centers for Disease Control and Prevention (CDC)
Centers for Medicare and Medicaid Services (CMS)
Health Resources and Services Administration (HRSA)

CMS Opening Remarks

MAP Pre-Rulemaking Approach

MAP Pre-Rulemaking Approach

October

- The Workgroups and Coordinating Committee meet via web meeting to:
  - *Review the pre-rulemaking approach and evaluation of measures under consideration*
  - *Familiarize themselves with finalized program measure set for each program*

November

- The Rural Health Workgroup meets via web meetings to provide rural perspectives on the selection of quality measures in MAP

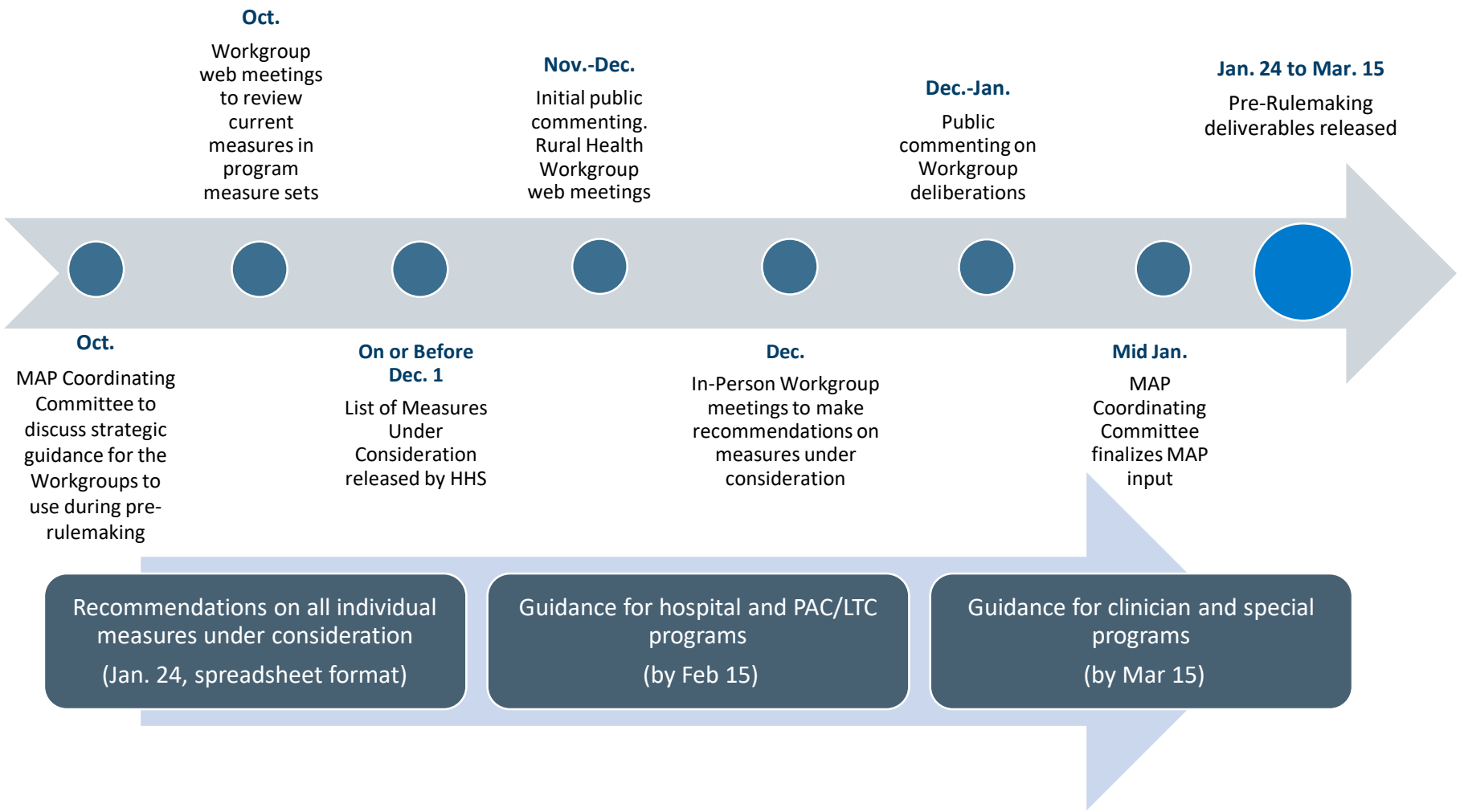
December

- The MAP setting-specific Workgroups will evaluate measures under consideration during their December in-person meetings informed by the preliminary evaluations completed by NQF staff

January

- The MAP Coordinating Committee will examine the MAP Workgroup recommendations and key cross-cutting issues

MAP Pre-Rulemaking Approach



MAP Pre-Rulemaking Approach — Goals for Today's meeting

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

Overview of Clinician Programs under Consideration

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

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 proposed 2020 weights:*
    - Quality (40%)
    - Promoting Interoperability (25%)
    - Improvement Activities (15%)
    - Cost (20%)
    - 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.*

2019 MIPS Current Measures

Divided by Meaningful Measure Area

Healthcare Priority	# of Measures
Effective Prevention and Treatment	115
Making Care Safer	30
Communication/Care Coordination	30
Best Practices of Healthy Living	0
Making Care Affordable	47
Person and Family Engagement	36
Total	**258**

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 over use.

Workgroup Discussion

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

Medicare Shared Savings Program (SSP)

- Program Type: Quality Payment Program
- 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.*
    - » ACOs share in savings generated when lower per beneficiary costs
    - » Must perform on SSP quality metrics AND demonstrate savings
- Program Goals:
  - *Promote accountability for a patient population.*
  - *Coordinate items and services for Medicare FFS beneficiaries.*
  - *Encourage investment in high quality and efficient services.*

2019 SSP Current measures

