NATIONAL QUALITY FORUM
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Meeting Summary

Measure Applications Partnership Clinician Workgroup In-Person Meeting

The National Quality Forum (NQF) convened a public in-person meeting for the Measure Applications Partnership (MAP) Clinician Workgroup on December 5, 2019.

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

Sam Stolpe, NQF Senior Director, welcomed participants to the in-person meeting. MAP Clinician Co-chairs, Bruce Bagley and Robert Fields, then provided opening remarks. Dr. Stolpe then reviewed the following meeting objectives: to review and provide input on Measures Under Consideration (MUC) for federal Merit-Based Incentive Payment System (MIPS) and Medicare Shared Savings Program (SSP), and Medicare Parts C & D Star Ratings quality programs and to identify gaps in measures for federal MIPS, SSP, and Parts C & D Star Ratings quality programs.

CMS Opening Remarks and Meaningful Measures Update and Institute for Healthcare Improvement Presentation

Michelle Schreiber, CMS QMVIG Group Director, offered opening remarks and provided a presentation on the Meaningful Measures Initiative. Following Dr. Schreiber, IHI Vice President Somava Saha gave a presentation on new approaches and innovations in quality measurement. MAP provided feedback on the presentations and on proposed changes to the initiative.

MAP focused the discussion on advanced analytics, transparency, emerging data sources, and support for CMS's focus on maternal mortality and morbidity. MAP encouraged CMS to continue its efforts to optimize predictive analytics and artificial intelligence to understand opportunities for quality improvement. These efforts should prioritize increased feedback to providers through actionable quality measurement and clinical decision support. MAP supported CMS's commitment to transparency and enabling consumers and patients to have the information that enables them to select providers.

MAP noted that this effort should be part of a larger approach to engage beneficiaries in their care, including understanding the measures that are reported publicly. MAP offered the example that beneficiaries could misinterpret when providers are doing well in publicly reported measures of lowered cost for beneficiaries; providers often understand that this means that patients experience fewer complications and other unnecessary expenditures, but the patients themselves may construe this as fewer services being provided to appropriately manage their health. MAP encouraged CMS to focus on patient safety in public reporting, allowing beneficiaries to choose healthcare providers who perform especially well. It was noted that consumers find these types of measures more intuitive and useful than many others.

MAP voiced support of efforts by local communities, health systems, specialty societies, and others to develop new types of performance measures using emerging data sources. Many measures are already deployed in qualified clinical data registries that could be taken through the NQF process and

deployed into federal programs more broadly and with more confidence than new measures. MAP supported efforts to move to greater electronic measurement emphasizing the need for eCQMs, but MAP also expressed the concern that interoperability continues to impose challenges for the implementation and meaningful use of eCQMs. This is particularly apparent when patients transition between providers, and the information about prior care does not travel with them, but the accountability for performance on quality measures related to the beneficiary does.

MAP also supported CMS's priority in addressing maternal mortality and morbidity. MAP favored the decision by CMS to bring MUC2019-114 *Maternal Morbidity* (reviewed by the MAP Hospital Workgroup) to MAP for consideration and encouraged CMS to address the U.S. maternal morbidity and mortality crisis through appropriate transition to outcomes measurement. Finally, MAP acknowledged that wellness measures represent an opportunity to align payment and quality initiatives across healthcare settings.

Overview of Pre-Rulemaking Approach

Kate Buchanan, NQF Senior Project Manager, provided an overview of the three-step approach to pre-rulemaking, which includes program overview, review of current measures, and evaluation of Measures Under Consideration for what they would add to the program measure set. Ms. Buchanan then reviewed the four decision categories that the Workgroup members could vote on following the discussion of each measure. Finally, Ms. Buchanan briefly summarized the voting process and discussed the Rural Health Workgroup charge.

