NATIONAL QUALITY FORUM

Measure Applications Partnership

Clinician Workgroup Web Meeting

November 9, 2017

Welcome, Introductions, and Review of Meeting Objectives

Agenda

- Welcome, Introductions, and Review of Meeting Objectives
- MAP Pre-Rulemaking Approach
- Meaningful Measures
- Overview of Programs Under Considerations
- CMS Updates on Prior Measures Under Consideration (MUC)
- Opportunity for Public Comment
- Next Steps

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Clinician Workgroup Membership

Workgroup Co-chairs (Voting): Bruce Bagley, MD and Amy Moyer

Organizational Members (Voting)

American Academy of Ophthalmology	Scott Friedman, MD
American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
American Association of Nurse Practitioners	Diane Padden, PhD, CRNP, FAANP
American College of Cardiology	Paul N. Casale, MD, FACC
American College of Radiology	David J. Seidenwurm, MD
Anthem	Kevin Bowman
CAPG*	Amy Nguyen
Carolina's HealthCare System	Scott Furney, MD, FACP
Consumers' CHECKBOOK	Robert Krughoff, JD
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Patient-Centered Primary Care Collaborative	Ann Greiner
Primary Care Information Project	Charlene Ngamwajasat
St. Louis Area Business Health Coalition	Patti Wahl, MS

Clinician Workgroup Membership

Subject Matter Experts (Voting)

Dale Shaller, MPA
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Eric Whitacre, MD, FACS
Leslie Zun, MD

Federal Government Members (Non-Voting)

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Centers for Medicare & Medicaid Services (CMS)	Pierre Yong, MD, MPH, MS
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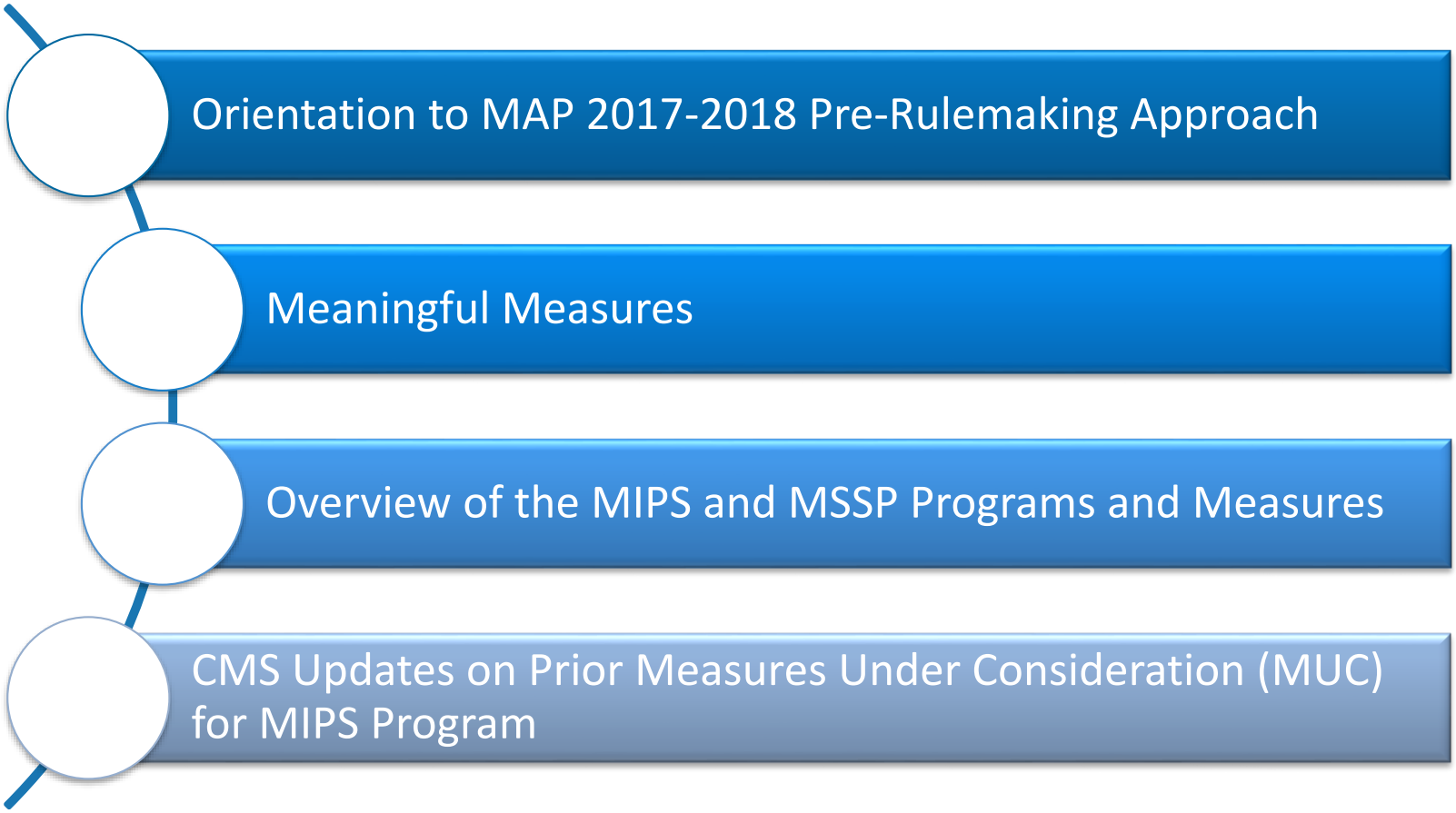
Meeting Objectives



MAP Pre-Rulemaking Approach

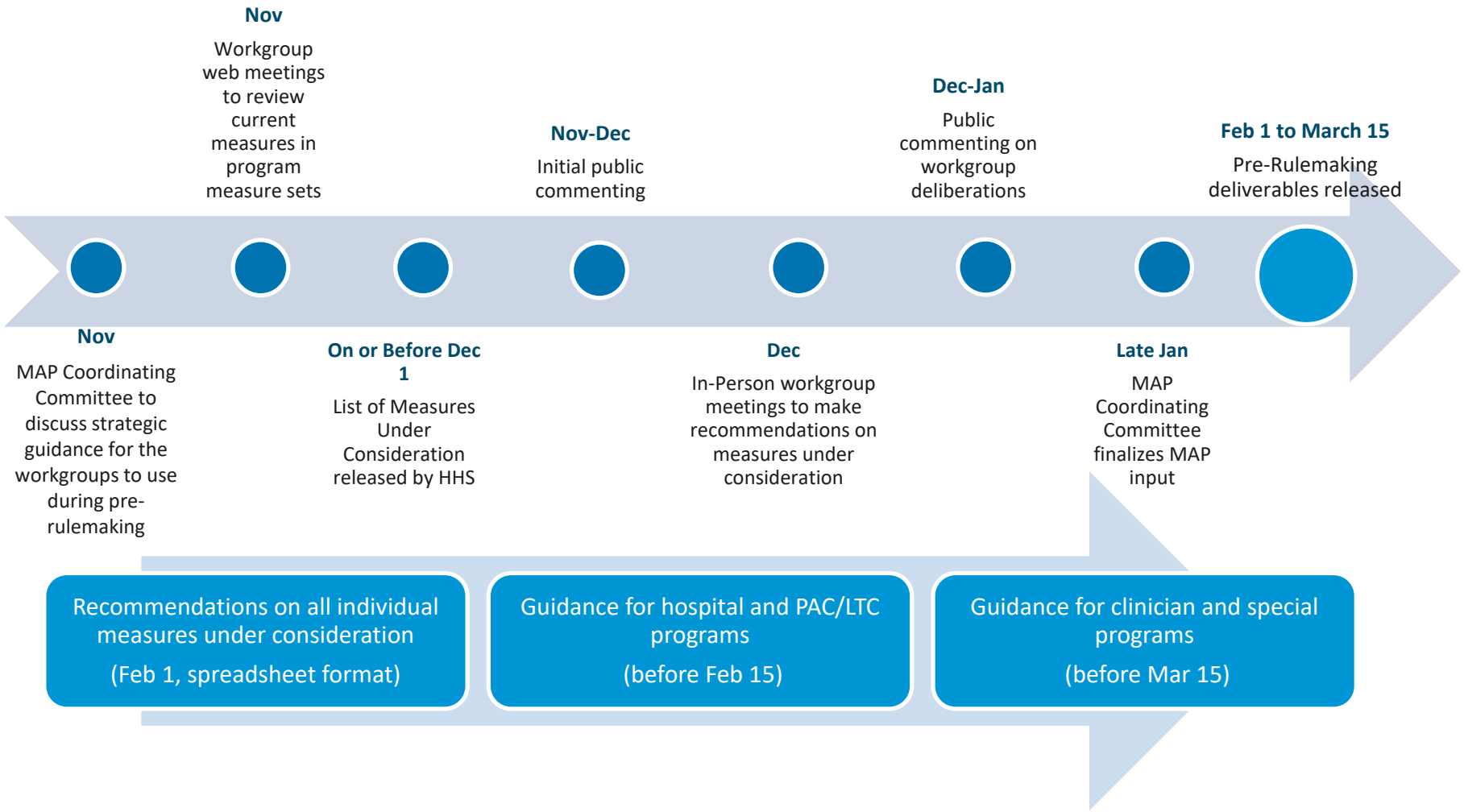
MAP Pre-Rulemaking Approach

A closer look into how recommendations will be made

- November
  - *The MAP Coordinating Committee examined key strategic issues to inform preliminary evaluations of measures under consideration*
  - *During today's meeting the Workgroup will familiarize themselves with finalized program measure set for each program and identify gaps in the current measure sets*
- December
  - *The MAP 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