Divided by Meaningful Measure Area

Healthcare Priority	# of Measures
Effective Prevention and Treatment	9
Making Care Safer	1
Communication/Care Coordination	3
Best Practices of Healthy Living	0
Making Care Affordable	0
Person and Family Engagement	10
Total	**23**

Workgroup Discussion

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

Part C and D Star Ratings

- Program Type: Quality Payment Program & Public Reporting
- Incentive Structure:
  - *Medicare Part C: Public reporting & Quality bonus payments—5% if 4 Stars or higher*
  - *Medicare Part D: Public reporting*
- Program Goal:
  - *Provide information about plan quality and performance indicators be provided to beneficiaries to help them make informed plan choices.*
  - *Incentivize high performing plans (Part C).*

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

- **Promote Effective Communication and Coordination of Care.** A primary goal is to coordinate care for beneficiaries in the effort to provide quality care. 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 Prevention and Treatment of Chronic Disease.** Medicare beneficiaries with multiple high-risk chronic conditions are at increased risk for fragmented care and poor health outcomes so attention to effectively preventing and treating chronic disease is important.

2020 Rate Announcement and Call Letter

- On April 1, 2019, the Centers for Medicare & Medicaid Services (CMS) released final policy and payment updates to the Medicare Advantage (MA) and Part D programs through the 2020 Rate Announcement and Call Letter.
- The Advance Notice was posted in two parts
  - *Part I on December 20, 2018*
  - *Part II on January 30, 2019 with the Draft Call Letter.*
- CMS accepted comments on all proposals through March 1, 2019.
- Summary of changes here.

Summary of 2020 Part C & D Star Rating Changes

- Addition of two measures.
  - *Transitions of Care Measure (Part C).*
  - *Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C).*
  - *Consistent with its policy for adopting new measures, CMS will first add these measures to the display page in CY 2020.*
- Temporary retirement of *Controlling Blood Pressure* to the display page due to new treatment guidelines and structural measure changes.
- Maintaining the *Statin Use in Persons with Diabetes* as a 1x-weighted measure despite previously announced plans to triple weight the measure.

