NATIONAL QUALITY FORUM

MAP Rural Health Workgroup Web Meeting

December 10, 2018

Welcome and Review of Meeting Agenda

Agenda

- Welcome and Roll Call
- Context for Today's Discussion
  - *Overview of MAP Pre-Rulemaking Process*
  - *Overview of MIPS and MSSP Programs*
- Review of Measures Under Consideration
  - *Shared Savings Program*
  - *MIPS program*
- Public and NQF Member Comment
- Next Steps

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MAP Rural Health Workgroup Roster

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American Academy of Physician Assistants	Daniel Coll, MHS, PA-C, DFAAPA
American College of Emergency Physicians	Steve Jameson, MD
American Hospital Association	Stephen Tahta, MD
Geisinger Health	Karen Murphy, PhD, RN
Health Care Service Corporation	Shelley Carter, RN, MPH, MCRP
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Michigan Center for Rural Health	Crystal Barter, MS
MN Community Measurement	Julie Sonier, MPA
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National Center for Frontier Communities	Susan Wilger, MPA
National Council for Behavioral Health	Sharon Raggio, LPC, LMFT, MBA
National Rural Health Association	Brock Slabach, MPH, FACHE
National Rural Letter Carriers' Association	Cameron Deml
RUPRI Center for Rural Health Policy Analysis	Keith Meuller, PhD
Rural Wisconsin Health Cooperative	Tim Size, MBA
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MAP Rural Health Workgroup Roster

Individual Subject Matter Experts (Voting)
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Federal Office of Rural Health Policy, DHHS/HRSA	Craig Caplan
Indian Health Service	Juliana Sadovich PhD, RN

Context for Today's Discussion

Context:
MAP Pre-Rulemaking Process

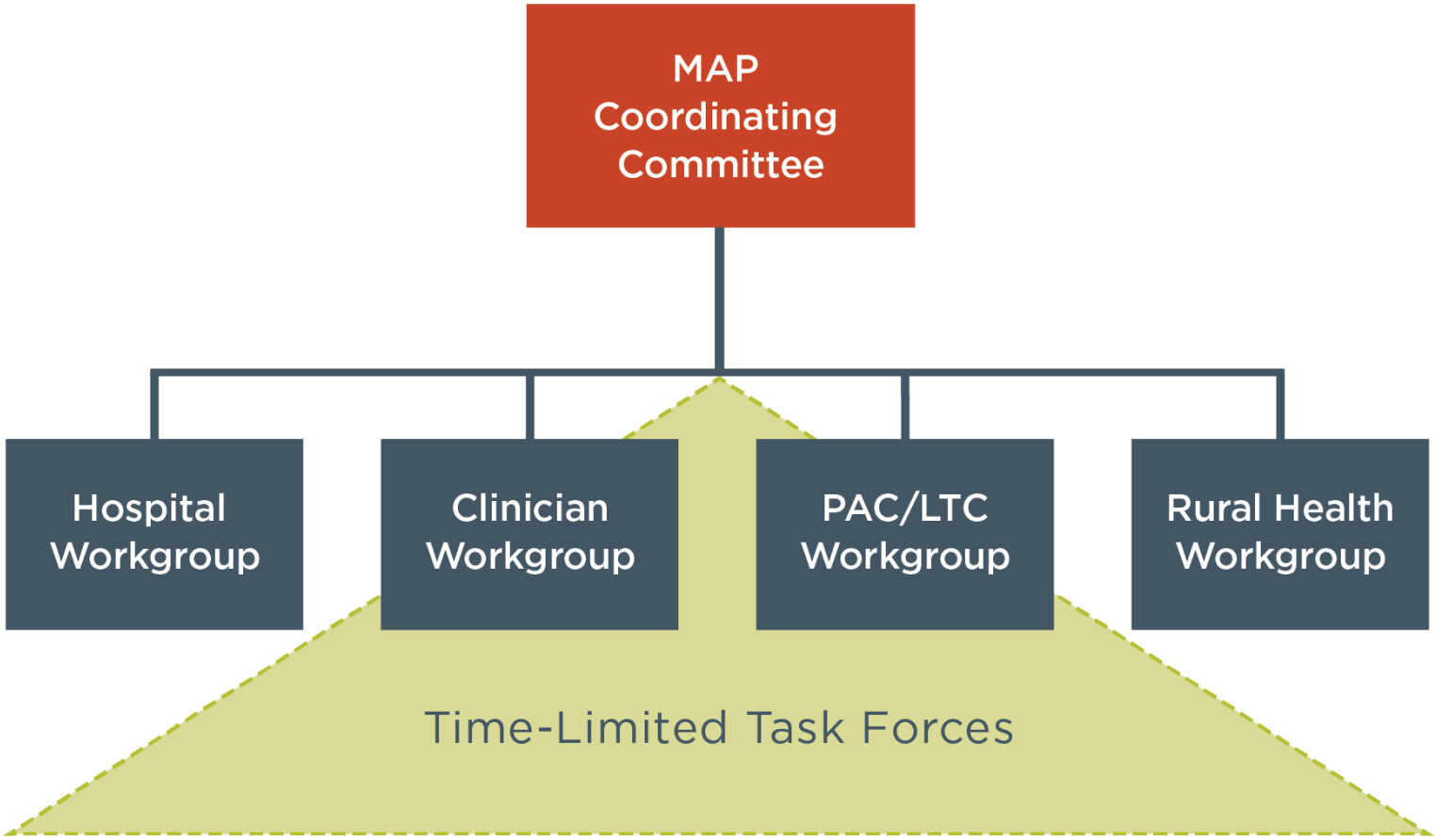
Measure Applications Partnership (MAP)

