NATIONAL QUALITY FORUM

# Measure Applications Partnership

Clinician Workgroup Web Meeting

*November 14, 2018*

# Welcome, Introductions, and Review of Meeting Objectives

# Agenda

- Welcome, Introductions, and Review of Meeting Objectives
- MAP Pre-Rulemaking Approach
- Overview of the Merit-Based Incentive Payment System (MIPS) Program
- Overview of the Medicare Shared Savings Program Program
- 2017-2018 MAP Clinician Overarching Themes
- Update on Prior Measures Under Consideration
- Introduction to NQF's Rural Work
- Opportunity for NQF Member and Public Comment
- Next Steps

# MAP Clinician Team

- John Bernot, Vice President
- Miranda Kuwahara, Project Manager
- **Project email:** MAPClinician@qualityforum.org

# Clinician Workgroup Membership

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

## Organizational Members (Voting)

| | |
|---|---|
| American Academy of Pediatrics | Terry Adirim, MD, MPH, FAAP |
| American Association of Nurse Practitioners | Diane Padden, PhD, CRNP, FAANP |
| American College of Cardiology | J. Chad Teeters, MD, MS, RPVI, FACC |
| American College of Radiology | David J. Seidenwurm, MD |
| American Occupational Therapy Association (AOTA) | Trudy Mallinson, PhD, OTR/L, FAOTA |
| America's Physician Groups | Amy Nguyen, MD, MBA, FAAFP |
| Anthem | Kevin Bowman, MD |
| Atrium Health | Scott Furney, MD, FACP |
| Consumers' CHECKBOOK | Robert Krughoff, JD |
| Council of Medical Specialty Societies | Helen Burstin, MD, MPH, FACP |
| Genentech | Dae Choi, MBA, MPH |
| Health Partners, Inc. | Susan Knudson |
| National Association of Accountable Care Organizations (NAACOS) | Robert Fields, MD |
| Pacific Business Group on Health | Stephanie Glier, MPH |
| Patient-Centered Primary Care Collaborative | Ann Greiner, MS |
| St. Louis Area Business Health Coalition | Patti Wahl, MS |

# Clinician Workgroup Membership

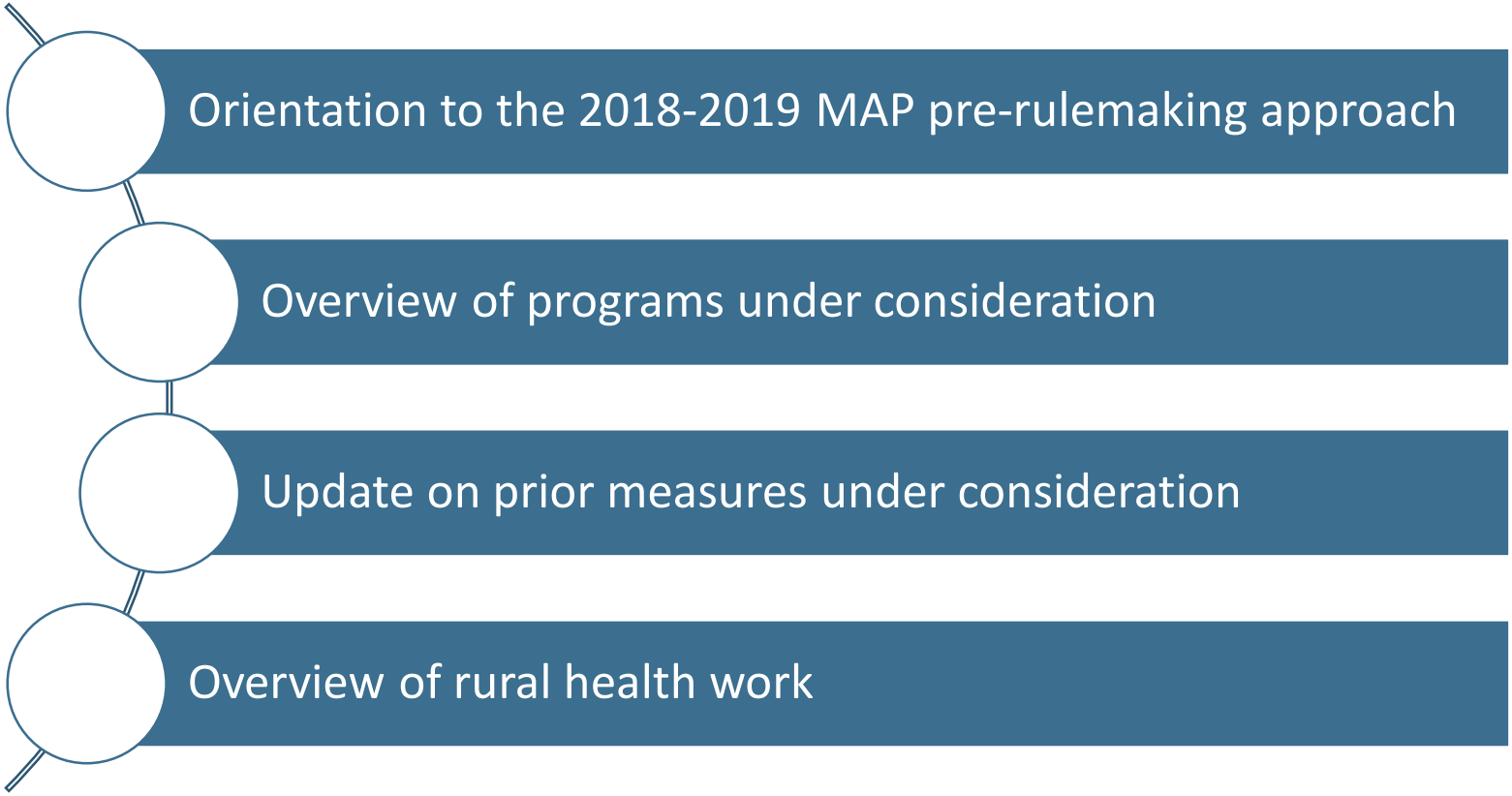
## Subject Matter Experts (Voting)

| |
|---|
| Dale Shaller, MPA |
| Michael Hasset, MD, MPH |
| Eric Whitacre, MD, FACS |
| Leslie Zun, MD |

## Federal Government Members (Non-Voting)

| | |
|---|---|
| Centers for Disease Control and Prevention (CDC) | Peter Briss, MD, MPH |
| Centers for Medicare & Medicaid Services (CMS) | Reena Duseja, MD |
| Health Resources and Services Administration (HRSA) | Girma Alemu, MD, MPH |