Summary of 2021 Changes from 2020 Call Letter

- Additions to Display Page
  - *Concurrent Use of Opioids and Benzodiazepines*
  - *Polypharmacy Use of Multiple Anticholinergic (ACH) Medications in Older Adults*
  - *Polypharmacy Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults*
- Temporary retirement of *Plan All Cause Readmissions* to the display page due to substantive measure changes.
- Reminder that *Patients' Experience and Complaints and Access* measures will receive 2x-weighting beginning with 2021 ratings.
- Current plans to retain *Medication Reconciliation Post-Discharge* as a standalone measure.

Summary of 2022 Changes from 2020 Call Letter

- Return of *Controlling Blood Pressure* to Star Ratings with 1x weight during the initial year of reintroduction.
- Temporary retirement of *Plan All Cause Readmissions* to the display page due to substantive measure changes.
- Temporary retirement of *Care of Older Adults – Functional Status Assessment* to the display page for the 2022 and 2023 ratings due to substantive measure changes.
- Removal of *Adult BMI Assessment* and both *Part D Appeals* measures.
- Adoption of new *MPF Price Accuracy* measure specifications.

Workgroup Discussion

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

2018-2019 MAP Clinician Overarching Themes

Overarching Themes

Emphasizing Appropriate Attribution and Level of Analysis for Incorporated Measures

Aligning Cost Measurements with Quality Improvement Efforts

Emphasizing Appropriate Attribution and Level of Analysis for Incorporated Measures

- Measures need both to assess high-priority topics and to demonstrate that they can evaluate performance at the appropriate level of analysis to ensure the information provided is meaningful and actionable.
- Measures must be actionable as well as valid and reliable at the level of analysis of the program.
- Selection of appropriate quality measures for accountability programs can have enormous impact on the acceptance of the program and engagement of clinicians

Aligning Cost Measurements with Quality Improvement Efforts

- Cost measures implemented in MIPS should include consideration of clinically coherent groups, specifically patient condition groups or care episode groups.
- Measures of cost and quality must be aligned in order to truly understand the efficiency and value of care.
- Align cost and quality measures while protecting against potential negative unintended consequences of cost measures such as the stinting of care or the provision of lower quality care.

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

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 all three pre-rulemaking meetings in December*

CMS Presentations

Quality Payment
PROGRAM

QUALITY PAYMENT PROGRAM YEAR 4 (2020)