A look at what to expect



Programs to Be Considered by the Clinician Workgroup

- Merit-based Incentive Payment System (MIPS)
- Medicare Shared Savings Program (MSSP)

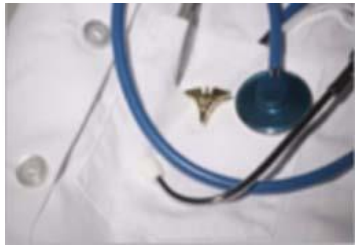
MAP Pre-Rulemaking Approach

Goals for today's meeting

- Review the CMS Meaningful Measures initiative
- Review the structure and priorities of each program
- Review the list of current measures in each program

Meaningful Measures

Meaningful Measures



A New Approach to Meaningful Outcomes

Empower patients and doctors to make decision about their health care

Usher in a new era of state flexibility and local leadership

Support innovative approaches to improve quality, accessibility, and affordability

Improve the CMS customer experience

Meaningful Measures Objectives

Meaningful Measures focus everyone's efforts on the same quality areas and lend specificity, which can help:

- *Address high impact measure areas that safeguard public health*
- *Patient-centered and meaningful to patients*
- *Outcome-based where possible*
- *Relevant for and meaningful to providers*
- *Minimize level of burden for providers*
  - *Remove measures where performance is already very high and that are low value*
- *Significant opportunity for improvement*
- *Address measure needs for population based payment through alternative payment models*
- *Align across programs and/or with other payers (Medicaid, commercial payers)*

Meaningful Measures Framework

Meaningful Measure Areas Achieve:

- ✓ *High quality healthcare*
- ✓ *Meaningful outcomes for patients*

Criteria meaningful for patients and actionable for providers

Draws on measure work by:

- Health Care Payment Learning and Action Network
- National Quality Forum – *High Impact Outcomes*
- National Academies of Medicine – *IOM Vital Signs Core Metrics*

Includes perspectives from experts and external stakeholders:

- Core Quality Measures Collaborative, led by America's Health Insurance Plans and American Hospital Association
- Agency for Healthcare Research and Quality

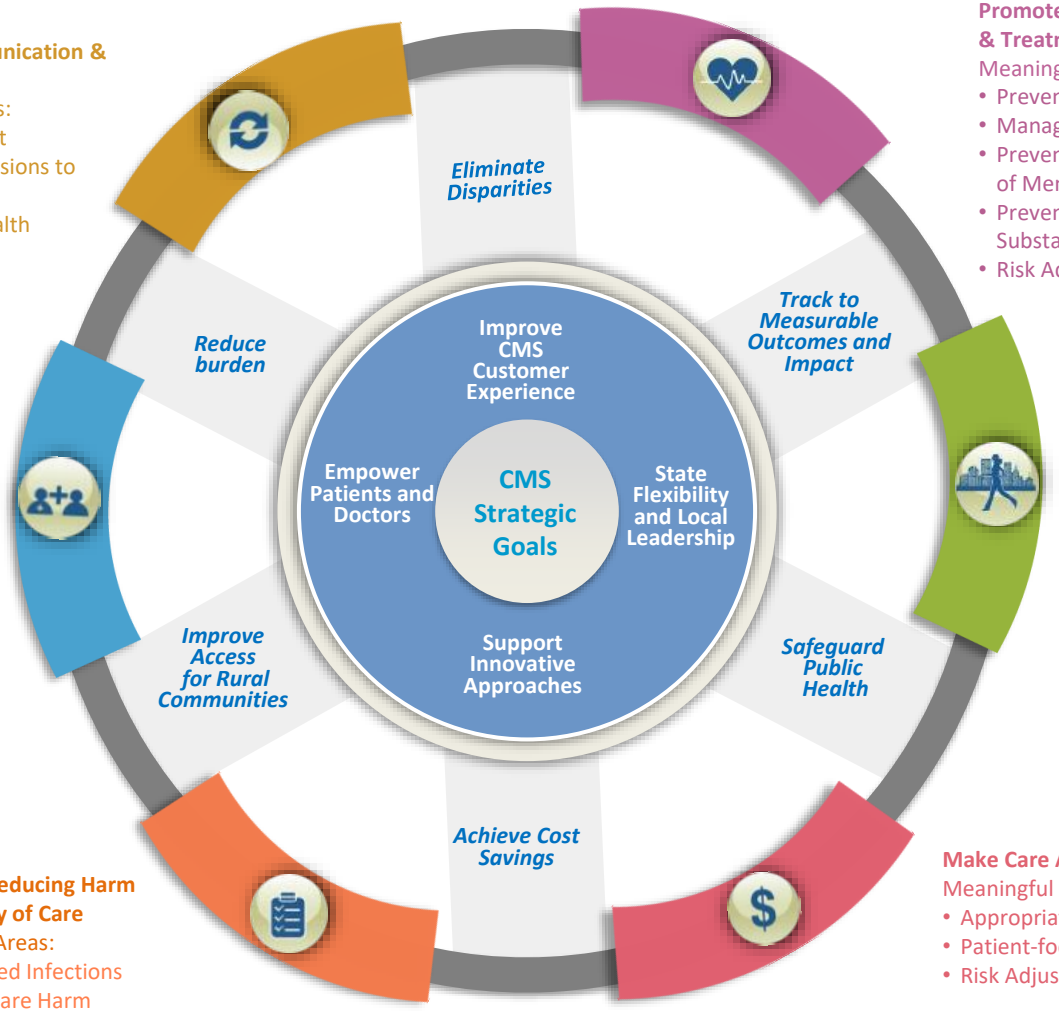
Quality Measures

Meaningful Measures

Promote Effective Communication & Coordination of Care
Meaningful Measure Areas:
- Medication Management
- Admissions and Readmissions to Hospitals
- Seamless Transfer of Health Information

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

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 and Functional Outcomes

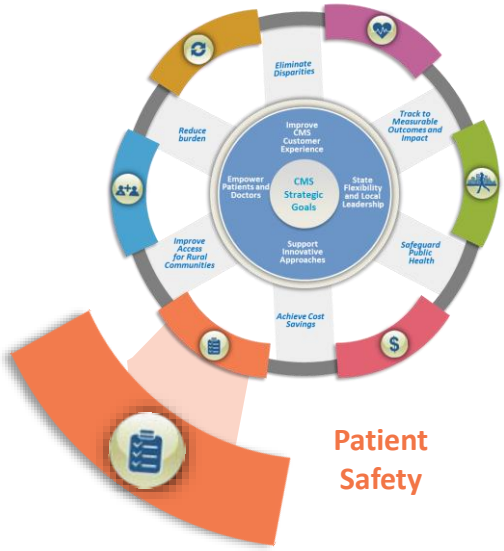


Work with Communities to Promote Best Practices of Healthy Living
Meaningful Measure Areas:
- Equity of Care
- Community Engagement

Make Care Safer by Reducing Harm Caused in the Delivery of Care
Meaningful Measure Areas:
- Healthcare-Associated Infections
- Preventable Healthcare Harm

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



Patient Safety

Meaningful Measure Areas

Healthcare-Associated Infections

Preventable Healthcare Harm

Measures

Central Line-Associated Bloodstream Infection (CLABSI) HACRP, LTCH QRP, Medicaid & CHIP, QIO