# 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

### December

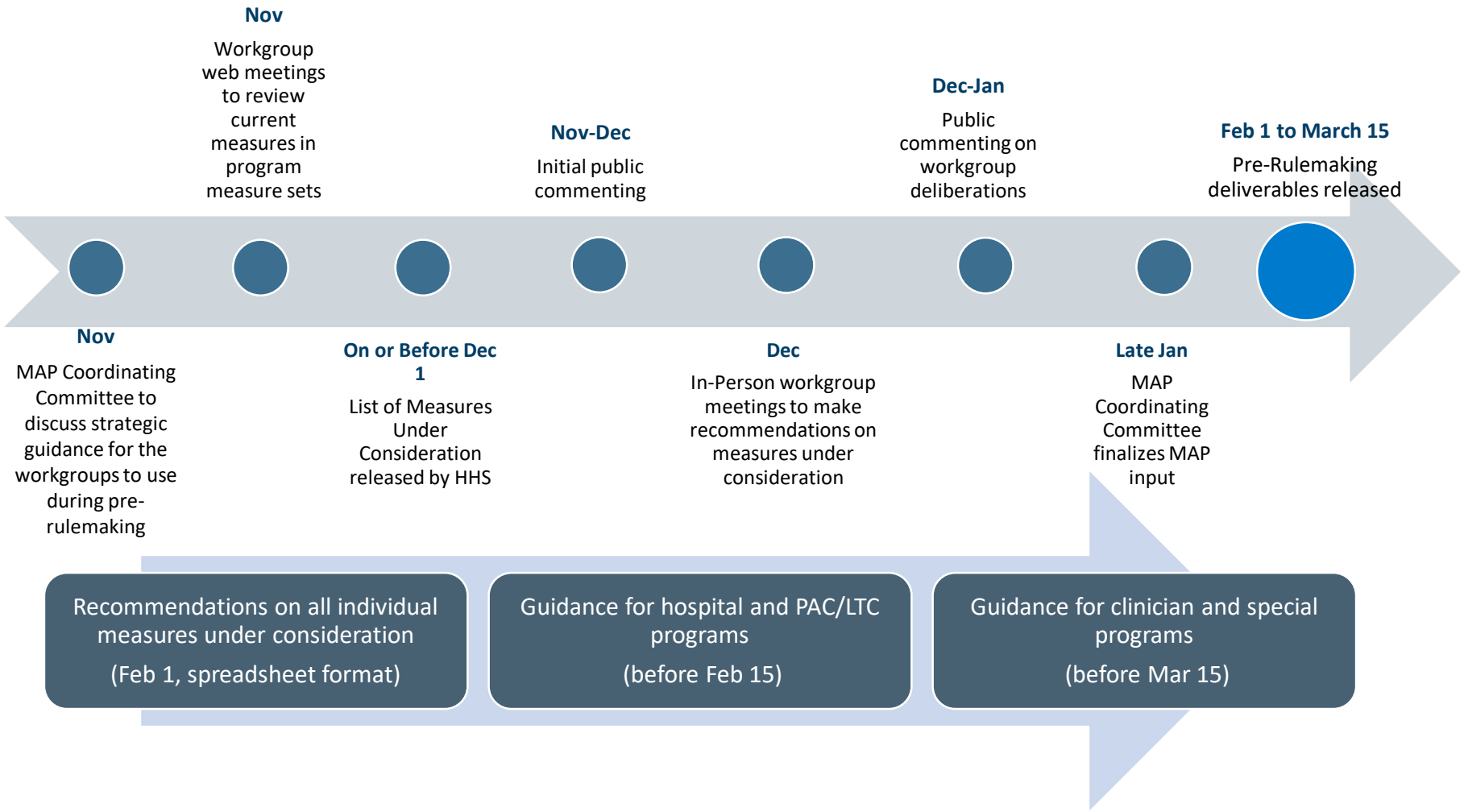
- The MAP workgroups will evaluate measures under consideration during their December in-person meetings informed by the preliminary evaluations completed by NQF staff

### 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

# 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
- Provide input to the Rural Health group

# Merit-Based Incentive Payment System (MIPS)

Quality Payment
PROGRAM

# QUALITY PAYMENT PROGRAM YEAR 3 (2019)

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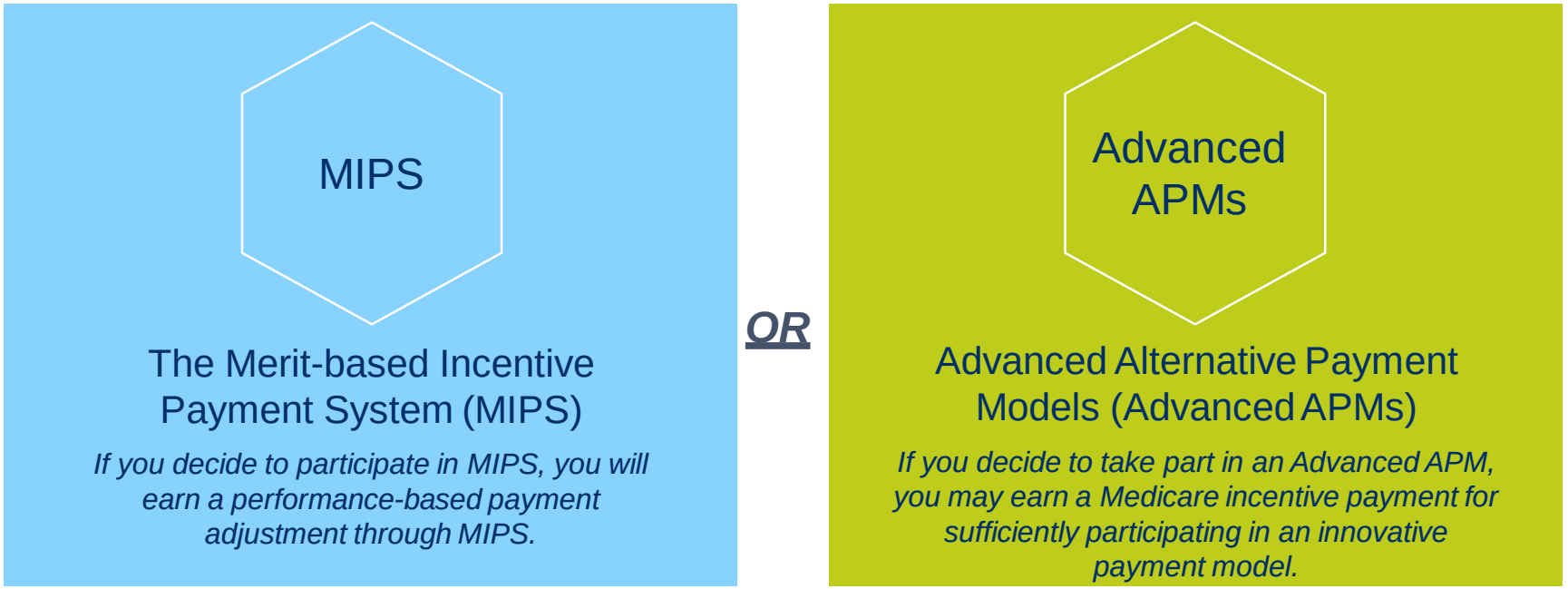
# Resource Library