Statutory Authority

The Affordable Care Act (ACA) requires HHS to contract with the consensus-based entity (i.e., NQF) to **"convene multi-stakeholder groups to provide input on the selection of quality measures" for public reporting, payment, and other programs.** (ACA Section 3014).

We refer to this input as the pre-rulemaking process

MAP Structure



MAP Rural Health Workgroup: Providing Input Into the Pre-Rulemaking Process

- Today: Provide a "rural lens" for measures considered by the MAP Clinician Workgroup
- Wednesday (the 12th): Ira Moscovice will serve as your liaison in the Clinician Workgroup's in-person meeting
  - *NOTE: Your attendance at this meeting is not required, but it is open to the public, so feel free to dial in if desired.*

Approach of the Clinician Workgroup

The approach to the analysis and selection of measures is a three-step process:

- Review relevant programs
- Review current measures in the program
- Evaluate Measures Under Consideration (MUCs) for what they would add to the program measure set

Preliminary Analysis of Measures Under Consideration

- To facilitate the Clinician Workgroup's voting process, NQF staff has conducted a **preliminary analysis** of each measure under consideration
- The preliminary analysis is an algorithm that asks a series of questions about each measure under consideration; this algorithm was:
  - *Developed from the MAP Measure Selection Criteria, and approved by the MAP Coordinating Committee*
  - *Intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions*

Tools Used to Guide Measure Review

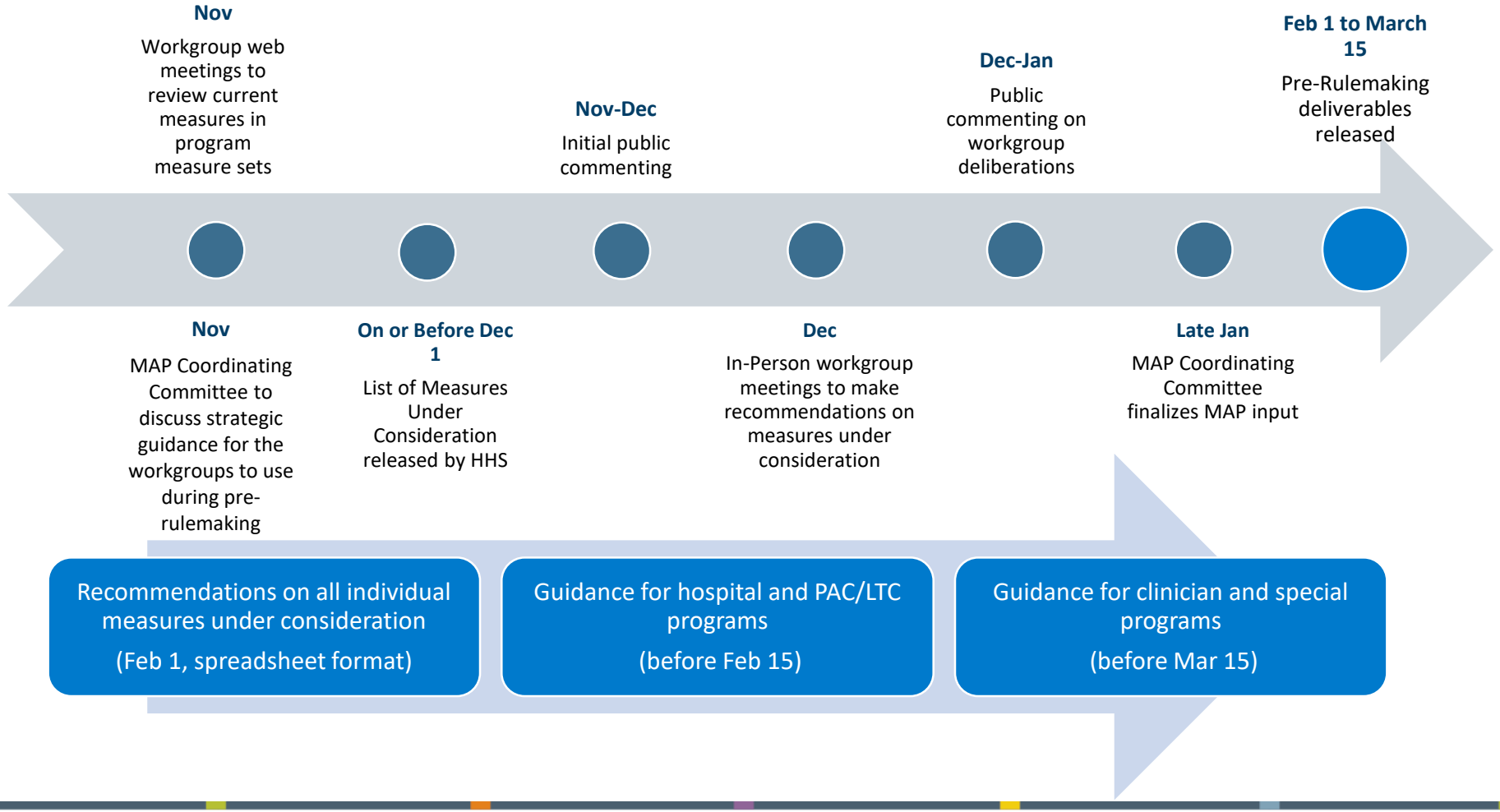
MAP's Measure Selection Criteria (MSC)