Surgical Site Infections (SSI) IQR

Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure LTCH QRP, IRF QRP

Catheter-Associated Urinary Tract Infection (CAUTI) IRF QRP, LTCH QRP, QIO

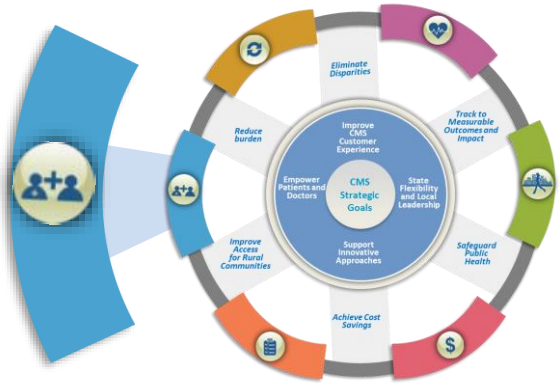
Early Elective Delivery Medicaid & CHIP

Percent of Patients or Residents with Pressure Ulcers that are New or Worsened IRF QRP, LTCH QRP, SNF QRP, HH QRP

Programs Using Illustrative Measures

Hospital-Acquired Condition Reduction Program (HACRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Hospital Inpatient Quality Reporting (IQR) Program
Home Health Quality Reporting Program (HH QRP)
Quality Improvement Organization (QIO)

Strengthen Person & Family Engagement as Partners in their Care



Person- and Family-Centered Care

Care is Personalized and Aligned with Patient's Goals

End of Life Care according to Preferences

Patient's Experience and Functional Outcomes

Meaningful Measure Areas

The Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function IRF QRP, LTCH QRP, SNF QRP, HH QRP

Care plan QPP

Hospice Visits while Death is Imminent HQRP

CAHPS In-Center Hemodialysis Survey ESRD QIP

Home and Community Based Services CAHPS Medicaid & CHIP

Functional Status Assessment for Total Hip Replacement QPP

Measures

Programs Using Illustrative Measures

Quality Payment Program (QPP)
Hospice Quality Reporting Program (HQRP)
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Home Health Quality Reporting Program (HH QRP)

Promote Effective Communication & Coordination of Care

Effective Communication and Care Coordination

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

Meaningful Measure Areas

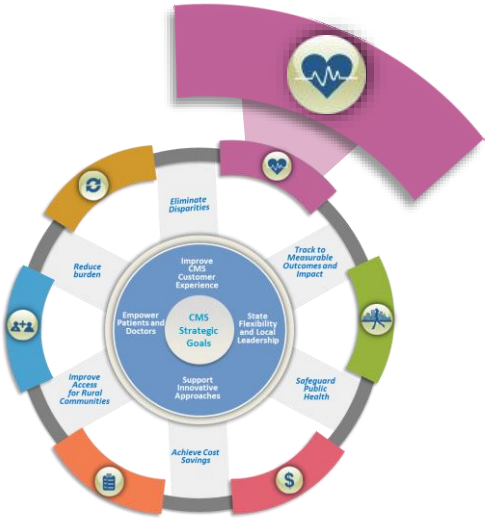
- Use of High Risk Medications in the Elderly QPP
- Medication Reconciliation Post-Discharge MSSP
- Drug Regimen Review Conducted with Follow-Up for Identified Issues IRF QRP, LTCH QRP, SNF QRP, HH QRP
- Standardized Readmission Ratio (SRR) ESRD QIP
- Plan All-Cause Readmissions Medicaid & CHIP
- Use of an Electronic Health Record IPFQR, QIO

Measures

Programs Using Illustrative Measures

Quality Payment Program (QPP)
Medicare Shared Savings Program (MSSP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Home Health Quality Reporting Program (HH QRP)
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
Medicaid and CHIP (Medicaid & CHIP)
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Quality Improvement Organization (QIO)

Promote Effective Prevention & Treatment of Chronic Disease



Prevention and Treatment of Leading Causes of Morbidity and Mortality

- 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

Meaningful Measure Areas

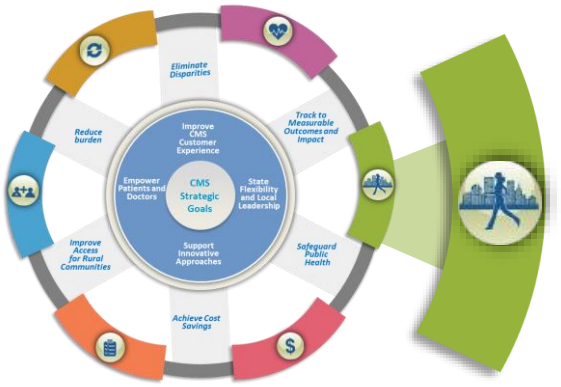
Measures

- Influenza Immunization Received for Current Flu Season HH QRP
- Timeliness of Prenatal Care (PPC) Medicaid
- Osteoporosis Management in Women who Had a Fracture QPP
- Follow-up after hospitalization for Mental Illness IPFQR
- Alcohol Use Screening IPFQR
- Use of Opioids at High Dosage Medicaid & CHIP
- Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization HVBP

Programs Using Illustrative Measures

Home Health Quality Reporting Program (HH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Quality Payment Program (QPP)
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Hospital Value-Based Purchasing (HVBP) Program

Work with Communities to Promote Best Practices of Healthy Living

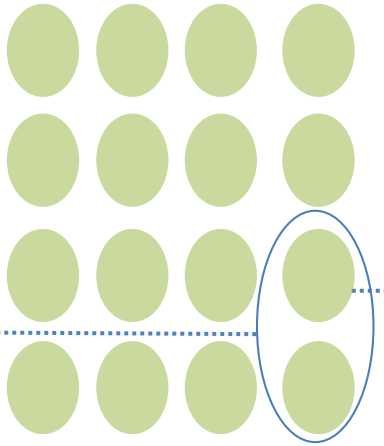


Health and Well-Being

Equity of Care

Community Engagement

Meaningful Measure Areas



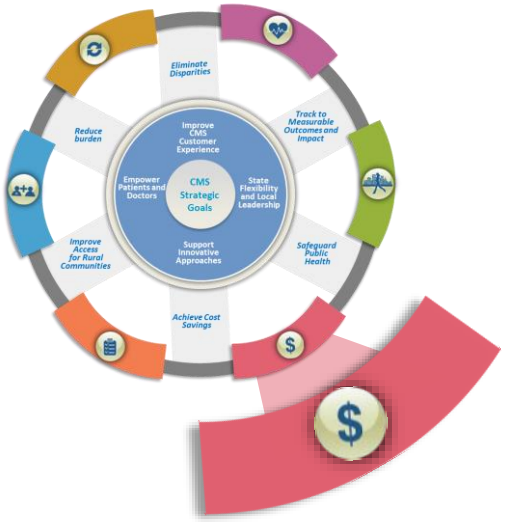
Measures

Discharge to Community-Post Acute Care HH QRP, LTCH QRP, IRF QRP, SNF QRP

Programs Using Illustrative Measures

Home Health Quality Reporting Program (HH QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

Make Care Affordable



Affordable Care

Appropriate Use of Healthcare

Patient-focused Episode of Care

Risk Adjusted Total Cost of Care

Meaningful Measure Areas

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis QPP

Caesarean Section Medicaid & CHIP

Spinal Fusion Clinical Episode-Based Payment (Sfusion Payment) Measure IQR

Medicare Spending Per Beneficiary IRF QRP, LTCH QRP, SNF QRP, HH QRP

Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care for Heart Failure (HF) HVBP

Oncology Care Model CMMI

Total Per Capita Costs for All Attributed Beneficiaries VM

Measures

Programs Using Illustrative Measures

Quality Payment Program (QPP)
Hospital Inpatient Quality Reporting (IQR) Program
Hospital Value-Based Purchasing (HVBP) Program
Center for Medicare and Medicaid Innovation (CMMI)
Value Modifier (VM) Program
Home Health Quality Reporting Program (HH QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

Meaningful Measures Summary

Meaningful Measure Areas

Guiding CMS's efforts to achieve better health and healthcare for the patients and families we serve

Give us your feedback!

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Meaningful Measures

Question & Answer

Merit-based Incentive Payment System (MIPS)

Quality Payment
PROGRAM

FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

Final Rule with Comment Period for Year 2

When and Where to Submit Comments

- We will not consider feedback during the presentation as formal comments on issues open for comment. We ask that you please submit your comments in writing.
- See the Final Rule with Comment Period for information on submitting these comments by the close of the 60-day comment period on January 2, 2018. When commenting refer to file code CMS 5522-FC.
- Instructions for submitting comments can be found in the Final Rule with Comment Period; FAX transmissions will not be accepted. You can officially submit your comments in one of the following ways:
  - electronically through Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

Resource Library Update

- To make it easier for clinicians to search and find information on the Quality Payment Program, CMS has moved its library of QPP resources to CMS.gov.

