MEASURE APPLICATIONS PARTNERSHIP

MAP 2015 Considerations for Implementing Measures in Federal Programs: Clinicians

FINAL REPORT

MARCH 2015

NATIONAL QUALITY FORUM

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CONTENTS

GUIDANCE ON CROSS-CUTTING ISSUES

Summary

- Noteworthy progress to more high-value measures in federal programs is seen in a few areas but remains uneven or slow for many conditions. Incentives are needed to promote the development of meaningful and impactful measures, particularly those used for public reporting.
- Greater focus on parsimony and alignment of measures in programs is essential to reduce burden and improve participation in quality reporting, to avoid confusing audiences of public reports of performance, and to synergize quality improvements across providers and settings of care.
- Financial incentives are needed for more meaningful measures.

The Measure Applications Partnership (MAP) provides multistakeholder, pre-rulemaking input to the Centers for Medicare & Medicaid (CMS) on measures in more than 20 federal health programs. MAP's Measure Selection Criteria identify characteristics that are associated with ideal measure sets used for public reporting and payment programs. MAP's Measure Selection Criteria complement program-specific statutory and regulatory requirements. The Measure Selection Criteria focus on selecting high-quality measures that optimally address the National Quality Strategy's three aims, filling critical measure gaps, and increasing alignment among programs. Additionally, the selection criteria emphasize the use of NQF-endorsed measures whenever possible; and seek measures that include a mix of measures types, i.e., outcome, composite, efficiency, patient-reported outcomes, etc.; enable measurement of person- and family-centered care and services; consider healthcare disparities and cultural competency; and promote parsimony and alignment among public and private quality programs.

MAP reviewed measures under consideration for the following clinician quality reporting programs:

- Physician Quality Reporting System (PQRS) - PQRS is a voluntary reporting program for individual clinicians, practices, and groups. The PQRS measures will be publicly reported on CMS's website Physician Compare beginning in 2014 with large groups and increasing to all professionals in 2016. The PQRS measures will be also used in the quality component of the Physician Value-Based Payment Modifier beginning in 2015.
- Medicare and Medicaid EHR Incentive Programs (Meaningful Use) - The EHR incentive programs encourage adoption and meaningful use of electronic health records. These voluntary quality reporting programs use payment incentives to encourage participation by "eligible professionals (EPs)," i.e., Medicare physicians, practitioners, and therapists allowed by law to participate in the quality programs.

OVERARCHING THEMES

Include More High-Value Measures in Federal Programs

MAP has identified high-value measures as more meaningful and usable for various stakeholders and more likely to drive improvements in quality. MAP members emphasized high-value measures such as outcome measures, patient-reported outcomes (PROs), composite measures, intermediate outcome measures, process measures that are closely linked by empirical evidence to outcomes, cost and resource use measures, appropriate use measures, care coordination measures and patient safety measures. Additional measures of value to patients and consumers for public reporting include patient experience and population health. Similarly, the MAP Dual Eligible Beneficiaries Workgroup emphasized that new and improved measures are needed to evaluate goal-directed, person-centered care planning and implementation; shared decisionmaking; systems to coordinate acute care, long-term services and supports, and nonmedical community resources; beneficiary sense of control/autonomy/self-determination; psychosocial needs; community integration/inclusion and participation; and optimal functioning (e.g., improving when possible, maintaining, managing decline).

MAP is concerned that availability of high-value measures had not changed much over the past few years, particularly now that public reporting of performance measure results for PQRS is imminent. In past years, MAP noted that some condition/topic areas had more high-value measures and requested a "scorecard" to judge progress toward more high-value measures under consideration. Table 1 presents a tally of the high-value measures by condition/topic area for the 2015 PQRS measures and the measures under consideration this year. Some topic areas have significantly more high-value measures for PQRS 2015 including cardiac care, eye care, renal disease, and surgery. MAP noted that clinicians who report on more high-value measures receive the same incentive payments even though they are reporting more challenging measures. Greater incentives for those who report on high-value measures might prompt faster development of high-value measures in other condition/topic areas.

MAP noticed a definite shift toward more high-value measures in the current measures under consideration though it is uneven across conditions. MAP specifically praised the patient-reported, functional outcome measures and episode-based payment measures for hip and knee replacement that address both quality and cost. A few patient-reported outcomes and appropriate use measures are included in this year's list of measures under consideration.

Important gaps include measures for multiple chronic conditions and complex conditions, outcome measures for cancer patients, measures for palliative/end-of-life care, measures for specialist EPs with few or no measures and EHR measures that promote interoperability and health information exchange. MAP encourages moving from physician-centered measures to patient-centered measures with greater use of patient-reported data for patient experience, shared decisionmaking, care coordination, patient-reported outcomes, etc.