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2. Program measure set actively promotes key healthcare improvement priorities, such as those highlighted in CMS' "Meaningful Measures" Framework
3. Program measure set is responsive to specific program goals and requirements
4. Program measure set includes an appropriate mix of measure types
5. Program measure set enables measurement of person- and family-centered care and services
6. Program measure set includes considerations for healthcare disparities and cultural competency
7. Program measure set promotes parsimony and alignment

Decision Categories for 2018-2019

Decision Category	Definition	Evaluation Criteria
Support for Rulemaking	MAP supports implementation with the measure as specified and has not identified any conditions that should be met prior to implementation.	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP Preliminary Analysis Algorithm. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	MAP supports implementation of the measure as specified but has identified certain conditions or modifications that would ideally be addressed prior to implementation.	The measure meets assessments 1-3, but may need modifications. A designation of this decision category assumes at least one assessment 4-7 is not met. MAP will provide a rationale that outlines each suggested condition (e.g., measure requires NQF review or endorsement OR there are opportunities for improvement under evaluation). Ideally, the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to MAP prior to rulemaking.
Do Not Support for Rulemaking with Potential for Mitigation	MAP does not support implementation of the measure as specified. However, MAP agrees with the importance of the measure concept and has suggested modifications required for potentials support in the future. Such a modification would considered to be a material change to the measure. A material change is defined as any modification to the measure specifications that significantly affects the measure result.	The measure meets assessments 1-3 but cannot be supported as currently specified. A designation of this decision category assumes at least one assessment 4-7 is not met.
Do Not Support for Rulemaking	MAP does not support the measure.	The measure under consideration does not meet one or more of assessments 1-3.

MAP Approach to Pre-Rulemaking: A look at what to expect



Programs to Be Considered by the Clinician Workgroup

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

Context:
Merit-Based Incentive Payment System (MIPS)

Quality Payment
PROGRAM

QUALITY PAYMENT PROGRAM YEAR 3 (2019)

Disclaimer

- This presentation was prepared as a tool and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference
- The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

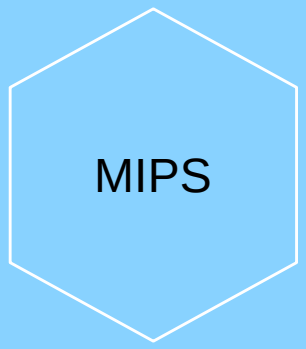
Resource Library

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

Quality Payment 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:



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

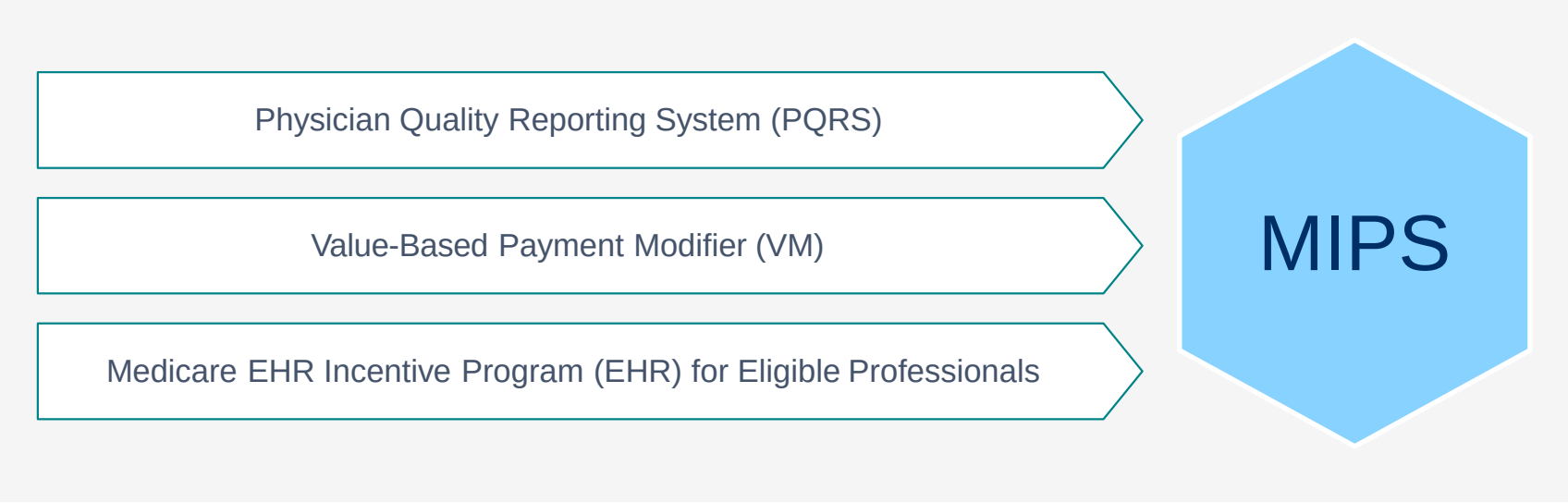
Deliver IT systems capabilities that meet the needs of users

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 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.*

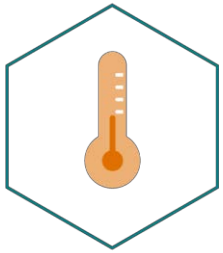
MIPS Year 3 (2019)

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)

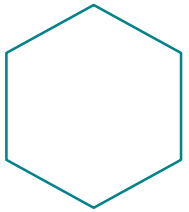
Below the low-volume threshold

- 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.

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

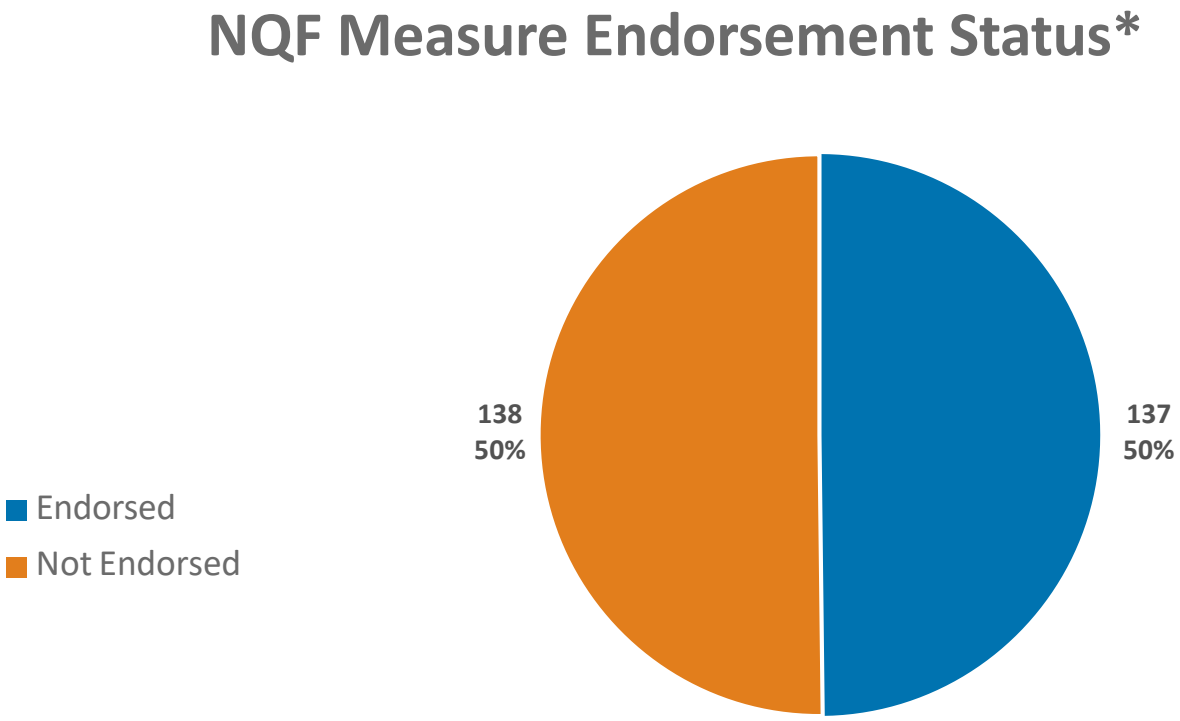
MIPS Current Measures Divided by MIPS Measure Domain