Disclaimer

- This presentation was prepared as a tool and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
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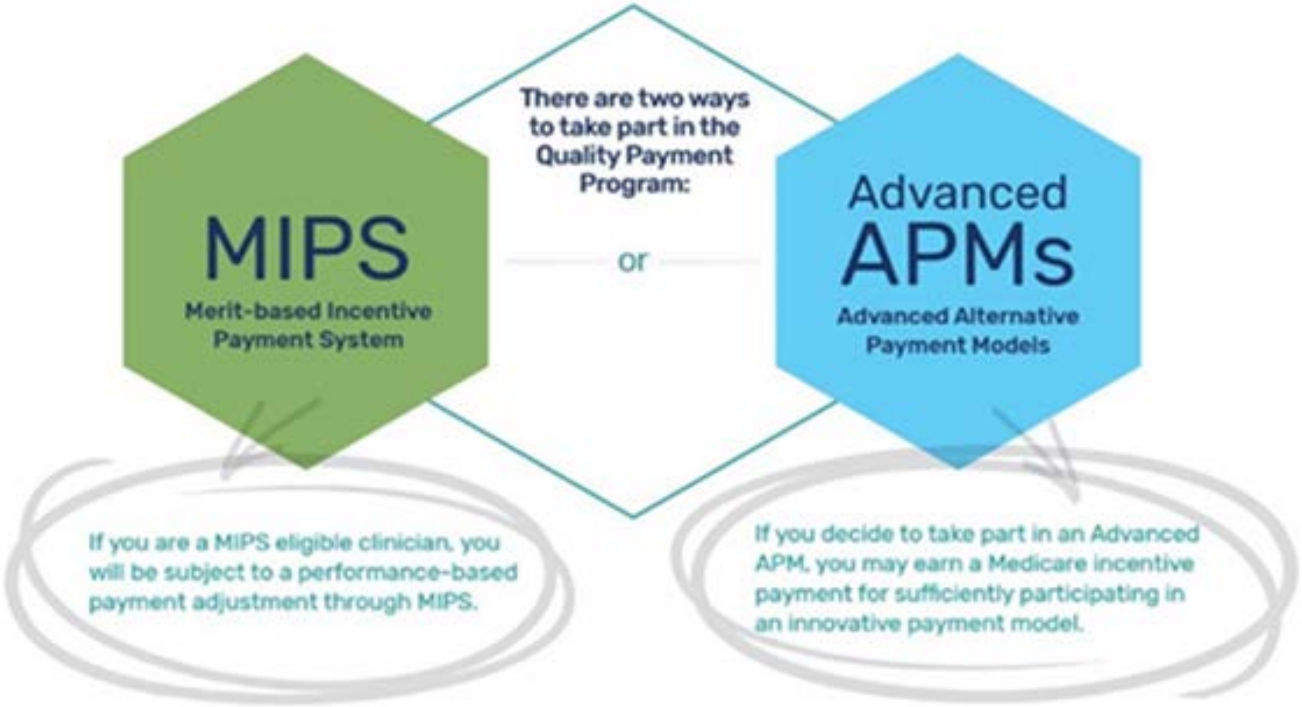
Resource Library

- 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 Program

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)

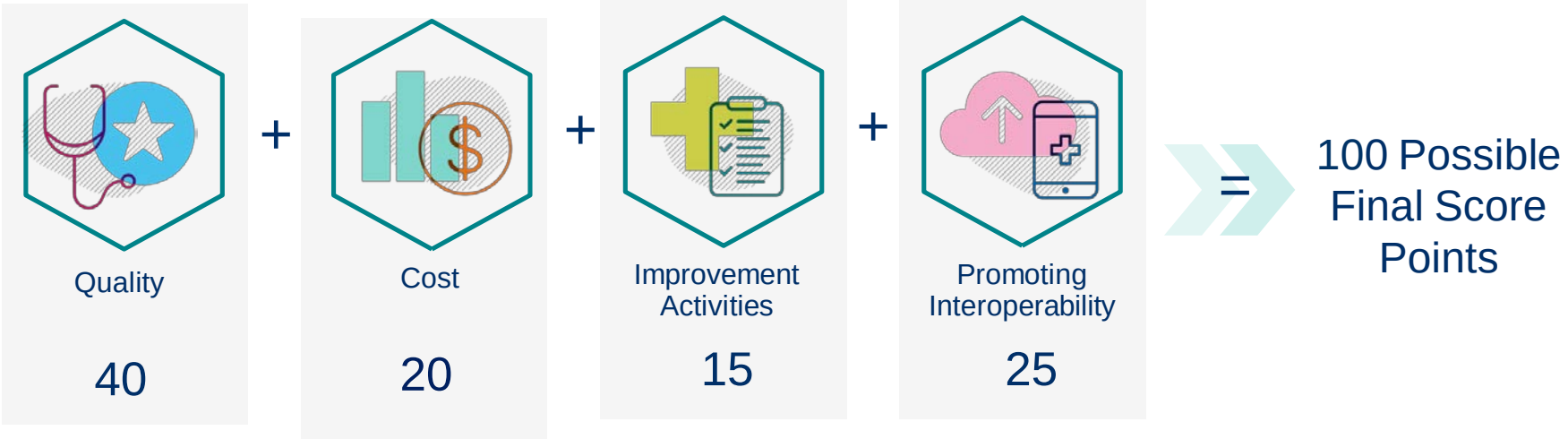
Quick Overview

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 Proposed Rule, we proposed that the weight of the quality performance category will be reduced to 40, and the weight of the cost performance category is increasing to 20.
- 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.*