Public comments were varied in whether they agreed with MAP's priority to move towards more high-value measures. Some public commenters disagreed with MAP's assessment that high value measures are better and would reduce reporting burden, and that moving towards these measures will spur increased development of such measures. Some commenters disagreed with moving away from process measures and removing "topped

out" measures from the programs. Commenters expressed concern about the gaps created when measures are removed from the program without time to identify appropriate replacements. Several commenters believed it would be unfair to penalize doctors for not reporting high-value measures because they do not have control over measure development.

TABLE 1. PROGRESS TO HIGH-VALUE MEASURES

Condition/Topic Area	PQRS 2015							Measures Under Consideration for PQRS 2014-2015						
	Total Measures	Outcomes	PROs	Composites	Intermediate Outcomes	Patient Experience	Efficiency/ Appropriate Use	Total Measures	Outcomes	PROs	Composites	Intermediate Outcomes	Patient Experience	Efficiency/ Appropriate Use
Asthma	3		1					1			1			
CAHPS/Patient Experience	2		2											
Cancer	23													
Cardiovascular Conditions	15	3		1	1			2			1			
Care Coordination	3	1						4						
CKD/ESRD	9				4			2						
COPD	2													
Cognitive Impairment/ Dementia	9							2						
Diabetes	11			1	2			1						
Emergency Care	2							4						2
Ear, Nose, Throat/Head and Neck	7													
Eye Care	12	7			1	1		1						
Geriatric Care	2													
Gastrointestinal	6							2						
Genitourinary	1							11	3					
Hepatitis	7							1						
HIV/AIDS	7				1									
Hypertension	2	2						1				1		
Imaging	12						3	6	1					2
Interventional Radiology								3	2					
Medication Management	4							6						
Mental Health	10	1						2		1				
Multiple Chronic Conditions	1													

Condition/Topic Area	PQRS 2015							Measures Under Consideration for PQRS 2014-2015						
	Total Measures	Outcomes	PROs	Composites	Intermediate Outcomes	Patient Experience	Efficiency/ Appropriate Use	Total Measures	Outcomes	PROs	Composites	Intermediate Outcomes	Patient Experience	Efficiency/ Appropriate Use
Musculoskeletal	22	5						3						
Neurologic Conditions	8							17		1				
Oral Health	2	1												
Pain Management	1													
Palliative care/End of Life	2		1											
Perinatal	5	1						2	2					
Population Health	20				2			10						2
Respiratory Infections	3													
Skin conditions	5							2	1					
Sleep Apnea	4													
Stroke/TIA	3							2	2					
Substance Use	1													
Perioperative and Anesthesia	8	2						6	1					
Surgery – Cardiac	7	5												
Surgery – Colorectal	1	1												
Surgery – Orthopedic	4							2		2				
Surgery – Vascular	8	4			3			2	1					

Parsimony and Alignment Across Programs

MAP noted that continually adding measures to programs needs a counterbalancing effort toward assessment of overall value of the measures in the programs for public reporting and payment. The right measures should provide effective and comprehensive support for patients and be meaningful to EPs to promote quality improvement. MAP's priority on high-value measures focuses on measures that are most meaningful to patients and professionals. Greater focus on selecting composite measures, appropriate use measures, and outcome measures could promote greater parsimony and reduce the burden of measurement for professionals. Calls for alignment of the measures in federal programs recognize the benefits of reducing data collection and reporting burdens on clinicians and providers, avoiding confusion for audiences of the publicly reported information and promoting synergies among providers across settings.

MAP's Measure Selection Criteria and the critical program objectives for the clinician programs used to make recommendations on the measures under consideration emphasize the importance

of alignment among the programs. The MAP Coordinating Committee continues to identify alignment of measures across federal programs and across public and private programs as a cross-cutting priority. The Coordinating Committee encouraged the three workgroups to consider alignment of similar measures under consideration from different settings or levels of analysis.

Clinicians must coordinate the reporting for overlapping programs that sometimes include different implementation rules. In October 2014, the American Medical Association outlined the growing burden on clinicians and requested that CMS "synchronize and simplify" the requirements of the programs. The 2015 Physician Fee Schedule (PFS) final rule reflects a growing effort by CMS to align the federal quality programs for clinicians by using PQRS measures reported by clinicians for both public reporting on Physician Compare and for the quality component of the Physician Value-Based Payment Modifier. Additionally, EPs that satisfactorily report to PQRS using the EHR-based reporting option will also satisfy the Clinical Quality Measurement (eCQM) component of the EHR Incentive program.

The growing use of registries suggests the possibility for greater interaction between measures for public reporting and payment and measures for quality improvement that can reinforce each other and reduce the burden of measurement. Public commenters appreciated MAP's recognition of the growing role of registries.