Merit-Based Incentive Payment System (MIPS) Program Measures

Dr. Bagley opened the web meeting to allow for public comment. Two public commenters offered two comments apiece. The first commenter stressed the important move to electronic measures and stated that MAP should consider the fact that measures based on claims are done with retrospective analysis, as physicians do not receive this information in real time in order to make care improvements within practices. Additionally, this commenter voiced concern with the MUC process by which late testing information would be included for measures to be reviewed. The second commenter stated concern with the hospital utilization measure (which was removed from the MUC and not discussed during the meeting) because it lacked considerations of social factors. Additionally, this commenter suggested that patient-reported outcome measures should be used in lieu of MUC2019-28 *Risk-standardized complication rate (RSCR) following elective primary total hop arthroplasty (THA) and/or total knee arthroplasty (TKA).*

MUC2019-27 Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate

MAP conditionally supported for rulemaking MUC2019-27. Support for this measure is pending removal and replacement of NQF 1789 in the MIPS program measure set with this measure and pending NQF CDP Standing Committee review of reliability performance at the physician group level in spring 2020. MAP noted that this measure is a re-specified version of the measure *Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any conditions* (NQF 1789), which was developed for patients 65 years and older using Medicare claims. MAP emphasized the importance of addressing unplanned readmissions and noted that physician groups can influence this outcome by supporting appropriate discharge, reconciling medications, reducing infection risk, and ensuring proper outpatient follow-up. MAP suggested that this measure promotes a systems level approach by clinicians and that there should be a focus on especially high-risk conditions such as COPD and heart failure in the future. MAP noted that the

NQF All-Cause Admissions and Readmissions Standing Committee had requested additional information from the developer on reliability performance of this measure at various case sizes for the physician group level of analysis in the course of the consensus development process (CDP).

MUC2019-28 Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

MAP supported for rulemaking MUC2019-28. MAP noted that this measure can improve the quality of surgical care delivery and follow-up care for a common and costly surgical procedure performed for Medicare beneficiaries. MAP agreed that patient-reported outcomes performance measures related to TKA and THA would also be desirable but would be complementary to this measure. MUC2019-18 is endorsed as NQF 3493 and is a re-specified version of *Hospital-level Risk-standardized Complication rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)* (NQF 1550), which was developed for patients 65 years and older using Medicare claims.

MAP noted that NQF 1550 is currently being used in the CMS Hospital Inpatient Quality Reporting Program, though it underwent substantial respecification to allow for clinician and clinician group attribution. In adapting the hospital-level measure for MIPS-eligible clinicians, the same cohort of patients will be measured, but the outcomes will be attributed to a larger number of healthcare entities with a shared responsibility for delivery of high-quality, post-surgical care. The MAP Rural Health Workgroup noted that this measure will be limited to clinicians/clinician groups with at least 25 patients, and as such, the low case-volume issue will not come into play for rural providers. However, access to supportive services prior to surgery will be even more critical when these procedures are done in the outpatient setting, and access to such services may be more limited in rural areas.

MUC2019-66 Hemodialysis Vascular Access: Practitioner Level Long-Term Catheter Rate

MAP conditionally supported for rulemaking MUC 2019-66. As the measure has not been reviewed by an NQF CDP Standing Committee to determine the strength of the measure's reliability and validity, MAP's support is conditional upon NQF endorsement. MAP noted that the use of a long-term catheter has a higher observed mortality rate than the use of arteriovenous fistula, thus this measure has the potential to provide greater quality of care for patients by reducing the associated mortality and morbidity from long-term catheter use.

MAP noted that a modified version of this measure is currently being used in a CMS quality program—the End-Stage Renal Disease Quality Improvement Program (ESRD QIP). The measure is undergoing changes to allow specification for individual clinicians and clinician groups. While MAP questioned the ability of providers to move patients from catheters to fistulas, the measure developer noted that clinicians can influence this, as evidenced by rate improvements after implementation of this measure in ESRD QIP. MAP expressed concern about the reliability of the measure and encouraged CMS to test the measure rigorously. The Rural Health Workgroup noted that kidney diseases are prevalent conditions in rural populations. They emphasized that rural patients on dialysis are older and have more comorbidities, and voiced concern that these patients might be pressed to use a fistula, even when there is little benefit.

MUC2019-37 Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

MAP does not support MUC2019-37 for rulemaking in MIPS with potential for mitigation. The measure has updated specifications from an existing NQF endorsed measure (NQF 2888), last reviewed for endorsement in 2016. MAP noted that the newly developed measure differs from its predecessor in a few ways.

- Cohort: CMS added diabetes as a cohort-qualifying condition.
- Outcome: CMS narrowed the outcome to focus on admissions where risk can be reduced by providing high-quality ambulatory care, so that the measure can be used to assess ambulatory (rather than ACO-wide) care quality.
- Risk-adjustment: CMS added social risk factors to the risk-adjustment model.