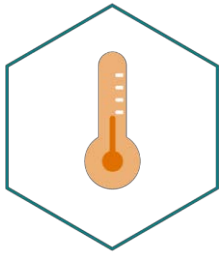
MIPS Year 4 (2020)

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 3 (2019) 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)

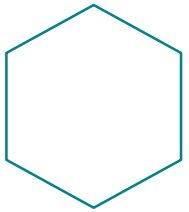
Below the low-volume threshold

- 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:

- ***Change***: **40%** 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) Proposed
Weight to Final Score	• 45%	• 40%
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:

- ***Change***: **40%** 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) Proposed
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: • Proposing to develop 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:

- ***Change***: **40%** 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:

- ***Proposed Change:*** **20%** Counted toward Final Score in 2020

- *Proposed Change*: Cost performance category weight is **20% 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

Proposed 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.

MIPS Year 4 (2020)

Promoting 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

Measures and Objectives:

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

Proposed 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
- Changing the Query of Prescription Drug Monitoring Program (PDMP) measure to a “yes” or “no” response
- Removing the Verify Opioid Treatment Agreement measure
- Redistributing the points 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
- Revising 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)

- 45 point performance threshold
- Exceptional performance bonus set at 80 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.*

MEDICARE SHARED SAVINGS PROGRAM

Overview of Medicare Shared Savings Program

For the Measures Application Partnership

- October 24, 2019

- 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
- 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.
- Pathways to Success policy redesign provides for a quicker transition to risk, new flexibilities and tools for risk based ACOs to be successful, regional benchmarks to provide a stronger incentive, strengthened program integrity, and streamlined quality measure set to 23 measures to make more outcome oriented and reduce burden.
- As of July 1, 2019, 518 Shared Savings Program ACOs were serving approximately 10.9 million Medicare FFS beneficiaries.
  - *206 New BASIC and ENHANCED ACOs*
  - *29% of ACOs are under risk arrangements*

Overview of Quality Measurement Approach

MEDICARE SHARED SAVINGS PROGRAM

- The quality measurement approach in the Shared Savings Program 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*
- The proposals for PY2020 in the Medicare Physician Fee Schedule proposed rules include:
  - *removing ACO-14 Preventive Care and Screening: Influenza Immunization and replacing it with ACO-47: Adult Immunization Status,*
  - *reverting ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ) Prevention Quality Indicator (PQI)#91 to pay for reporting due to substantive changes by the measure owner,*
  - *Updating the numerator guidance of ACO-17 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention and making the measure pay for performance.*
  - *Seeking comment on aligning the SSP quality score with the MIPS Quality Performance Category score*

Overview of Quality Measurement Approach

In Performance Year 2019, 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 the following mechanisms:

- Patient Survey (CAHPS for ACOs)
- Claims
- 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.

2019 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 (new)
ACO-46 CAHPS: Care Coordination (new)

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

2019 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

2019 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*

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

2019 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

Future Measure Considerations

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Part C and D Star Ratings

October 03, 2019

The Part C & Part 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 & Part D Star Ratings Program