- 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

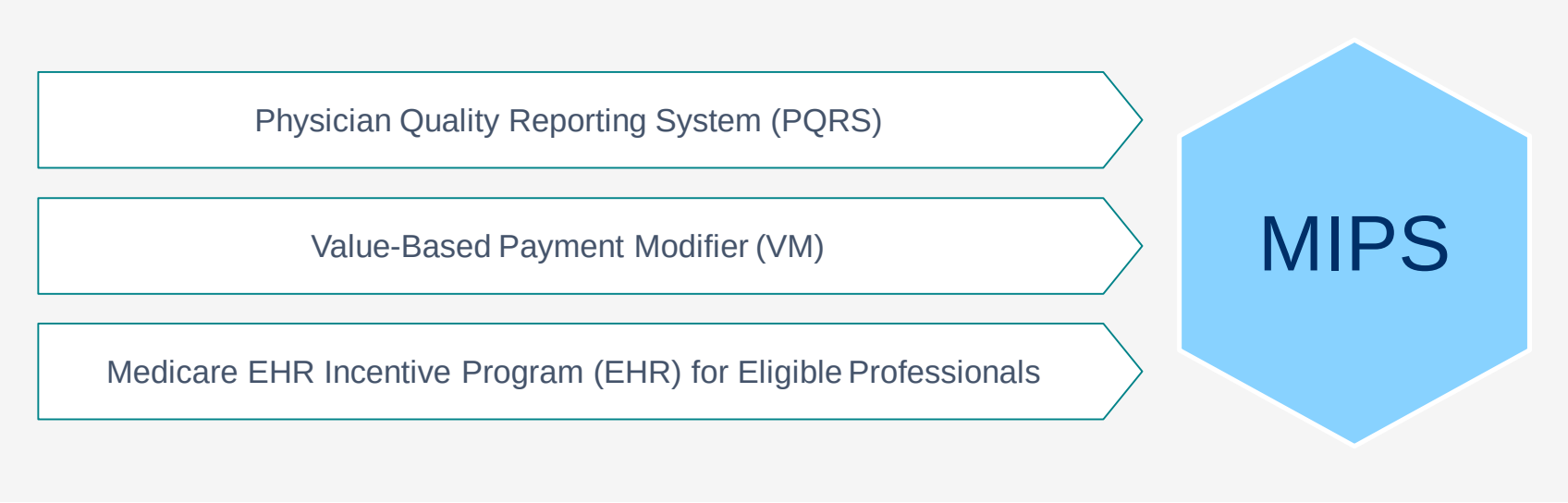
Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit 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 3 (2019)


- In the CY 2019 PFS Final Rule, we finalized that the weight of the quality performance category will be reduced to 45, and the weight of the cost performance category is increasing to 15.
- All performance categories are calculated for MIPS Final Score.
- *The points from each performance category are added together to give you a MIPS Final Score.*

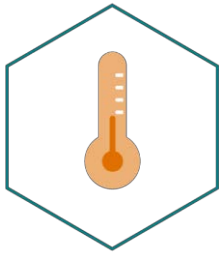
# MIPS Year 3 (2019)

## 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):**

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

# MIPS Year 3 (2019)

## Who is Included?

*Change to the Low-Volume Threshold for 2019.*

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 2 (2018) Final**


**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 3 (2019)

## Who is Exempt?

### Newly-enrolled in Medicare

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

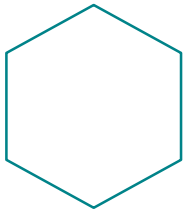
### Below the low-volume threshold

- 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 3 (2019)

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 3 (2019)

## Performance Period

### Year 3 (2019) Finalized

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

# MIPS Year 3 (2019)

## 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 3 (2019)

## Quality

Basics:

- ***Change***: **45%** of Final Score in 2019
- 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 2 (2018) Final | Year 3 (2019) Finalized |
|---|---|---|
| Weight to Final Score | • 50% | • 45% |
| Data Complete-ness | • 60% for submission mechanisms except for Web Interface and CAHPS.<br>• Measures that do not meet the data completeness criteria earn 1 point.<br>• Small practices that do not meet data completeness will receive 3 points. | • Same requirements as Year 2 |

# MIPS Year 3 (2019)

## Quality

Basics:

- ***Change***: **45%** of Final Score in 2019
- 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 2 (2018) Final | Year 3 (2019) Finalized |
|---|---|---|
| Scoring | • 3-point floor for measures scored against a benchmark.<br>• 3 points for measures that do not have a benchmark or do not meet case minimum.<br>• 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.<br>• Cap bonus points at 10% of category denominator. | Same requirements as Year 2, with the following change:<br><br>Add small practice bonus of 3 points for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure |

# MIPS Year 3 (2019)

## Quality

### Basics:

- ***Change***: **45%** of Final Score in 2019
- 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 3 (2019)

## Cost

Basics:

- ***Change:*** **15%** Counted toward Final Score in 2018

- *Change*: Cost performance category weight is **15%  for 2019.**
- Medicare Spending per Beneficiary (MSPB) and Total per Capita Cost measures are included in calculating Cost performance category score for the 2019 MIPS performance period.
- These measures were used in the Value Modifier, in the MIPS transition year, and in MIPS Year 2 (2018).
- New episode-based measures were developed with significant clinician and stakeholder input. 8 episode-based measures will be added for the 2019 MIPS performance period
- 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 3 (2019)

## 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 2019 performance to an assumed 2018 Quality performance category score of 30%.

- For Cost:
  - There will be no cost improvement scoring for MIPS Year 3.
  - The cost performance category percent score will not take into account improvement until the 2024 MIPS payment year.

# MIPS Year 3 (2019)

## Improvement Activities

### Basics:

- **15%** of Final Score in 2019
- Select Improvement Activities and attest "yes" to completing
  - Activity Weights remain the same from Year 2
  - 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 6 new Improvement Activities
- Modifying 5 existing Improvement Activities
- Removing 1 existing Improvement Activity

### Nominating Activities:

- Adding one new criterion and removing one existing criterion to the criteria for nominating new improvement activities
- Improvement activity nominations received in Year 3 will be reviewed and considered for possible implementation in Year 5 of the program
- The submission timeframe/due dates for nominations is February 1st through June 30th, providing approximately 4 additional months to submit nominations

# MIPS Year 3 (2019)

## Promoting Interoperability

### Basics:

- **25%** of Final Score in 2019
- Must use 2015 Edition Certified EHR Technology (CEHRT) in 2019
- New performance-based scoring
- 100 total category points.

### CEHRT Requirements:

- Must use the 2015 Edition Certified EHR Technology in 2019

### Measures and Objectives:

- One objectives and measures set, based on the 2015 Edition CEHRT.

### Scoring:

- Eliminating the base, performance, and bonus scores for 2019.
- Proposing a new performance-based scoring at the individual measure level.
- Each measure will be scored on performance for that measure based on the submission of a numerator and denominator or, for measures associated with the Public Health and Clinical Data Exchange objective, a “yes or no”.
- Scores for each of the individual measures would be added together to calculate the Promoting Interoperability performance category score of up to 100 possible points.

# MIPS Year 3 (2019)

## MIPS: Performance Threshold & Payment Adjustment

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

| Year 2 (2018) Final | Year 3 (2019) |
| --- | --- |
| • 15 point performance threshold<br>• Exceptional performance bonus set at 70 points<br>• Payment adjustment set at +/- 5% | • 30 point performance threshold<br>• Exceptional performance bonus set at 80 points<br>• Payment adjustment set at +/- 7% |

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 3 (2019)

## 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).*

# MIPS Year 3 (2019)

## Extreme and Uncontrollable Circumstances

*We have also issued a policy in the CY 2019 PFS final rule for extreme and uncontrollable circumstances where clinicians are exempt from the Quality, Improvement Activities, and Advancing Care Information performance categories by submitting a hardship exception application.*

*What does that mean for Year 3 (2019)?*

- Reweight the quality, cost, and improvement activities performance categories based on a request submitted by a MIPS eligible clinician, group, or virtual group that was subject to extreme and uncontrollable circumstances.

- If a MIPS eligible clinician submits an application for reweighting based on extreme and uncontrollable circumstances, but also submits data on the measures or activities specified for the quality or improvement activities performance categories, he or she will be scored on the submitted data like all other MIPS eligible clinicians, and the categories will not be reweighted.

- For groups, we will evaluate whether sufficient measures and activities are applicable and available to MIPS eligible clinicians in the group on a case-by-case basis and determine whether to reweight a performance category based on the information provided.

- This policy does not apply to APMs.