- QPP.CMS.GOV redirects to the CMS.GOV Resource Library:

  - CMS.GOV Resource Library: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html

  - Final Rule Materials Posted: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html

Quality Payment Program

MIPS and Advanced APMs

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

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

OR

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

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

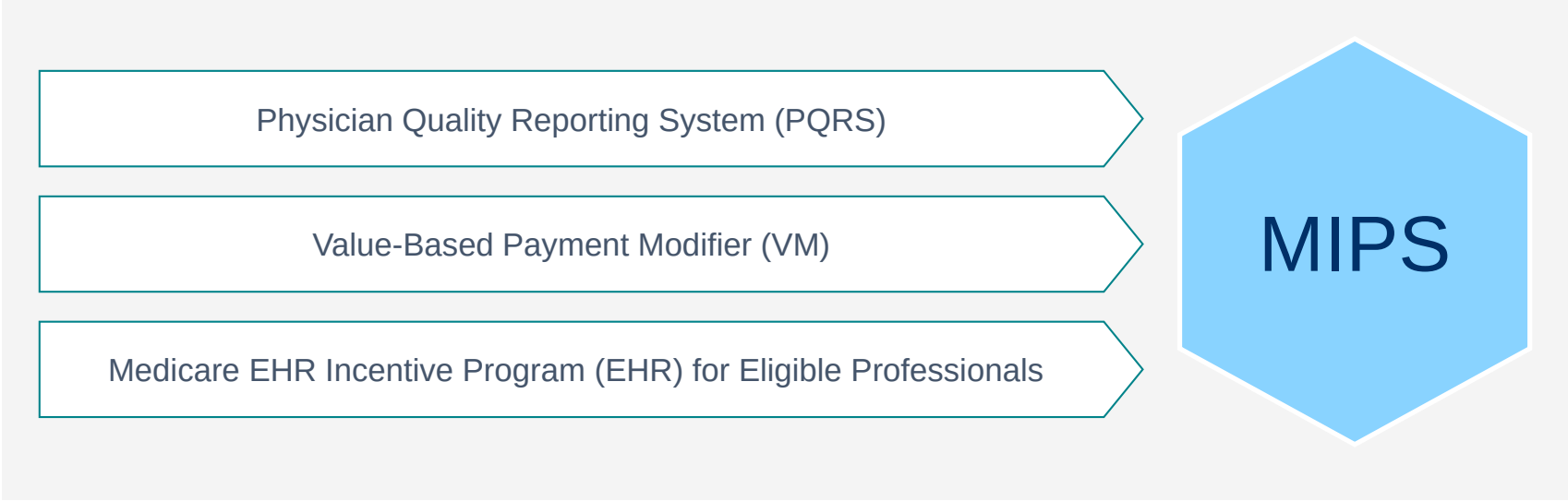
Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit 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 2 (2018)

- Comprised of four performance categories in 2018.
- All performance categories are calculated for MIPS Final Score.
- So what? *The points from each performance category are added together to give you a MIPS Final Score.*

MIPS Year 2 (2018)

Who is Included?

***No change** in the types of clinicians eligible to participate in 2018*

MIPS eligible clinicians include:

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

MIPS Year 2 (2018)

Who is Included?

***Change** to the Low-Volume Threshold for 2018.* Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges **AND** providing care for more than 200 Medicare patients a year.

Transition Year 1 (2017) Final

BILLING >$30,000 AND >100

Year 2 (2018) Final

BILLING >$90,000 AND >200

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

MIPS Year 2 (2018)

Who is Exempt?

No Change in Basic Exemption Criteria*

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

OR

- See **200** or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

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

**Only Change to Low-volume Threshold*

MIPS Year 2 (2018)

Performance Period

Change: *Increase to Performance Period*

Transition Year 1 (2017) Final

Performance Category	Minimum Performance Period
Quality	90-days minimum; full year (12 months) was an option
Cost	Not included. 12-months for feedback only.
Improvement Activities	90-days
Advancing Care Information	90-days

Year 2 (2018) Final

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Advancing Care Information	90-days

MIPS Year 2 (2018)

Virtual Groups

New: 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 2 (2018)

Quality

Basics:

- ***Change***: **50%** of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
  - 1 must be an Outcome measure
    OR
  - High-priority measure
- You may also select a specialty-specific set of measures

Component	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to Final Score	• 60%	• 50%
Data Completeness	• 50% for submission mechanisms except for Web Interface and CAHPS. • Measures that do not meet the data completeness criteria earn 3 points.	• 60% for submission mechanisms except for Web Interface and CAHPS. • Measures that to not meet data completeness criteria earn 1 point. • Burden Reduction Aim: Small practices will continue to receive 3 points.

MIPS Year 2 (2018)

Quality

Basics:

- ***Change***: **50%** of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
  - 1 must be an Outcome measure
    OR
  - High-priority measure
- You may also select a specialty-specific set of measures

Component	Transition Year 1 (2017) Final	Year 2 (2018) 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 for additional high priority measures up to 10% of denominator for performance category. • Bonus for end-to-end electronic reporting up to 10% of denominator for performance category.	• No changes

MIPS Year 2 (2018)

Quality

Basics:

- ***Change***: **50%** of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
  - 1 must be an Outcome measure
    OR
  - High-priority measure
- You may also select a specialty-specific set of measures

Topped Out Measures:

- Topped out measures with measure benchmarks that have been topped out for *at least 2 consecutive years* will receive up to 7 points.
- The 7-point scoring policy for the 6 topped out measures identified for the 2018 performance period is finalized. These measures are identified on the next slide.
- Topped out measures will only be removed after a review of performance and additional considerations.
- Topped out policies **do not apply** to CMS Web Interface measures, but this will be monitored for differences with other submission options.
- CAHPS will be addressed through future rulemaking.

MIPS Year 2 (2018)

Cost

Basics:

- ***Change:*** **10% Counted toward Final Score in 2018**

- *Change*: Cost performance category weight is **finalized at 10% for 2018.**
- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year
- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.
- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall for informational purposes only.
- 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 2 (2018)

MIPS: Scoring Improvements

New: MIPS Scoring Improvement for Quality and Cost

- For Quality:
  - Improvement scoring will be based on the rate of improvement such that higher improvement results in more points for those who have not previously performed well.
  - Improvement will be measured at the performance category level.
  - Up to 10 percentage points available in the Quality performance category.

- For Cost:
  - Improvement scoring will be based on statistically significant changes at the measure level.
  - Up to 1 percentage point available in the Cost performance category.

MIPS Year 2 (2018)

Improvement Activities

Basics:

- **15%** of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- You attest to participating in activities that improve clinical practice

Number of Activities:

- No change in the number of activities that MIPS eligible clinicians must report to achieve a total of 40 points.
- Burden Reduction Aim: MIPS eligible clinicians in small practices and practices in a rural areas will continue to report on no more than 2 activities to achieve the highest score.

Patient-centered Medical Home:

- We finalized the term “recognized” is equivalent to the term “certified” as a patient centered medical home or comparable specialty practice.
- **50%** of practice sites* within a TIN need to be recognized as patient-centered medical homes for the TIN to receive the full credit for Improvement Activities in 2018.

*We have defined practice sites as the *practice address that is available within the Provider Enrollment, Chain, and Ownership System (PECOS)*.

MIPS Year 2 (2018)

Improvement Activities

Basics:

- **15%** of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- You attest to participating in activities that improve clinical practice

Additional Activities:

- We are finalizing additional activities, and changes to existing activities for the Improvement Activities Inventory including credit for using Appropriate Use Criteria (AUC) through a qualified clinical support mechanism for all advanced diagnostic imaging services ordered.

Scoring:

- Continue to designate activities within the performance category that also qualify for an Advancing Care Information performance category bonus.
- For group reporting, only one MIPS eligible clinician in a TIN must perform the Improvement Activity for the TIN to receive credit.
- Continue to allow simple attestation of Improvement Activities.

MIPS Year 2 (2018)

Advancing Care Information

Basics:

- **25%** of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

CEHRT Requirements:

- Burden Reduction Aim: MIPS eligible clinicians may use either the 2014 or 2015 CEHRT or a combination in 2018.
- A **10% bonus** is available for using only 2015 Edition CEHRT.

Measures and Objectives:

- CMS finalizes exclusions for the E-Prescribing and Health Information Exchange Measures.

Scoring:

- No change to the base score requirements for the 2018 performance period/2020 payment year.
- For the performance score, MIPS eligible clinicians and groups will earn 10% for reporting to any one of the Public Health and Clinical Data Registry Reporting measures as part of the performance score.
- For the bonus score a 5% bonus score is available for reporting to an additional registry not reported under the performance score.
- Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus for completion of at least 1 of the specified Improvement Activities using CEHRT.
- Total bonus score available is 25%

MIPS Year 2 (2018)

MIPS: Performance Threshold & Payment Adjustment

Change: *Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

How can I achieve 15 points?