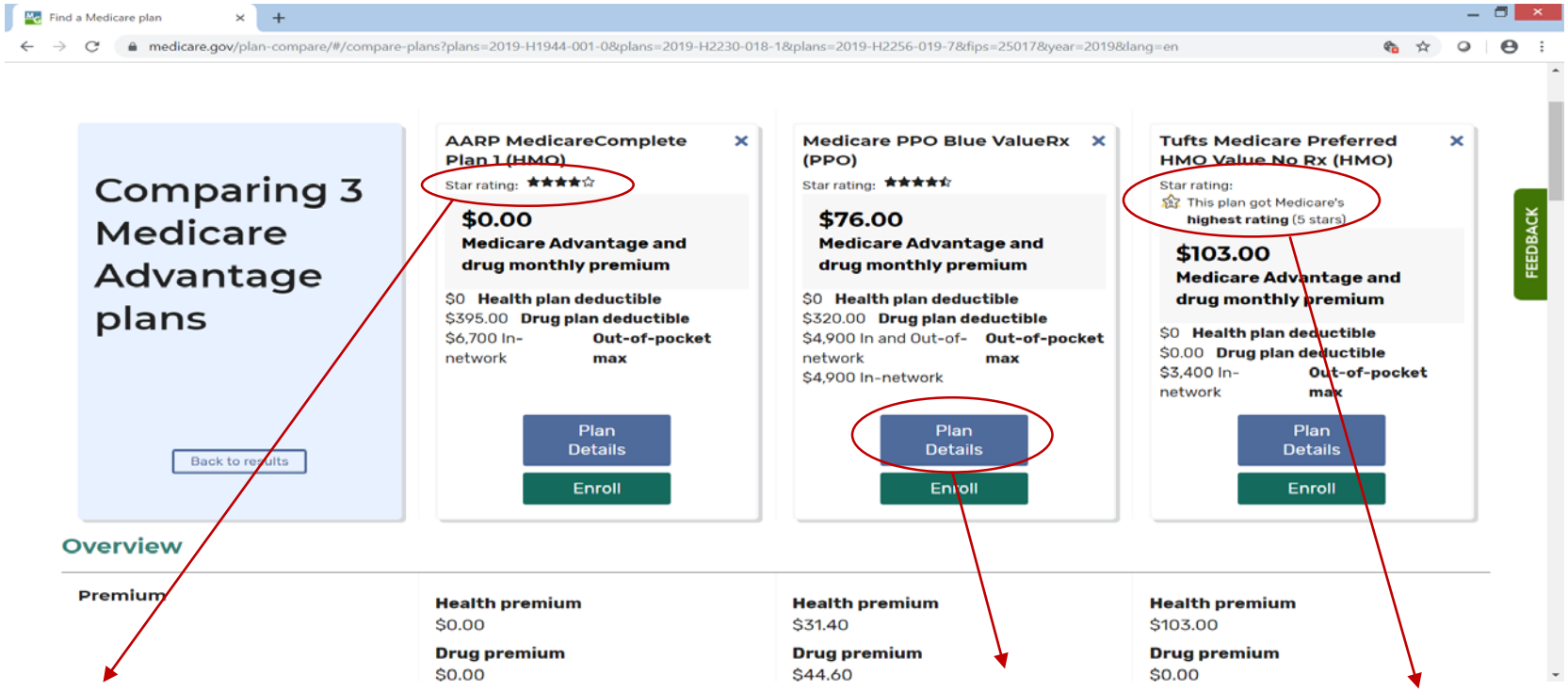
In 2019, approximately 66 million Americans are enrolled in Medicare.