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.

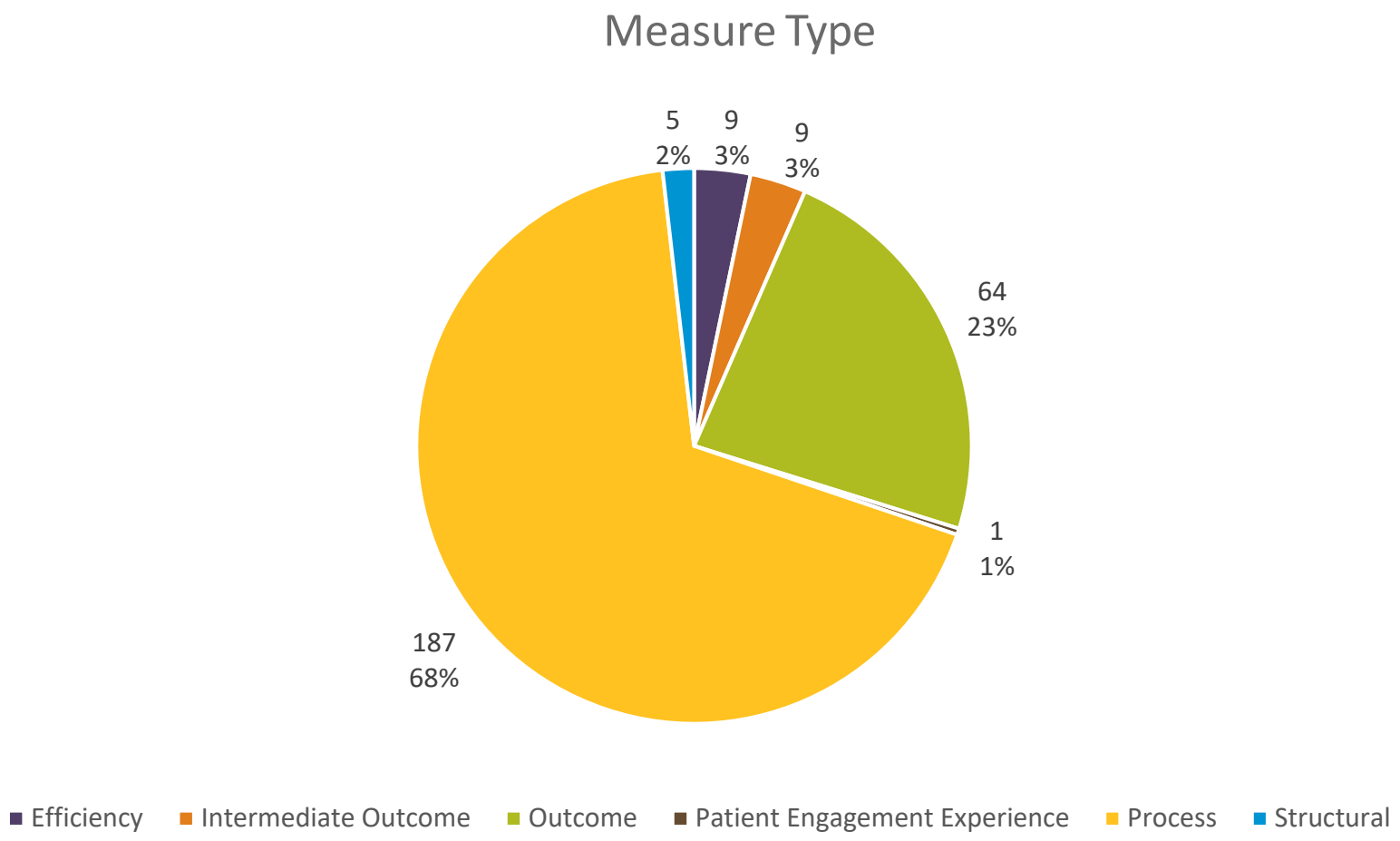
2018 MIPS Measures



*Status as of June 2018 *Quality Measure Specification Supporting Document*

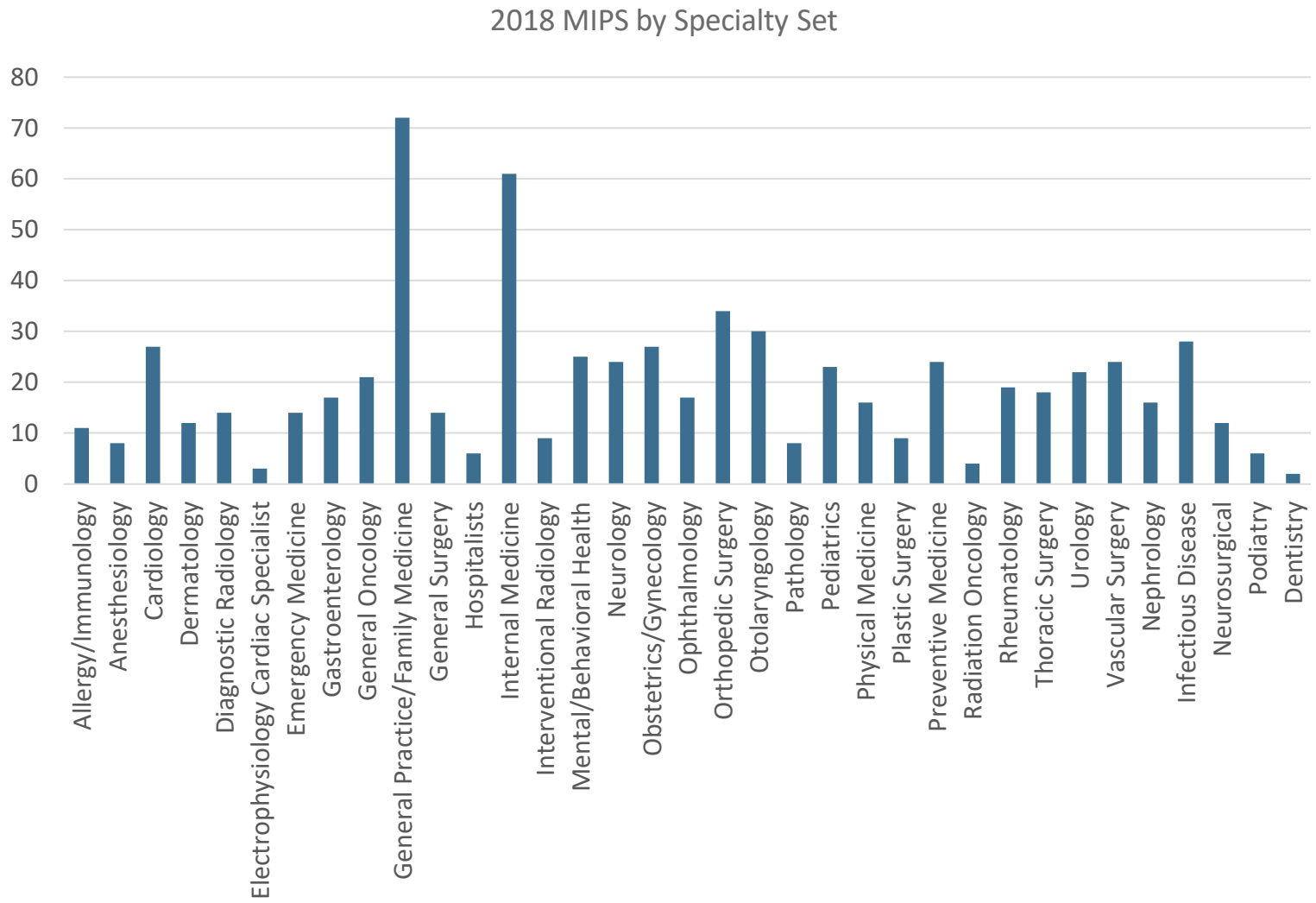
- Total of 275 measures

2018 MIPS Measures



- Total of 275 measures

2018 MIPS Measures



- Total of 275 measures (*measure can be part of more than 1 specialty set)

Context:
Medicare Shared Savings Program (Shared Savings Program)