# Role of MAP for Merit-based Incentive Payment System (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

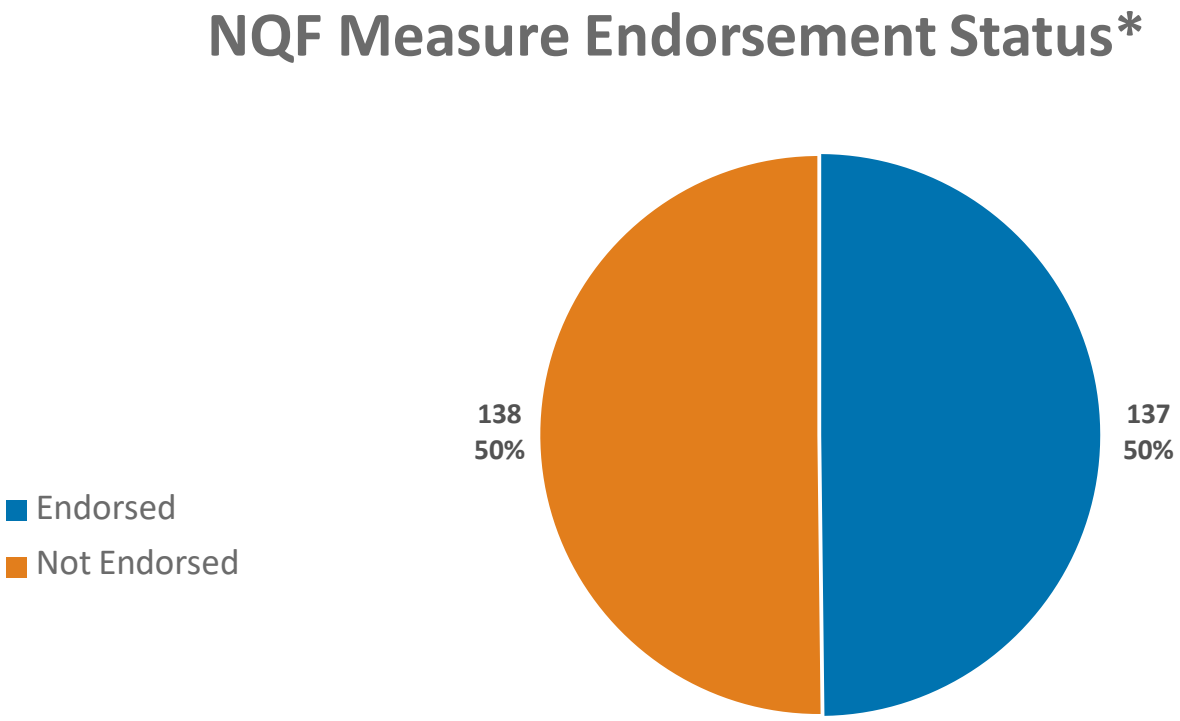
Divided by MIPS Measure Domain

| Domain | # of Measures |
|---|---|
| Effective Clinical Care | 130 |
| Patient Safety | 46 |
| Communication/Care Coordination | 43 |
| Community/Population Health | 16 |
| Efficiency and Cost Reduction | 22 |
| Person and Caregiver-Centered Experience and Outcomes | 19 |

- Total of 275 measures

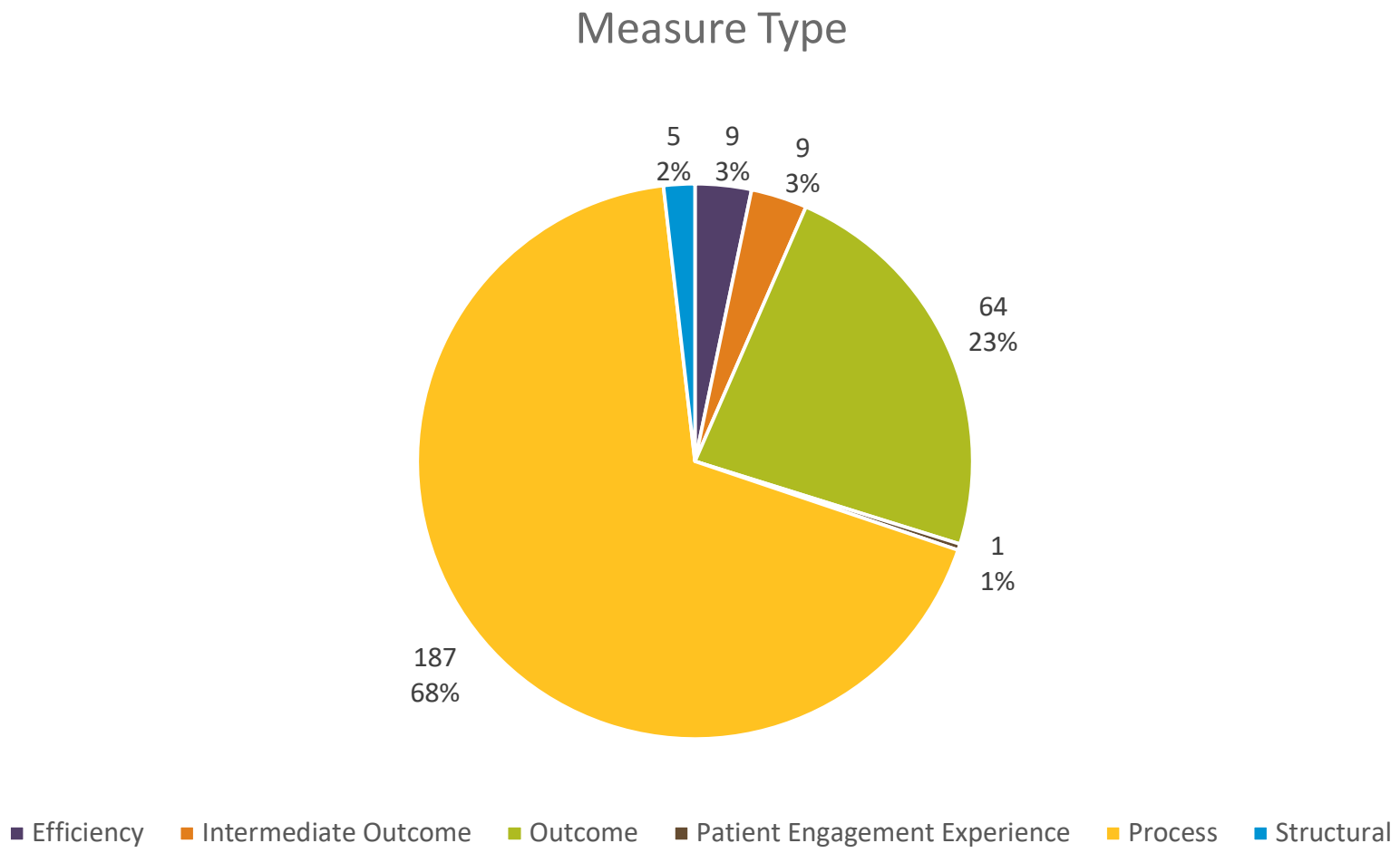
Note: One measure was included in two domains.