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

MIPS Year 2 (2018)

Extreme and Uncontrollable Circumstances

CMS knows that areas affected by the recent hurricanes, specifically Hurricanes Harvey, Irma, and Maria, have experienced devastating disruptions in infrastructure and clinicians face challenges in submitting data under the Quality Payment Program.

We have addressed extreme and uncontrollable circumstances for both the Transition Year (2017) and Year 2 (2018) MIPS performance periods.

Transition Year (2017):

- If a MIPS eligible clinician's CEHRT is unavailable as a result of extreme and uncontrollable circumstances, the MIPS eligible clinician may submit a hardship exception application to be considered for reweighting of the Advancing Care Information Performance category.

- This application is **deadline** is **December 31, 2017**.

MIPS Year 2 (2018)

Extreme and Uncontrollable Circumstances

Extreme and Uncontrollable Circumstances in Year 2 (2018):

- The Final Rule with Comment Period for Year 2 **extends** the Transition Year hardship exception reweighting policy for the Advancing Care Information performance category to now include Quality, Cost, and Improvement Activities.
- This policy applies to the 2018 MIPS performance category.
- The hardship exception application **deadline** is **December 31, 2018**.

MIPS Year 2 (2018)

Extreme and Uncontrollable Circumstances

We have also issued an **Interim Final Rule** with an automatic extreme and uncontrollable circumstances policy where clinicians are exempt from the Quality, Improvement Activities, and Advancing Care Information performance categories *without* submitting a hardship exception application.

What does the Interim Final Rule mean for me in the Transition Year (2017)?

- We will automatically weight the Quality, Improvement Activities, and Advancing Care Information performance categories to **0%** of the MIPS Final Score.
- This will result in a MIPS Final Score equal to the performance threshold, unless the MIPS eligible clinician submits data.
- Clinicians who do submit data (as an individual or group) will be scored on their submitted data.
- This policy does not apply to APMs.

Role of MAP for Merit-based Incentive Payment System (MIPS)

Role of MAP

- MAP provides input on measures under consideration for MIPS

CMS Priorities and Needs for MIPS

- Outcome measures
- Measures relevant for specialty providers
- High-priority domains for future measure consideration:
  - *Person and caregiver-centered Experience and Outcomes (Specific focus on PROMs)*
  - *Communication and Care Coordination*
  - *Efficiency/Cost Reduction*
  - *Patient Safety*
  - *Appropriate Use*
- MACRA requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals prior to implementing in MIPS.

CMS Priorities and Needs for MIPS

- Available for public reporting on Physician Compare
- Measures are fully developed and tested and ready for implementation
- Not duplicative of measures in set
- Identify opportunities for improvement – avoid “topped out” measures

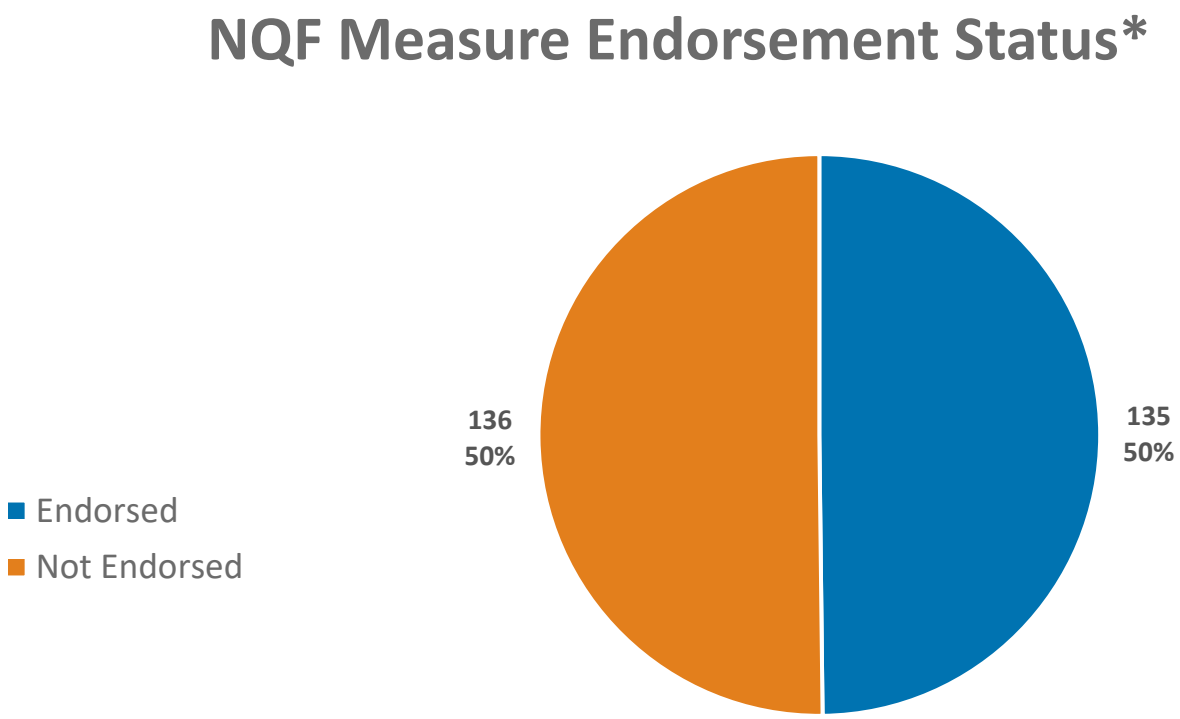
MIPS Current measures

Divided by MIPS Measure Domain

Domain	# of Measures
Effective Clinical Care	129
Patient Safety	45
Communication/Care Coordination	43
Community/Population Health	15
Efficiency and Cost Reduction	23
Person and Caregiver-Centered Experience and Outcomes	16

- Total of 271 measures

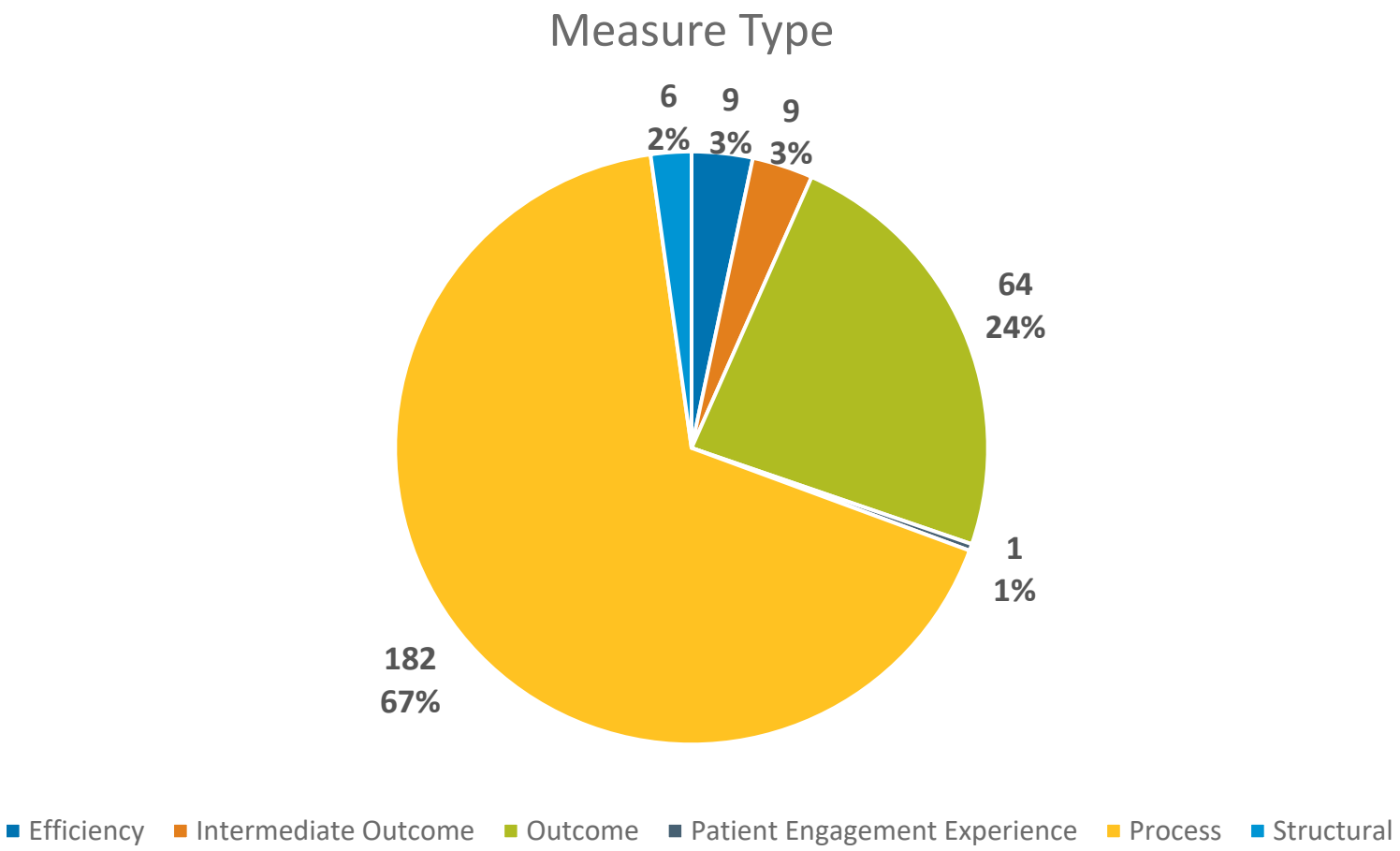
2017 MIPS Measures



- *Status as of October, 2016, *Quality Measure Specification Supporting Document*