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

Overview of Quality Measurement Approach

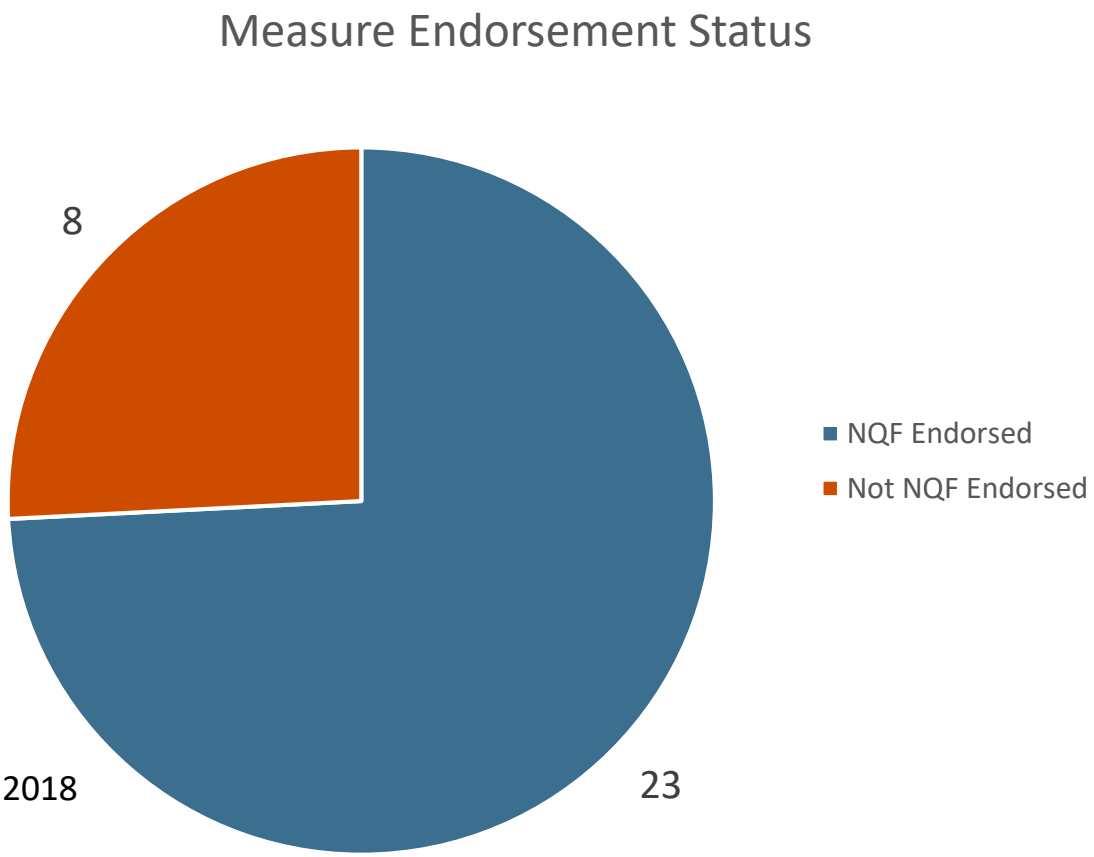
In Performance Year 2018, there are 31 quality measures separated into the following four key domains:

- Patient/Caregiver Experience (n=8)
- Care Coordination/Patient Safety (n=10)
- Preventive Health (n=8)
- At-Risk Population (n=5)

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

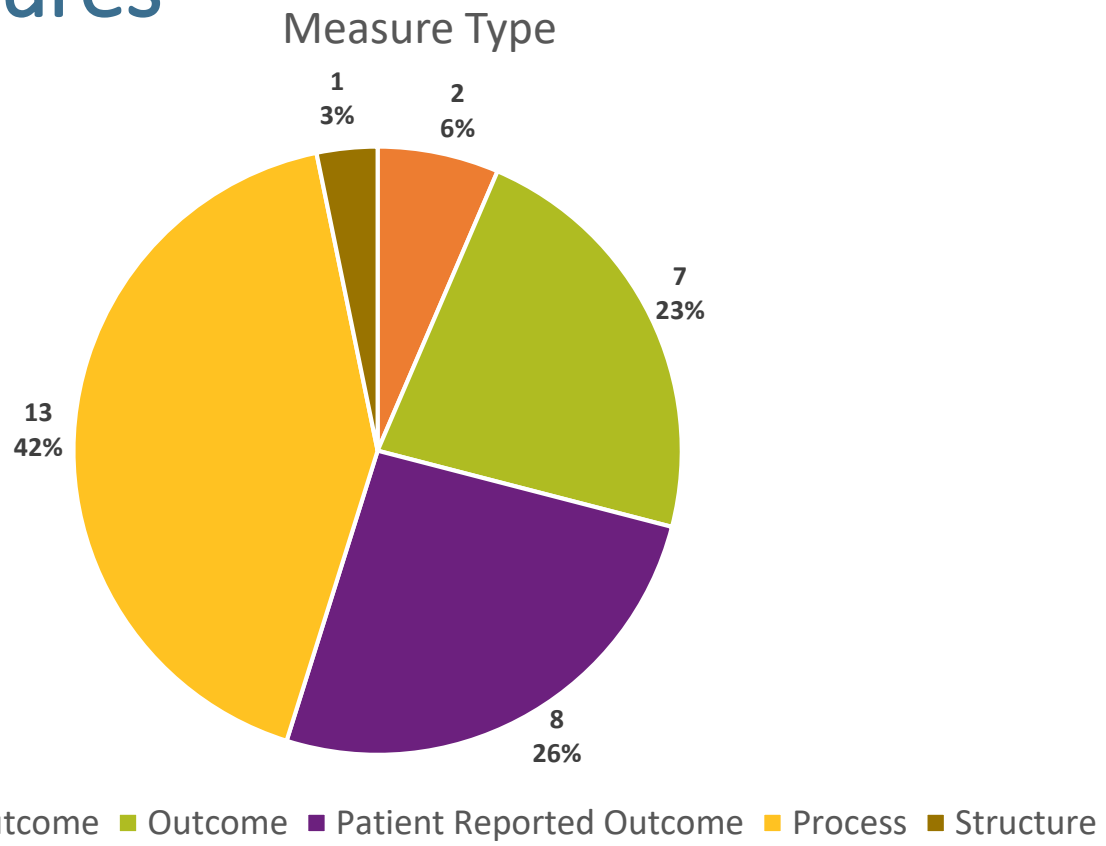
Shared Savings Program Performance Year 2018 Measures