# 2018 MIPS Measures



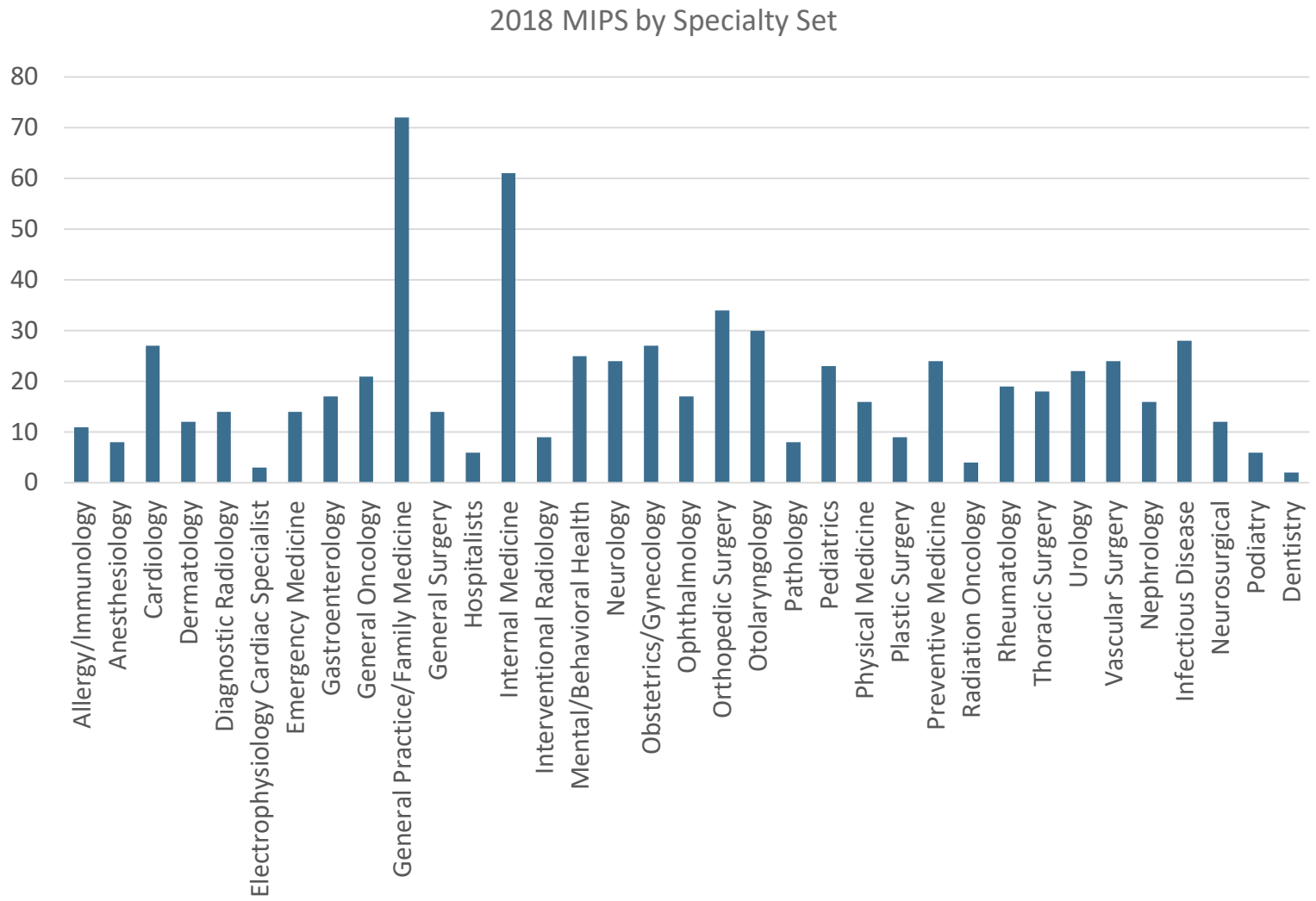

- *Status as of June 2018 *Quality Measure Specification Supporting Document*
- Total of 275 measures

# 2018 MIPS Measures




- Total of 275 measures

# 2018 MIPS Measures




- Total of 275 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 (Shared Savings Program)

MEDICARE SHARED SAVINGS PROGRAM

# Overview of Medicare Shared Savings Program

## For the Measures Application Partnership

- November 14, 2018


- Fiona Larbi, MS, RN
- Division of Program Alignment and Communications

# 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, 2018, 561 Shared Savings Program ACOs were serving approximately 10.5 million Medicare FFS beneficiaries.
- CMS assesses ACO performance annually based on quality and financial performance to determine shared savings or losses.

# ACO Quality Performance Highlights

- Over 98% of ACOs continue to satisfactorily report quality measures on behalf of their clinicians annually
- ACOs that reported quality in 2016 and 2017 improved on 93 percent of the quality measures that were reported in both years.
- In 2017, 93 percent of ACOs received bonus points for improving quality performance in one of the four quality measure domains between 2016 and 2017. That is, more than 90 percent of ACOs in a second or third performance year or second agreement period during 2017 increased their overall quality performance score through Quality Improvement Reward points in at least one of four quality measure domains.

# 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
- Proposed in Calendar Year 2019 Medicare Physician Fee Schedule proposed rule to refine the ACO core quality measure set to reduce the number of measures by 7, to make the measure set more outcome oriented, and reduce burden on ACOs and providers

# Overview of Quality Measurement Approach



In Performance Year 2018, there are 31 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
- Quality Payment Program Promoting Interoperability data
- 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 and 3, 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. |

# 2017 and 2018 Quality Measures

- Aim 1: Better Care for Individuals

| 1. PATIENT/CARE GIVER EXPERIENCE<br>*CAHPS for ACOs* |
|---|
| 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 (continued)

| 4. Clinical Care for At-Risk Population |
|---|
| **Depression** |
| ACO-40 Depression Remission at 12 Months* |
| **Diabetes ('all-or-nothing' Composite)**** |
| 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

# Future Measure Considerations

- Align across CMS programs and with other private payers including measures reported through the CMS Web Interface, the CAHPS for ACOs survey, and calculated from CMS administrative claims data
  - *Measures that are outcome focused*
  - *Measures that fit a high priority gap area*
  - *Measures that are meaningful and can be feasibly implemented by CMS and reported by ACOs.*
  - *Consider the amount of burden associated with a given measure.*
- Address Meaningful Measures Objectives

# Role of MAP for the Shared Savings Program

# CMS Priorities and Needs for Shared Savings Program

- 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.

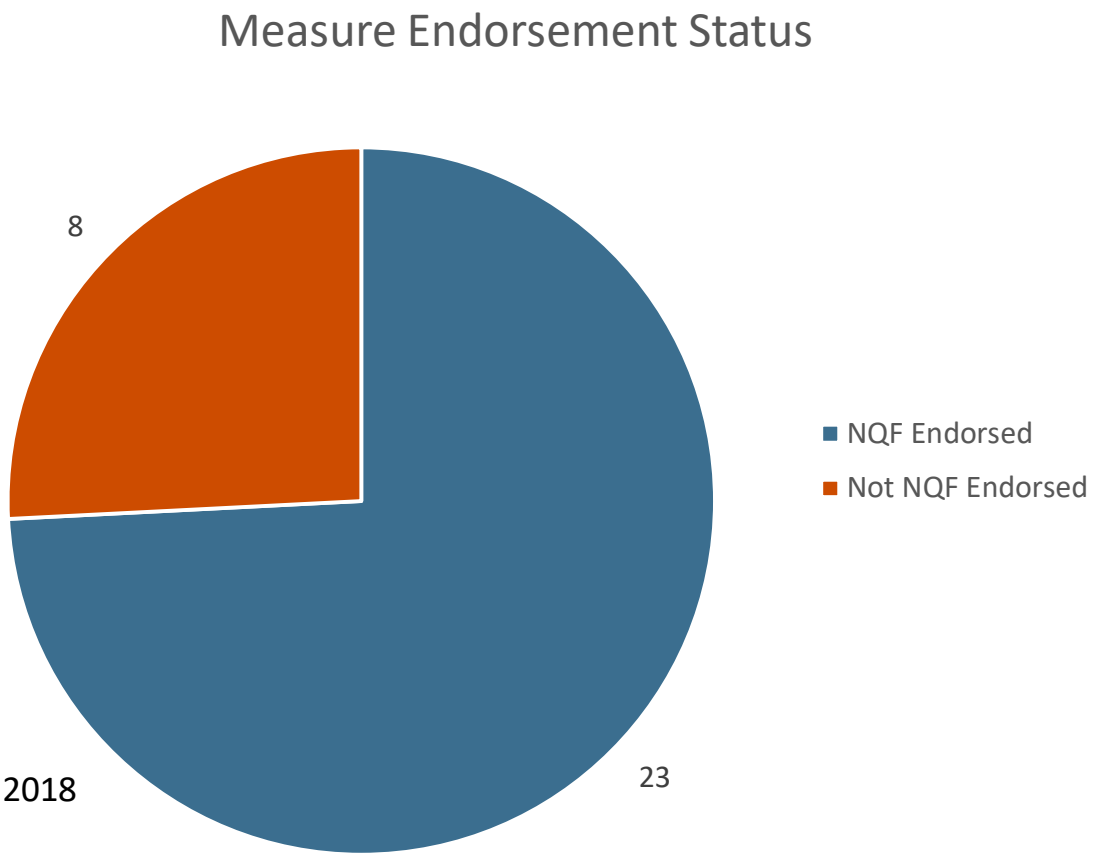
# Shared Savings Program Performance Year 2018 Measures