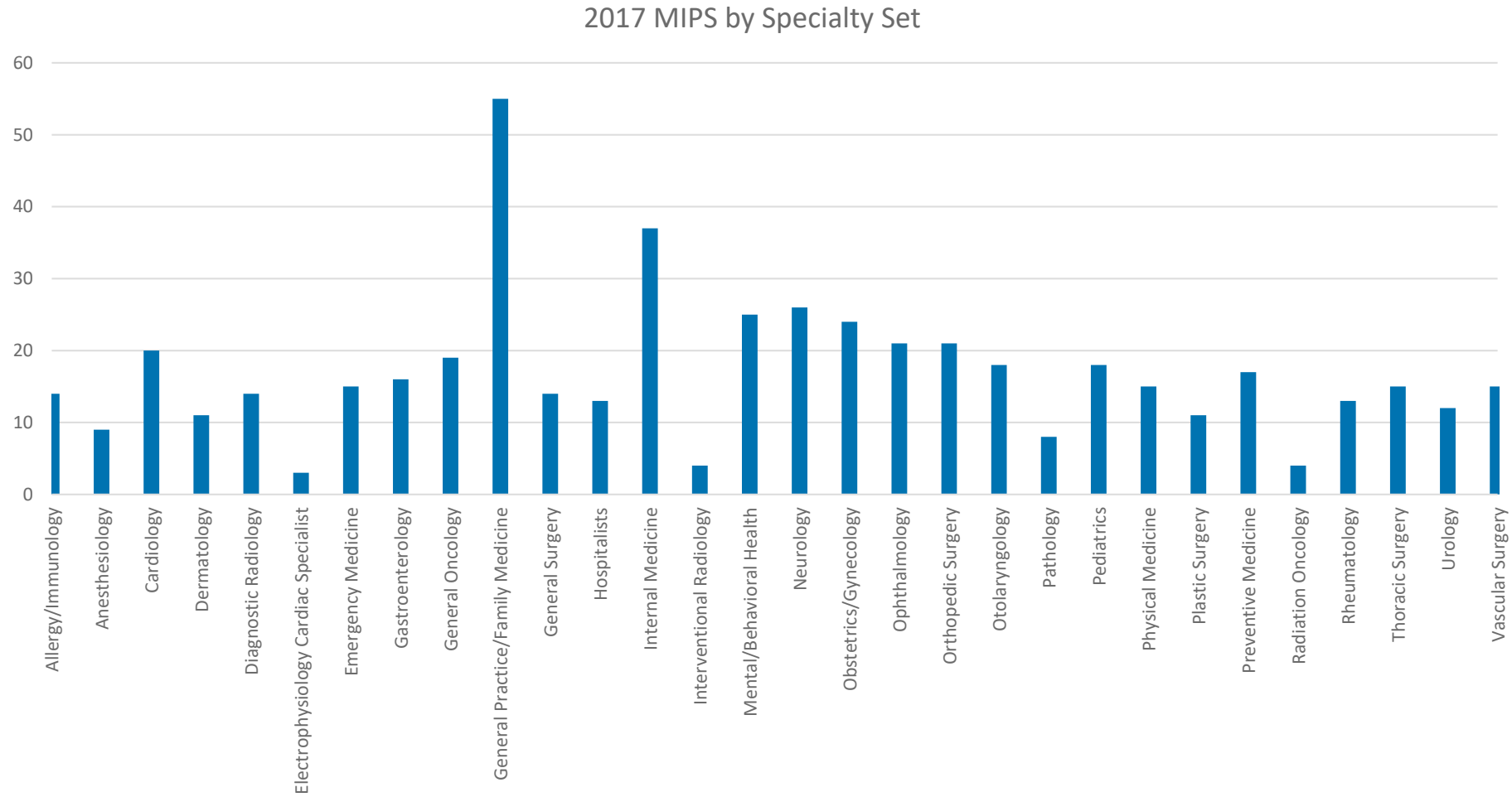
- Total of 271 measures

2017 MIPS Measures



- Total of 271 measures

2017 MIPS Measures



- Total of 271 measures (*measure can be part of more than 1 specialty set)

Workgroup Discussion

- Does the Workgroup have suggestions for refinement to future measurement in the high priority domains?

Medicare Shared Savings Program (MSSP)

Overview of Medicare Shared Savings Program

Rabia Khan, MPH

November 9, 2017

Agenda

- Medicare Shared Savings Program Overview
- Promising Results
- 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.
- As of January 1, 2017, 480 Shared Savings Program ACOs were serving approximately 9 million Medicare FFS beneficiaries.
- CMS assesses ACO performance annually based on quality and financial performance to determine shared savings or losses.

Promising Results: Quality Performance

Quality Performance Highlights:

- ACOs that reported quality in 2015 and 2016 improved on 94 percent of the quality measures that were reported in both years.
- In 2016, 93 percent of ACOs received bonus points for improving quality performance in one of the four quality measure domains. That is, more than 90 percent of ACOs in a second or third performance year or second agreement period during 2016 increased their overall quality performance score through Quality Improvement Reward points in at least one of four quality measure domains.

Promising Results: Financial Performance

Financial Performance Highlights:

- The number of ACOs that have generated savings has had a positive trend. For PY2016 and PY 2015, 31 percent of ACOs (PY2016: 134 of 432 and PY2015: 120 of 392) generated savings above their Minimum Savings Rate (MSR) compared to 28 percent (92 of 333) in PY2014 and 26 percent (58 of 220) in PY2013.
- ACOs with more experience in the program are more likely to generate savings. For PY2016, 42 percent of ACOs that started in 2012 generated savings above their MSR, compared to 36 percent of 2013 starters, 36 percent of 2014 starters, 26 percent of 2015 starters, and 18 percent of 2016 starters.
- ACOs that are physician-led have better results, on average. In PY2016, a higher share of the physician only ACOs had shared savings (41%) compared to ACOs with a hospital (23%). In PY2015, physician only ACOs were more likely than ACOs with a hospital to have shared in savings (35% versus 26%) and also in PY2014 (29% versus 24%).

Overview of Quality Measurement Approach

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

Overview of Quality Measurement Approach (continued)

- In Performance Year 2017, there are 31 quality measures separated into the following four key domains:
    1. Patient/Caregiver Experience
    2. Care Coordination/Patient Safety
    3. Preventive Health
    4. At-Risk Population
- Quality data is collected via the following mechanisms:
    - Patient Survey (CAHPS for ACOs)
    - Claims
    - Advancing Care Information data
    - CMS Web Interface

2017 and 2018 Quality Measures: Aim 1: Better Care for Individuals

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

*Measure is pay-for-reporting all years.

2017 and 2018 Quality Measures: Aim 1: Better Care for Individuals (continued)

2. CARE COORDINATION/PATIENT SAFETY
ACO-8 Risk-Standardized All Condition Readmission
ACO-35 Skilled Nursing Facility 30-Day All-Cause Readmission Measure
ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes
ACO-37 All-Cause Unplanned Admissions for Patients with Heart Failure
ACO-38 All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
ACO-43 Ambulatory Sensitive Condition Acute Composite (Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) #91)
ACO-11 Use of Certified Electronic Health Record (EHR) Technology
ACO-12 Medication Reconciliation Post-Discharge
ACO-13 Screening for Future Fall Risk
ACO-44 Use of Imaging Studies for Low Back Pain*

*Measure is pay-for-reporting all years.