MAP noted the several potential areas of mitigation for the measure. The measure should apply to clinician groups with an appropriate reliability threshold, e.g., 0.7. MAP also noted that the measure developer should consider the NQF guidance on attribution and consider patient preference and selection as a method of attribution as those data become available. MAP suggested that rather than moving directly to this outcome measure, process measures that would get to the desired outcome might be an appropriate stepwise approach to increasing accountability. The MAP Rural Health Workgroup noted that chronic conditions included in this measure are prevalent in rural residents. However, the Rural Health Workgroup does not believe this measure should be linked to payment for rural clinicians or clinician groups.

Within the MIPS measure set, MAP identified several gaps, specifically in the areas of primary care, access, continuity, comprehension, and care coordination. MAP also suggested CMS consider adding measures that determine whether a course of therapy is indeed the best for the patient to optimize reductions in cost and harm. MAP also emphasized measures of diagnostic accuracy and the primary care patient-reported outcomes measure.

Medicare Shared Savings Program (SSP) Program Measures

Dr. Bagley opened the web meeting to allow for public comment. A single public comment was offered regarding alignment of quality measures and scoring methods across SSP and MIPS for Accountable Care Organizations (ACO). The commenter stated that ACOs should have a unique set of quality measures and methods in SSP, distinct from those in MIPS. Additionally, measures that address a gap area could be given a reporting-only trial in SSP before use for accountability.

MUC2019-37 Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

MAP conditionally supported MUC2019-37 *MIPS Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions* pending NQF endorsement. MAP noted that with over 80 percent of adults over the age of 65 having MCCs, this measure has the potential to significantly impact the quality of care for the Medicare beneficiary population. MAP also noted that this measure carries a higher reliability score than the measure considered for MIPS and considered it still appropriate for the SSP program. MAP noted that ACOs in SSP focus on processes and interventions that reduce disease progression and undesirable sequalae that lead to hospital admission for Medicare patients with MCCs. Moreover, the accountability structure of an ACO allows for stronger oversight and care coordination to influence measure performance within the ACO system.

MAP identified several measure gaps within SSP: diagnostic efficiency, measures of cultural change, and additional measures of care coordination and hand-offs using eCQMs.

Medicare Parts C and D Star Ratings Program Measures

Dr. Fields opened the web meeting to allow for public comment. A single public commenter offered comments for two different topics. First, the commenter stated that MAP needs to evolve the conversation around opioid utilization measures to discuss pain management and behavioral health needs. Second, the current measures in the Parts C & D Star Ratings Program measure set are clinically

focused and largely influenced by the clinicians in the plan's network. Because of this, coverage decisions within Medicare Advantage should be based on the clinical areas of the measures.

MUC2019-14 Follow-up after Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions

MAP conditionally supported for rulemaking measure MUC2019-14, pending NQF endorsement. MAP noted the importance of the care coordination domain as a CMS priority. MAP observed that care coordination is the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services. This measure is an additional process measure to the Medicare Part C & D Star Ratings that lends itself to better care efficiencies and coordination for health plans and their beneficiaries.

MAP also discussed the increase of utilization and costs associated with use of emergency departments for Medicare beneficiaries, particularly those with dual-eligible status and with a behavioral health diagnosis, both of which are much higher cost demographics. Coordinating the care of beneficiaries who use emergency services is an important component of ensuring that they also are receiving outpatient care and preventive services with the potential to mitigate disease progression that results in further unnecessary use of emergency facilities. The Rural Health Workgroup noted that the chronic conditions included in this measure are prevalent in rural residents, and that lack of access to care in rural areas may make performance on this measure more difficult for plans that cover rural residents. MAP was encouraged that telephone follow-up was included in this measure but encouraged CMS to ensure that the telephone follow-ups are meaningful to patients.

MUC2019-57 Use of Opioids at High Dosage in Persons without Cancer (OHD)

MAP conditionally supported for rulemaking for MUC2019-57 *Use of Opioids at High Dosage in Persons without Cancer (OHD)*. The condition of support was that other opioid measures considered would not move into the Star Ratings; this measure was otherwise considered fit for implementation without conditions. NQF has endorsed the measure at the health plan level as NQF 2940.