*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

Review of Measures Under Consideration for Clinician Programs

Pre-Rulemaking Input: Medicare Shared Savings Program (SSP) Measures

Opioid Use Measures (SSP)

Measure Group 1:

- MUC2018-077: Use of Opioids from Multiple Providers in Persons Without Cancer
- MUC2018-078: Use of Opioids at High Dosage in Persons Without Cancer
- MUC2018-079: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
- MUC2018-106: Initial opioid prescription compliant with CDC recommendations

Immunization Status Measure (SSP)

Measure Group 2:

- MUC2018-062: Adult Immunization Status

Pre-Rulemaking Input: MIPS Program Measures

Cost/Resource Use Measures (MIPS)

Measure Group 3:

- MUC2018-115: Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- MUC2018-116: Femoral or Inguinal Hernia Repair
- MUC2018-117: Lumbar Spine Fusion for Degenerative Disease, 1-3Levels
- MUC2018-119: Psychoses/Related Conditions
- MUC2018-120: Lumpectomy, Partial Mastectomy, Simple Mastectomy
- MUC2018-121: Acute Kidney Injury Requiring New Inpatient Dialysis
- MUC2018:122: Lower Gastrointestinal Hemorrhage
- MUC2018-123: Renal or Ureteral Stone Surgical Treatment
- MUC2018-126: Hemodialysis Access Creation
- MUC2018-137: Elective Primary Hip Arthroplasty
- MUC2018-140: Non-Emergent Coronary Artery Bypass Graft (CABG)
- MUC2018-148: Medicare Spending Per Beneficiary (MSPB) clinician measure
- MUC2018-149: Total Per Capita Cost

Quality Measures (MIPS)

Measure Group 4:

- MUC2018-32: Discouraging the routine use of occupational and/or physical therapy after carpal tunnel release

Quality Measures (MIPS)

Measure Group 5:

- MUC2018-18: Time to surgery for elderly hip fracture patients

Quality Measures (MIPS)

Measure Group 6:

- MUC2018-38: International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia

Quality Measures (MIPS)

Measure Group 7:

- MUC2018-47: Multimodal Pain Management
- MUC2018-48: Potential Opioid Overuse

Quality Measures (MIPS)

Measure Group 8:

- MUC2018-57: Annual Wellness Assessment: Preventive Care
- MUC2018-62: Adult Immunization Status

Quality Measures (MIPS)

Measure Group 9:

- MUC2018-063: Functional Status Change for Patients with Neck Impairments

Public Comment

Next Steps

Next Steps: Upcoming Pre-Rulemaking Activities

In-Person Meetings

- PAC/LTC Workgroup – **December 10**
- Hospital Workgroup – **December 11**
- Clinician Workgroup – **December 12**
- Coordinating Committee – **January 22-23**

Public Comment Period #2

- **December 19, 2018 – January 10, 2019**

Next Steps: Low Case-Volume TEP

- NQF Member and Public Comment Period on Draft Report
  - *January 18-February 8, 2019*
- TEP Call #: Discuss and Adjudicate Comments
  - *February 27, 2019*
- Complete Final Report
  - *March 29, 2019*

Project Contact Information

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Thank you!