2017 and 2018 Quality Measures: Aim 2: Better Health for Populations

3. PREVENTIVE HEALTH
ACO-14 Influenza Immunization
ACO-15 Pneumococcal Vaccination
ACO-16 Body Mass Index (BMI) Screening and Follow-Up
ACO-17 Tobacco Use: Screening and Cessation Intervention
ACO-18 Screening for Clinical Depression and Follow-Up Plan
ACO-19 Colorectal Cancer Screening
ACO-20 Breast Cancer Screening
ACO-42 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*

*Measure is pay-for-reporting all years.

2017 and 2018 Quality Measures: Aim 2: Better Health for Populations (cont.)

4. Clinical Care for At-Risk Population
Depression
ACO-40 Depression Remission at 12 Months*
Diabetes
ACO-27 Diabetes Mellitus: HbA1c Poor Control**
ACO-41 Diabetes: Eye Exam**
Hypertension
ACO-28 Controlling High Blood Pressure
Ischemic Vascular Disease
ACO-30 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

*Measure is pay-for-reporting all years
**The Diabetes Composite includes ACO-27 and ACO-41

Quality Performance Assessment

- CMS designates the quality performance standard depending on how long the ACO has been in the program (see table).
- 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. This qualifies the ACO to share in the maximum available sharing rate for payment.
2 and 3*	Pay-for-Performance	Completely and accurately report all quality measures and meet minimum attainment* on at least one measure in each domain. Final sharing rate for determining shared savings or losses determined based on quality measure performance.

* Performance at 30 percent or the 30th percentile of the performance benchmark for pay-for-performance measures and set at complete reporting for pay-reporting-measures.

Future Measure Considerations

- We would appreciate MAP recommendations for measures that:
  - Align with other value-based purchasing initiatives (e.g. MIPS, SNF VBP)
    - Measures aligning with MIPS include those reported through the CMS Web Interface and the CAHPS for ACOs survey
    - In addition, measures align with the Million Hearts Initiative and Core Quality Measures Collaborative recommendations
  - Sensitive to administrative burden for reporting
    - For PY 2017, QPP will use the ACO reported CMS Web Interface data to calculate the Quality performance category for all MIPS eligible clinicians participating in the ACO; and, the ACI reported data to calculate the ACO-11 measure for the Shared Savings Program
  - Address National Quality Strategy and CMS Quality Strategy goals and priorities

Role of MAP for Medicare Shared Savings Program (MSSP)

Role of MAP

- MAP provides input on measures under consideration for MSSP

CMS Priorities and Needs for MSSP

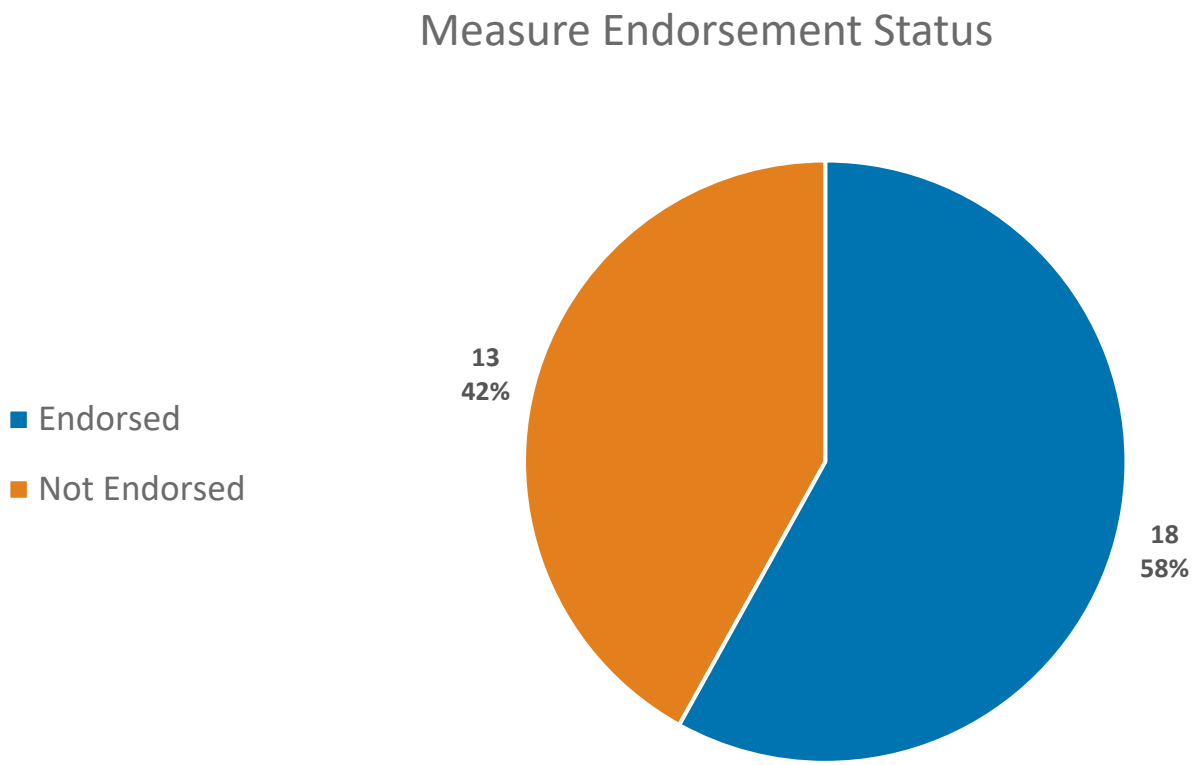
- Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients.
- Measures that are targeted to the needs and gaps in care of Medicare fee-for-service patients and their caregivers.
- Measures that align with CMS quality reporting initiatives, such as MIPS.
- Measures that support improved individual and population health.
- Measures that align with recommendations from the Core Quality Measures Collaborative.

MSSP Current Measures

Divided into 4 domains specified by ACA (31 Total Measures)

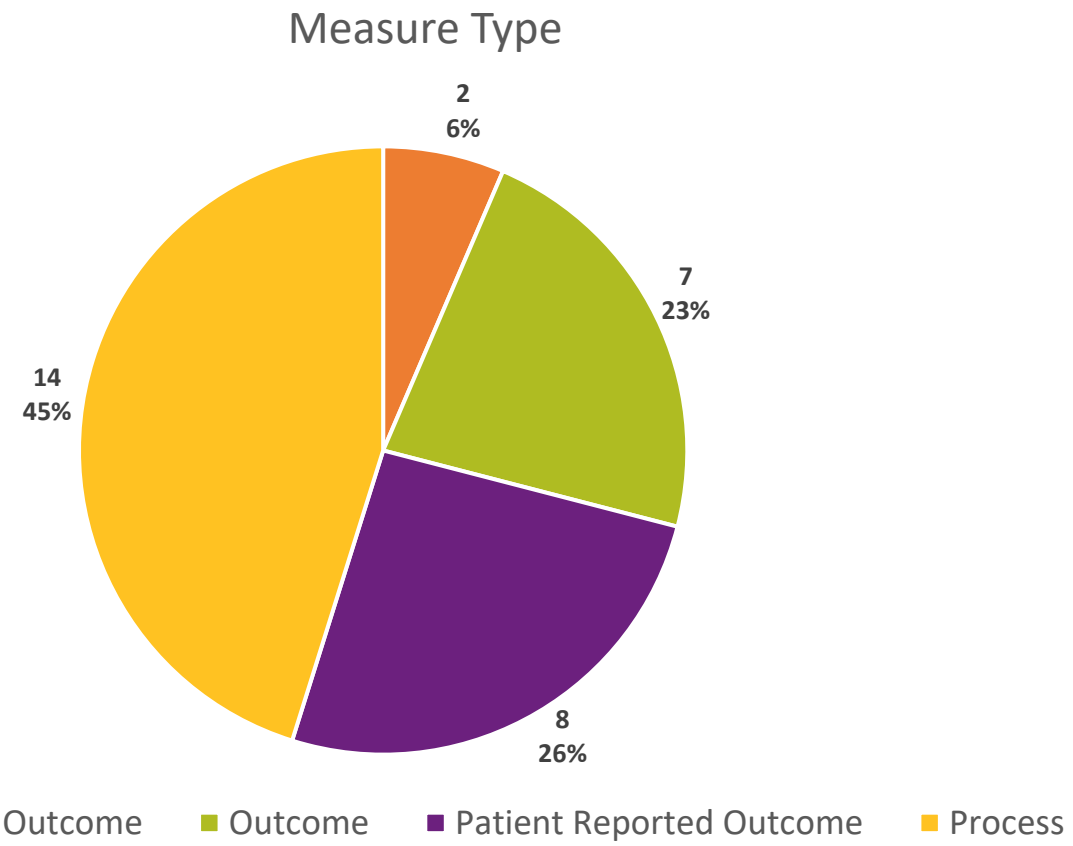
Domain	# of Measures
Patient/Caregiver Experience	8
Care Coordination/Patient Safety	10
Preventive Health	8
Clinical Care for At Risk Populations	5

2017 MSSP Measures



- Total of 31 measures

2017 MSSP Measures



- Total of 31 measures

Workgroup Discussion

- Does the Workgroup have suggestions for refinement to future measurement in the high priority domains?