- 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

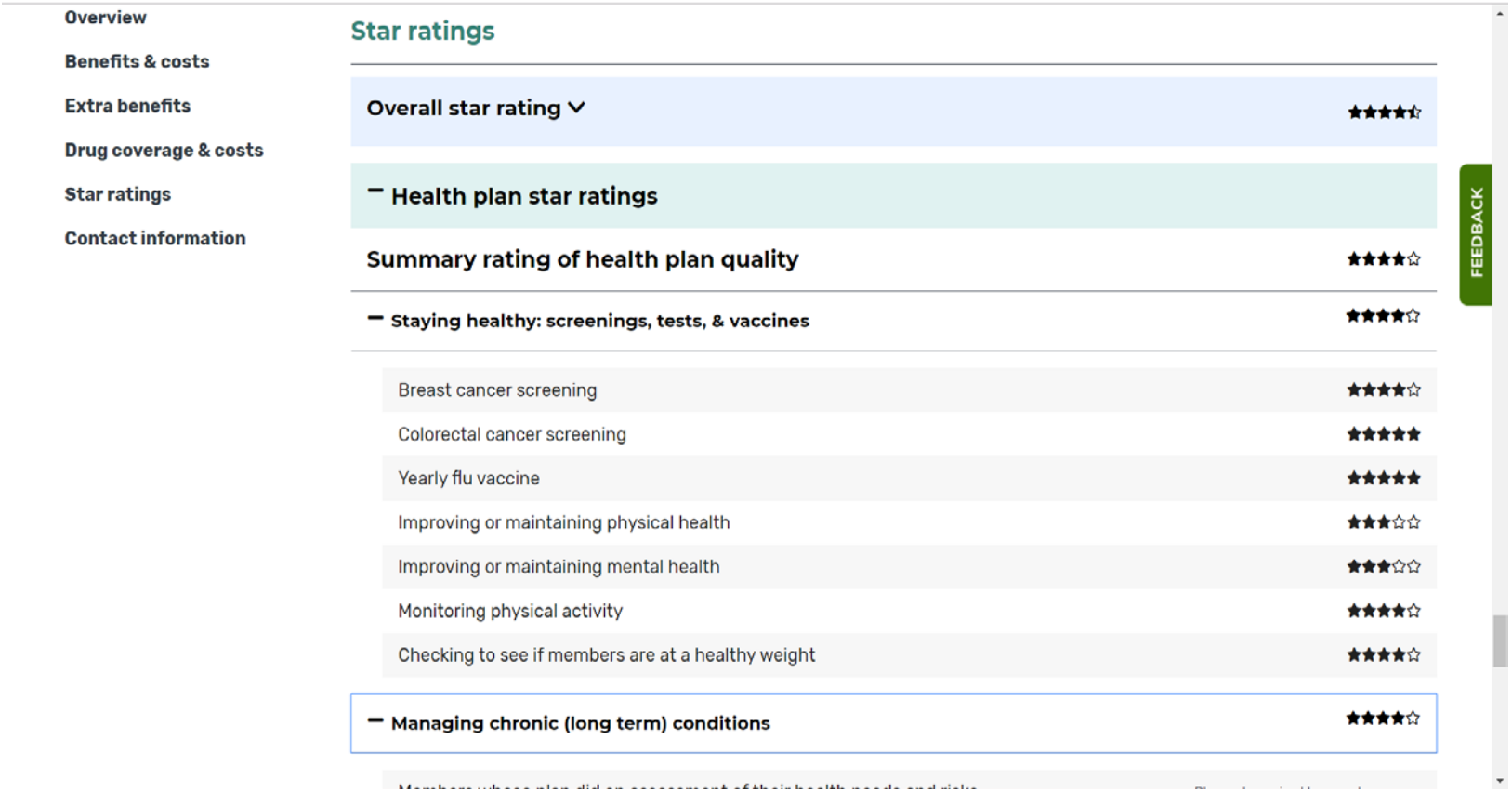


Plan's Overall Star Rating

Click Plan Details To view all Star Ratings

High Performing Icon 5 Star Plan

Medicare Plan Finder: Your Star Ratings Page



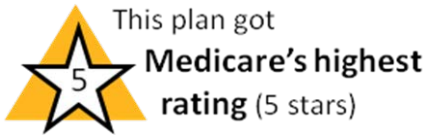
Quality Improvement

- 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.
- Notices are sent to beneficiaries in LPI plans explaining they are eligible for an 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 2019 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.