MAP noted that this measure leads to health plans carefully considering the needs of patients at high doses, encouraging appropriate nonopioid pain management, providing appropriate personalized pain care plans, directly addressing OUD, and potentially tapering patients off of high-dose opioid regimens. MAP noted that concerns have been raised that pressure from health plans to diminish prescribing could be associated with the unintended consequence of patients seeking illicitly obtained opioids or heroin. This may lead to changes in prescribing practices for clinicians to adhere to CDC prescribing guidelines that were intended to serve as guidance and not as a strict mandate. The MAP Rural Health Workgroup agreed that opioid use is a relevant issue for rural residents, but expressed concern that without a balancing measure, there is a potential for patient harm due to forced tapering and potential for seeking illicit drugs to treat pain. Rural residents have relatively less access to alternative pain treatment and other resources.

MUC2019-60 Use of Opioids from Multiple Providers in Persons without Cancer (OMP)

MAP supported for rulemaking for one measure in the Part C & D Star Ratings, MUC2019-60 *Use of Opioids from Multiple Providers in Persons without Cancer (OMP)*. This measure appropriately identifies either mismanaged pain or potential opioid seeking behavior. MAP observed that the measure will encourage health plans to address pain management and OUD within their beneficiary population while avoiding unintended consequences associated with rapid decline of opioid dosages. MAP noted that this measure is endorsed at the health plan level as NQF 2950. MAP pointed out that all three opioid measures are currently in use in the SSP Opioid Utilization Reports as well as in the Part D

Overutilization Monitoring System. The MAP Rural Health Workgroup suggested that although this measure could promote use of drug monitoring programs in rural areas, on the whole, it may not be particularly applicable because there are relatively few pharmacies in rural areas.

MUC2019-61 Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer (OHDMP)

MAP did not support for rulemaking MUC2019-61 *Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer (OHDMP).* MAP observed that this measure was endorsed in 2017 as NQF 2951. This measure was also seen as duplicative of the other two measures, with little added benefit to the program from the combined measure. MAP emphasized the need for parsimony in the measure set. Of the three proposed opioid measures, the MAP Rural Health Workgroup agreed this one was the least useful.

MUC2019-21 Transitions of Care between the Inpatient and Outpatient Settings including Notifications of Admissions and Dischargers, Patient Engagement and Medication Reconciliation Post-Discharge

MAP conditionally supported MUC2019-21 for rulemaking, pending NQF endorsement. MAP noted that this measure was also designated as a first-year measure for HEDIS 2018. MAP observed that Medicare beneficiaries are at particular risk during transitions of care because of higher comorbidities, declining cognitive function, and increased medication use. There is observed variance in performance among health plans on all four components of the measure. Further, evidence indicates that good care transitions and care coordination reduce healthcare costs and improve outcomes. MAP also noted that the medication reconciliation post-discharge component of this measure is already included in the Star Ratings as an independent measure and has been since 2017.

The measure developer (NCQA) indicated its intention to work with CMS to develop a plan to avoid the need for health plans to report on both measures. MAP expressed concern that this measure is not entirely electronic, but it was noted that alternative data sources are not available. The Rural Health Workgroup noted the importance of measures to assess transitions of care for rural residents but that the measure requires chart abstraction, which can be particularly burdensome for small rural providers. They also noted that a yes/no checkbox measure of medication reconciliation may not drive improvements in care quality. There was some concern with the medication reconciliation component, particularly given the lack of pharmacists in rural areas.

MAP discussed measure gaps associated with the Medicare Part C & D Star Ratings and suggested that CMS add measures of access to provider networks, patient-reported outcomes measures related to functional status, and care coordination within care transitions. MAP expressed concern that the medication adherence measures do not capture rational nonadherence and patient preference, and also suggested the removal of older process measures such as diabetes screening in favor of measures that beneficiaries might find more useful when selecting a plan, such as out-of-pocket cost. MAP also suggested the inclusion of telehealth into the existing measure.

Public Comment

Ms. Buchanan opened the web meeting to allow for public comment. No public comments were offered.

Next Steps

Jordan Hirsch, NQF Project Analyst, summarized next steps. Workgroup recommendations for the 10 MAP Clinician measures will be opened for public comment on December 18, 2019.