Update on Prior MUC List Measures (MIPS)

Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy (MUC 16-287)

- Steward: Oregon Urology Institute in collaboration with Large Urology Group Practice Association

- MAP Recommendation:
  - *Refine and Resubmit Prior to Rulemaking*

- MAP Rationale
  - *This measure provides information as to whether physicians are appropriately conducting and documenting bone density evaluation for patients undergoing androgen deprivation therapy. MAP discussed that an outcome measure would be much more meaningful in MIPS. Additionally, there were several concerns about the populations that would be included or excluded from the measure. More test data and specificity were also requested. If an outcome measure is not feasible at this time, MAP recommends resubmission after addressing the measure specifications and testing concerns.*

Prevention of Post-Operative Vomiting (POV) - Combination Therapy (Pediatrics) (MUC 16-312)

- Steward: American Society of Anesthesiologists
- MAP Recommendation:
  - *Conditional Support for Rulemaking*
- MAP Rationale
  - *This measure provides information as to whether physicians are appropriately treating post-operative vomiting after anesthetic use. MAP discussed whether a gap exists and felt that it did since this covers pediatric and adolescent patients. Conditional Support pending NQF review and endorsement.*

Uterine artery embolization technique: Documentation of angiographic endpoints and interrogation of ovarian arteries (MUC 16-343)

- Steward: Society of Interventional Radiology

- MAP Recommendation:
  - *Refine and Resubmit Prior to Rulemaking*

- MAP Rationale
  - *This measure does not appear to be tested at the clinician level. This measure provides information as to whether physicians are appropriately documenting procedural aspects of uterine artery embolization. MAP appreciated that this measure also addresses a potential disparity as the condition is more prevalent in African American patients. MAP indicated a preference for an outcome measure. MAP recommends that if an outcome measure is not feasible at this time, the measure should be resubmitted with testing that supports variation at the individual clinician level.*

Average change in back pain following lumbar discectomy and/or laminotomy (MUC 16-87)

- Steward: MN Community Measurement

- MAP Recommendation:
  - *Conditional Support for Rulemaking*

- MAP Rationale
  - *This measure would add a PRO-PM to the set as well as a measure specific to spine surgery . The submitter does not provide specific test data. In order to receive full support, the submitter will need to provide data at the individual clinician level. Patient-reported outcomes provide valuable information for patients and consumers when selecting healthcare providers. This measure would assess the outcome of a lumbar discectomy and/or laminectomy. Conditional support pending NQF endorsement and testing that supports variation at the individual clinician level. .*

Average change in back pain following lumbar fusion (MUC 16-88)

- Steward: MN Community Measurement

- MAP Recommendation:
  - *Conditional Support for Rulemaking*

- MAP Rationale
  - *This measure would add a PRO-PM to the set as well as a measure specific to spine surgery . The submitter does not provide specific test data. In order to receive full support, the submitter will need to provide data at the individual clinician level. Patient-reported outcomes provide valuable information for patients and consumers when selecting healthcare providers. This measure would assess the outcome of a lumbar fusion. Conditional support pending NQF endorsement and testing that supports variation at the individual clinician level.*

Average change in leg pain following lumbar discectomy and/or laminotomy (MUC 16-89)

- Steward: MN Community Measurement

- MAP Recommendation:
  - *Conditional Support for Rulemaking*

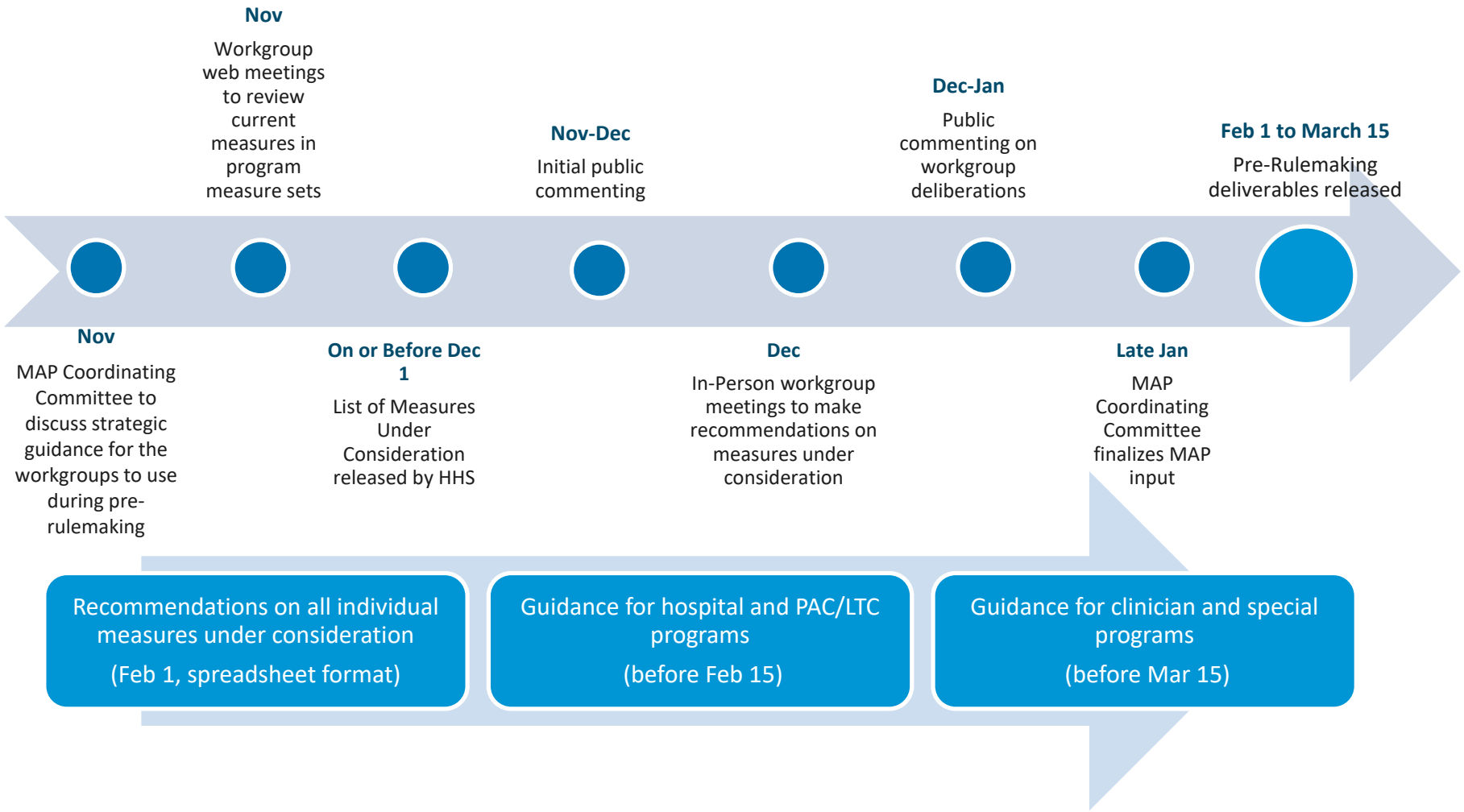
- MAP Rationale
  - *This measure would add PRO-PM to the set as well as spine surgery specific measures. The submitter does not provide specific test data. In order for full support, the submitter will need to provide data at the individual clinician level. Patient-reported outcomes provide valuable information for patients and consumers when selecting healthcare providers. This measure would assess the outcome of a lumbar discectomy and/or laminectomy. Conditional support pending NQF endorsement and testing that supports variation at the individual clinician level.*

Opportunity for Public Comment

Next Steps

MAP Pre-Rulemaking Approach

A look at what to expect



Next Steps: Upcoming Activities

- Release of the MUC List – by December 1
- Public Comment Period #1 – Timing based on MUC list release
- In-Person Clinician Workgroup Meeting – December 12
- Public Comment Period #2 – Following Workgroup In-Person Meetings
- Coordinating Committee – January 25-26

Resources

- CMS' Measurement Needs and Priorities Document:
  - *Final_4_11_2017_MUC_Program_Priorities_Needs*
- Pre-Rule Making 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
  - *mapclinician@qualityforum.org*