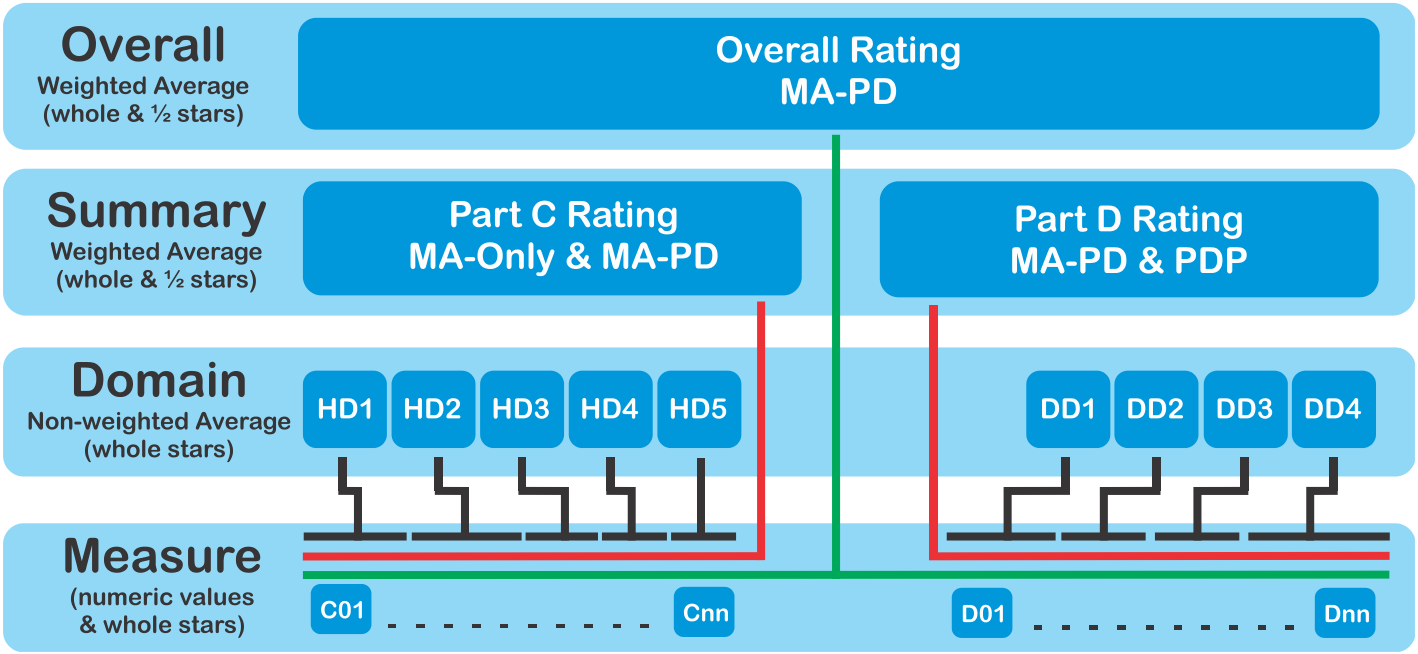
Overview of Star Ratings Methodology

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.

2020 Star Ratings measures listed in Appendix

Structure of the Star Ratings



Star Ratings Cover 9 Domains (45 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 – 1.5*
  - *Access – 1.5*
  - *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).

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:

CMS.gov > Medicare > Prescription Drug Contracting – General Information > Part C and D Performance Data

Mailbox for questions:

PartCandDStarRatings@cms.hhs.gov

Appendix – 2020 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

- 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
- Controlling Blood Pressure *(temporarily removed to display page for 2020 Star Ratings)*
- Rheumatoid Arthritis Management
- Reducing the Risk of Falling
- Improving Bladder Control
- Medication Reconciliation Post-Discharge
- Plan All-Cause Readmissions
- 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

Opportunity for NQF Member and Public Comment

Next Steps

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

- November 18, 19, 20

In-Person Meetings

- PAC/LTC Workgroup – **December 3**
- Hospital Workgroup – **December 4**
- Clinician Workgroup – **December 5**
- Coordinating Committee – **January 15**

Public Comment Period 2 – December 18, 2019 – January 8, 2020

Resources

- CMS' Measurement Needs and Priorities Document:
  - *Final 4_29_2019_MUC_Program_Priorities_Needs*
- Pre-Rulemaking URL:
  - *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html*
- MAP Member Guidebook:
  - *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=80515*

Questions?

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