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 |

*Status as of October 2018

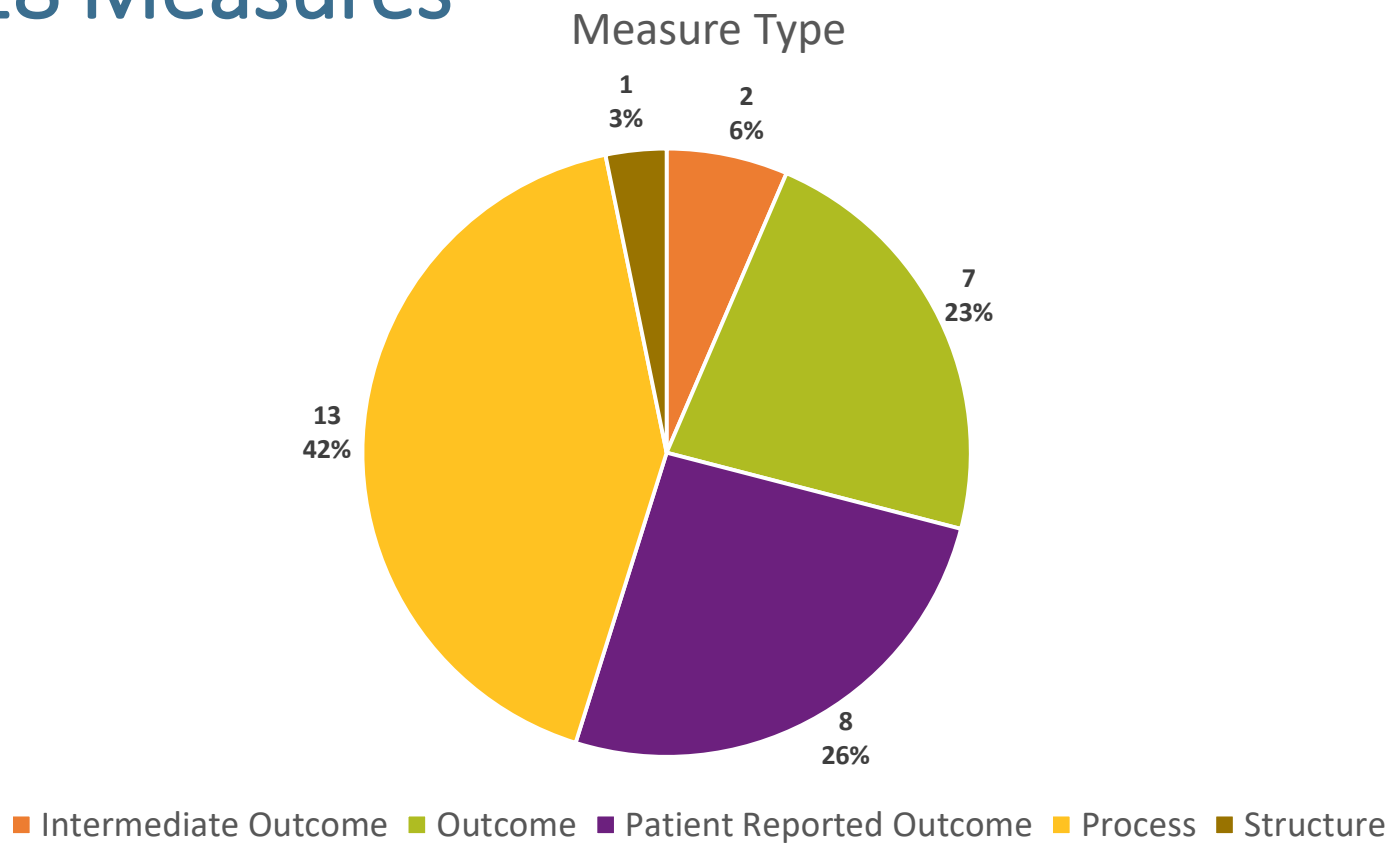
# Shared Savings Program Performance Year 2018 Measures




*Status as of October 2018
Total Measures = 31

Source: Centers for Medicare & Medicaid Services. Medicare Shared Savings Program Accountable Care Organization (ACO) 2018 Quality Measures. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-reporting-year-narrative-specifications.pdf

# Shared Savings Program Performance Year 2018 Measures




*Status as of October 2018
Total Measures = 31

Source: Centers for Medicare & Medicaid Services. Medicare Shared Savings Program Accountable Care Organization (ACO) 2018 Quality Measures. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-reporting-year-narrative-specifications.pdf

# Workgroup Discussion

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

# 2017-2018 MAP Clinician Overarching Themes

# Overarching Issues

- Balance the need to assess costs while ensuring accurate measurement

- Implement composite measures to drive improvements across multiple quality domains and provide more understandable information to patients

# MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for Clinician Programs

The MAP Clinician Workgroup reviewed measures under consideration for two federal programs:

| Program | # of Measures |
|---|---|
| Merit-Based Incentive Payment System (MIPS) | 22 |
| Medicare Shared Savings Program | 3 |

# Clinician Workgroup Meeting Themes

**Cost Measurement**

- Importance of incorporating cost measures into value-based payment programs
- Cost measures should appropriately risk adjust to ensure clinical and social risk factors and evaluate a heterogeneous population
- Cost measures need to be routinely re-evaluated and tested during early stages of implementation

# Clinician Workgroup Meeting Themes

## Composite Measures

- Composite measures are well suited to capture the care provided for a condition and serve as a comprehensive view of performance

- Composite measures could pose additional challenges:
  - *Technical challenges in the measurement development process (i.e., target different target subpopulations; collection of data)*
  - *Challenge at the clinician level if a particular clinician or specialist does not have complete control over the care for that particular condition*

# MAP 2018 Considerations for Implementing Measures in MIPS

**MAP Clinician Workgroup Input:**

- Desire to see more outcome measures
- Use of composite measures with consideration to attribution
- Importance of efficiency and cost reduction measures
- Encouraged the use of appropriate use measures with consideration of inappropriate use as well

# MAP 2018 Considerations for Implementing Measures in the Shared Savings Program

**MAP Clinician Workgroup Input:**

- Desire to see more outcome measures
- Use of composite measures with consideration to attribution
- Importance of measures that align with other programs including MIPS

# Update on prior measures under consideration

# Merit-Based Incentive Payment System Workgroup Recommendations

| Measure Title | Steward | MAP Recommendation |
|---|---|---|
| ★ Continuity of Pharmacotherapy for Opioid Use Disorder | RAND Corporation | Refine and Resubmit Prior to Rulemaking |
| ★ Average change in functional status following lumbar spine fusion surgery | MN Community Measurement | Support for Rulemaking |
| ★ Average change in functional status following total knee replacement surgery | MN Community Measurement | Support for Rulemaking |
| ★ Average change in functional status following lumbar discectomy laminotomy surgery | MN Community Measurement | Conditional Support for Rulemaking |
| ★ Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture | Centers for Medicare & Medicaid Services | Conditional Support for Rulemaking |
| ★ Average change in leg pain following lumbar spine fusion surgery | MN Community Measurement | Conditional Support for Rulemaking |
| Optimal Diabetes Care | MN Community Measurement | Conditional Support for Rulemaking |
| Optimal Vascular Care | MN Community Measurement | Support for Rulemaking |

★ Measures finalized for use in the 2019 MIPS Performance Period and future years

# Merit-Based Incentive Payment System Workgroup Recommendations, cont.

| Measure Title | Steward | MAP Recommendation |
|---|---|---|
| ★ Knee Arthroplasty | Centers for Medicare & Medicaid Services | Conditional Support for Rulemaking |
| ★ ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) | Centers for Medicare & Medicaid Services | Conditional Support for Rulemaking |
| ★ Revascularization for Lower Extremity Chronic Limb Ischemia | Centers for Medicare & Medicaid Services | Conditional Support for Rulemaking |
| ★ Zoster (Shingles) Vaccination | PPRNet | Conditional Support for Rulemaking |
| Patient reported and clinical outcomes following ilio-femoral venous stenting | Society of Interventional Radiology | Refine and Resubmit Prior to Rulemaking |
| ★ Elective Outpatient Percutaneous Coronary Intervention (PCI) | Centers for Medicare & Medicaid Services | Conditional Support for Rulemaking |
| ★ Intracranial Hemorrhage or Cerebral Infarction | Centers for Medicare & Medicaid Services | Conditional Support for Rulemaking |
| ★ Simple Pneumonia with Hospitalization | Centers for Medicare & Medicaid Services | Conditional Support for Rulemaking |
| ★ HIV Screening | Centers for Disease Control and Prevention | Conditional Support for Rulemaking |

★ Measures finalized for use in the 2019 MIPS Performance Period and future years

# Merit-Based Incentive Payment System Workgroup Recommendations, cont.

| Measure Title | Steward | MAP Recommendation |
|---|---|---|
| Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication | MN Community Measurement | Conditional Support for Rulemaking |
| ★ Routine Cataract Removal with Intraocular Lens (IOL) Implantation | Centers for Medicare & Medicaid Services | Conditional Support for Rulemaking |
| International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia | Large Urology Group Practice Association In collaboration with Oregon Urology Institute | Conditional Support for Rulemaking |
| ★ Screening/Surveillance Colonoscopy | Centers for Medicare & Medicaid Services | Conditional Support for Rulemaking |
| Diabetes A1c Control (< 8.0) | MN Community Measurement | Conditional Support for Rulemaking |

★ Measures finalized for use in the 2019 MIPS Performance Period and future years

# Medicare Shared Savings Program Workgroup Recommendations

| Measure Title | Steward | MAP Recommendation |
|---|---|---|
| Optimal Diabetes Care | MN Community Measurement | Conditional Support for Rulemaking |
| Diabetes A1c Control (< 8.0) | MN Community Measurement | Conditional Support for Rulemaking |
| Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication | MN Community Measurement | Conditional Support for Rulemaking |

# Introduction to NQF's Rural Work

# Recommendations from the 2018 MAP Rural Health Workgroup

*NQF's MAP Rural Health Workgroup Project Team*
*and*
*Ira Moscovice, PhD, MAP Rural Health Workgroup co-chair*

*November 14, 2018*

# Overview of Presentation

- Overview of NQF's 2015 work in rural health and key activities of the MAP Rural Health Workgroup
- 2018 recommendations of the MAP Rural Health Workgroup
  - *Core set of measures, gaps in measurement, access to care*
- Next steps for the NQF and the Workgroup
- Discussion

# NQF's 2015 Rural Health Project

**Overarching Recommendation**

- Make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers, but allow a phased approach for full participation across program types and explicitly address low case-volume

**Some Supporting Recommendations**

- Use guiding principles for selecting quality measures that are relevant for rural providers
- Use a core set of measures, along with a menu of optional measures, for rural providers
- Create a Measure Applications Partnership (MAP) workgroup to advise CMS on the selection of rural-relevant measures

# MAP Rural Health Workgroup
## Key Activities for 2017-2018

- Assemble MAP Rural Health Workgroup
- Identify a core set of the best available rural-relevant measures
- Identify gaps in measurement and provide recommendations on alignment and coordination of measurement efforts
- Make recommendations regarding measuring and improving access to care for the rural population

# MAP Rural Health Workgroup Recommendations

# Rural Health Core Set

- 20 measures in the core set
  - *9 measures for the hospital setting (facility level of analysis)*
  - *11 measures for ambulatory setting (clinician level of analysis)*
- 7 additional measures for ambulatory setting, but currently endorsed for health plan/integrated delivery system levels of analysis
- Apply to majority of rural patients and providers
  - *NQF-endorsed*
  - *Cross-cutting*
  - *Resistant to low case-volume*
- Includes process and outcome measures
- Includes measures based on patient report
- Majority used in federal quality programs

# Rural Health Core Set
## Hospital Setting

| NQF # | Measure Name |
|---|---|
| 0138 | National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure |
| 0166 | HCAHPS (includes 11 performance measures) |
| 0202 | Falls with injury |
| 0291 | Emergency Transfer Communication Measure |
| 0371 | Venous Thromboembolism Prophylaxis |
| 0471 | PC-02 Cesarean Birth |
| 1661 | SUB-1 Alcohol Use Screening |
| 1717 | National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure |
| 1789 | Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) |

# Rural Health Core Set
## Ambulatory Care Setting

| NQF # | Measure Name |
|---|---|
| 0005 | CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child |
| 0028 | Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention |
| 0041 | Preventive Care and Screening: Influenza Immunization |
| 0059 | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) |
| 0097 | Medication Reconciliation Post-Discharge |
| 0326 | Advance Care Plan |
| 0418 | Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan |

# Rural Health Core Set
## Ambulatory Care Setting

| NQF # | Measure Name |
|---|---|
| 0421 | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up |
| 0711 | Depression Remission at Six Months |
| 0729 | Optimal Diabetes Care |
| 2152 | Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling |

# Additional Measures

## Ambulatory Care Setting, Health Plan/Integrated Delivery System Level of Analysis (not clinician level)

| NQF # | Measure Name |
|---|---|
| 0018 | Controlling High Blood Pressure |
| 0024 | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) |
| 0032 | Cervical Cancer Screening (CCS) |
| 0034 | Colorectal Cancer Screening (COL) |
| 0038 | Childhood Immunization Status (CIS) |
| 2372 | Breast Cancer Screening |
| 2903 | Contraceptive Care – Most & Moderately Effective Methods |

# 2017-2018 MAP Rural Health Workgroup
## Measurement Gaps

- Access to care
- Transitions in care
- Cost
- Substance use measures, particularly those focused on alcohol and opioids
- Outcome measures (particularly patient-reported outcomes)

# Considering Access to Care from a Rural Perspective

- Identified facets of access that are particularly relevant to rural residents
- Documented key challenges to access-to-care measurement from the rural perspective
- Identified ways to address those challenges

- Some key aspects of discussion
  - *Access and quality difficult to de-link*
  - *Both clinician-level and higher-level accountability needed*
  - *Distance to care and transportation issues are vital issues*
  - *Telehealth can address several of the barriers to access, but there are still limitations to its use*

# Key Domains of Access to Care from a Rural Perspective

- **Availability**
  - *Specialty care, appointment availability, timeliness*
  - *Address via: workforce policy; team-based care and practicing to top of license; telehealth; improving referral relationships; partnering with supporting services*
- **Accessibility**
  - *Transportation, health information, health literacy, language interpretation, physical spaces*
  - *Address via: tele-access to interpreters; community partnerships; remote technology; clinician-patient communication*
- **Affordability**
  - *Out-of-pocket costs; delayed care due to out-of-pocket costs*
  - *Address via: appropriate risk adjustment; policy/insurance expansion; protecting the safety net; monitoring patient balance after insurance*

# A Final Recommendation from the MAP Rural Health Workgroup

- CMS should continue to fund the MAP Rural Health Workgroup
  - *View the current core set as a "starter set"*
  - *Would like the opportunity to refine the core set over time*
    - » New measures continually being developed
    - » Measures often are modified
    - » Need to monitor for unintended consequences
  - *Would like opportunity to provide a rural perspective on other topics going forward*

# Post-Report Activities and Next Steps

# Subsequent Activities by NQF Related to Rural Health

- Organized a Capitol Hill Briefing on the report and recommendations (September 2018)
- NQF's "splash screen" focused on the work
- Positive media coverage (at least 6 publications including Modern Healthcare)
- Health Affairs blog article

# Next Steps for the MAP Rural Health Workgroup

- NQF has received continued funding to convene the workgroup; key tasks include:
  - *Sharing recommendations with the Clinician, Hospital, and PAC/LTC Workgroups*
  - *Gather feedback from the Workgroup on clinician-specific measures included on the 2018 Measures Under Consideration (MUC) list*
  - *Convene a 5-person Technical Expert Panel (TEP) to develop recommendations on how to calculate healthcare measures when case-volume is low*
    - » First call with the TEP is scheduled for October 31, 2018 from noon-3pm ET

# Discussion

# Discussion

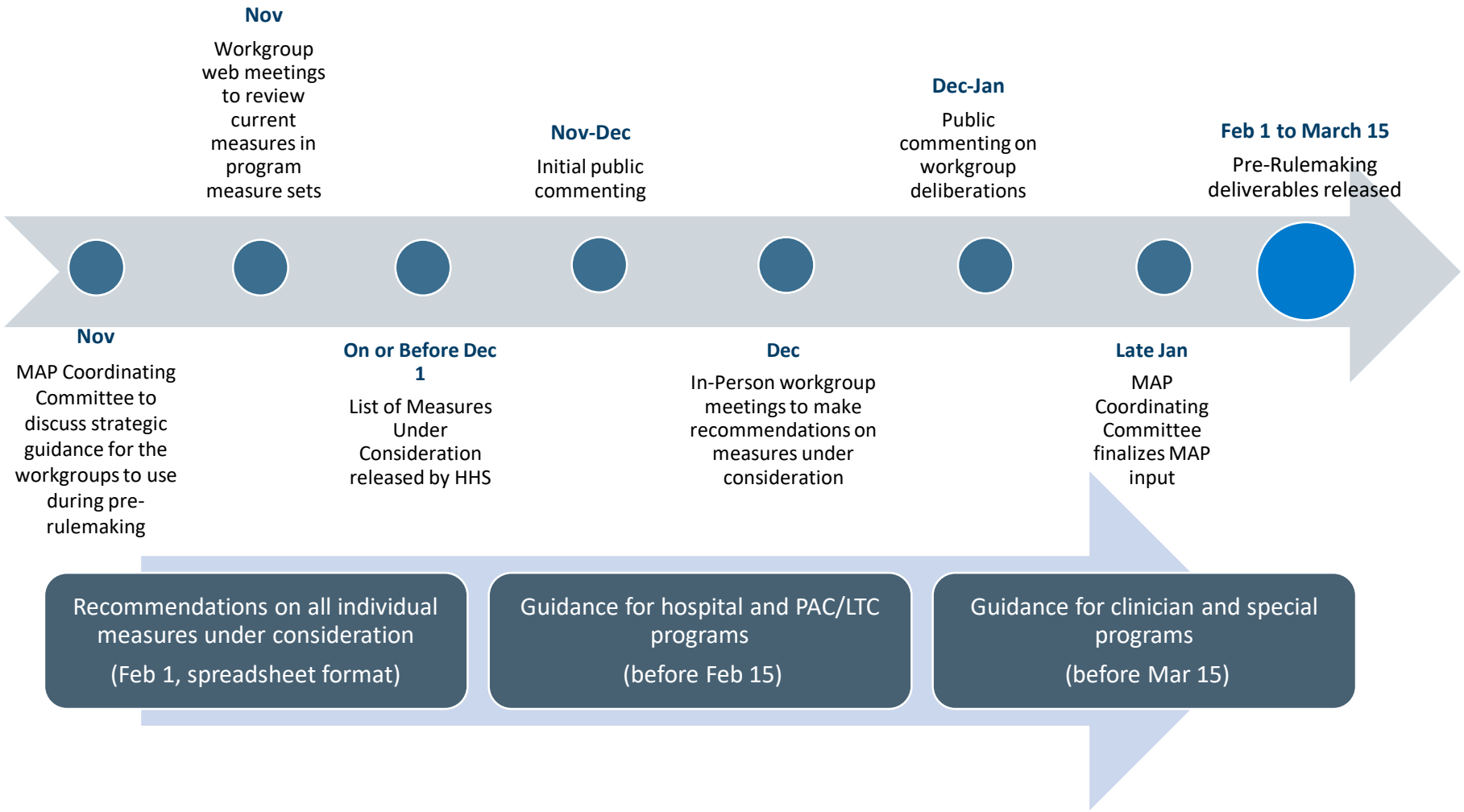
- Core set
  - *Do you agree with the overall topic areas that were covered?*
    - » Is anything missing?
  - *Do you have any particular concerns or questions about particular measures?*
- Gaps
  - *What are your initial thoughts on the identified gaps?*
- Access to care
  - *What did you think of the approach?*
  - *Do the three domains seem like the right ones to focus on?*
  - *Was anything particularly surprising or intriguing?*
  - *Did we miss anything?*

# Opportunity for NQF Member and 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 Workgroup Meeting – December 12
- Public Comment Period #2 – Following Workgroup In-Person Meetings
- Coordinating Committee – January 22-23

# Resources

- CMS' Measurement Needs and Priorities Document: Final_5_29_2018_MUC_Program_Priorities_Needs
- Pre-RulemakingURL: 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/Project_Pages/MAP_Clinician_Workgroup.aspx*
- Workgroup SharePoint site
  - *http://share.qualityforum.org/Projects/MAP%20Clinician%20Workgroup/SitePages/Home.aspx*
- Email: MAP Clinician
  - *MAPClinician@qualityforum.org*