Incentives for More Meaningful Measurement

Financial incentives for quality measure development are often limited in scope and timeframe. There are no predictable financial supports to evolve measures from basic "building block" measures to more meaningful measures, e.g., outcomes, patient-reported outcomes, appropriate use, etc. Measure developers need on-going financial support, and clinicians must invest in infrastructure to support reporting data for measurement. CMS indicated a need for testing sites for eMeasures in development. MAP suggests that CMS could consider innovative incentives to further the enterprise such as waiving non-participation penalties in quality programs in exchange for acting as a test site or participating in a registry. Primary care and emergency medicine physicians have not yet developed registries despite growing pressure to do so and are seeking a business case that would make a registry viable. Public comments strongly support the need for steady funding for measure development. Commenters also support the idea of waiving quality program non-participation penalties if an EP acted as a testing site or participated in a registry.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

This section provides an overview of MAP's 2014-2015 pre-rulemaking recommendations for each program. This section outlines MAP's critical program objectives, highlights important measure gaps, and provides a high level insight into the 2014-2015 MAP recommendations on the measures under consideration. Details on specific measures can be found in the accompanying table.

Physician Quality Reporting System (PQRS), Physician Compare, Physician Value-Based Payment Modifier

PQRS uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). Now in its eighth year PQRS has finalized 285 measures in the 2015 Physician Fee Schedule final rule. All PQRS measures will be used for public reporting on Physician Compare and for the quality component of the Value-Based Payment Modifier. As noted above, MAP encourages a focus on high-value measures; however, the availability of high-value measures varies greatly by condition/topic (Table 1). CMS has identified 19 "cross-cutting measures" on the recommendation of MAP for a core set of measures that can be reported on by most EPs.

MAP identified the following critical program objectives for PQRS:

- Include more high-value measures, e.g., outcomes, patient-reported outcomes, composites, intermediate outcomes, process measures close to outcomes, cost and resource use measures, appropriate use measures, care coordination measures, patient safety, etc.
- To encourage widespread participation in PQRS, many measures are needed for the variety of EP's specialties and subspecialties.
- The measures chosen by EPs to submit for PQRS will be reported on Physician Compare and used to determine the Value-Based Payment Modifier; therefore, all PQRS measures will be used for accountability purposes.
- Measures selected for the program that are not NQF-endorsed should be submitted for endorsement.
- For measures that are not endorsed, include measures under consideration that are fully specified and that:
  - support alignment (e.g., measures used in other programs, registries);
  - measure outcomes that are not already addressed by outcome measures included in the program; and
  - are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures.

More than half of the measures under consideration for PQRS are still in development. MAP encouraged the continued development of most measures with specific recommendations on developing high-value measures. MAP questioned the value of measures that are "building blocks" to more meaningful measures that require investments by EPs to comply with the measures—is this helpful in reducing burden if the measures will be replaced?

MAP noted that very few of the measures under consideration for use in the PQRS program are NQF-endorsed or have been submitted to NQF. MAP relies on the detailed information about measures used in the evaluation by NQF for endorsement. In the absence of information obtained for an NQF review, MAP is provided very limited information about the measures under consideration.

MAP identified many gaps in measurement including measures for end-of-life and palliative care, geriatrics, COPD, and trauma care (increasingly important in the elderly population). Measures of diagnostic accuracy are critical because most quality measures are based on diagnosis codes. MAP noted that current measures for specific conditions are challenging for patients with multiple chronic conditions or overall frailty—focusing on improving outcomes in one condition may worsen outcomes in another.

Medicare and Medicaid EHR Incentive Programs

The Medicare and Medicaid Electronic Health Care Record (EHR) Incentive Programs provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. The programs promote widespread adoption of certified EHR technology by providers and incentivize "meaningful use" of EHRs to improve quality, safety, efficiency, and reduce health disparities; engage patients and family; improve care coordination, and population and public health; and maintain privacy and security of patient health information. As of September 2014, more than 414,000 healthcare providers received payment for participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The EHR Incentive Programs align with the PQRS program to allow individual EPs and groups to report electronic clinical quality measures (eCQMs) through the PQRS portal. The programs also allow groups to report eCQMs through Pioneer ACO participation or Comprehensive Primary Care Initiative participation.

EHR measures under consideration for the current pre-rulemaking cycle are intended for Meaningful Use Stage 3. CMS has determined that the measures under consideration for the EHR Incentive Programs have been appropriately specified as eCQMs or "eMeasures" but all eCQMs are being revised to reflect recently revised standards. CMS indicates that the eCQMs under consideration for pre-rulemaking should be considered as measures under development. MAP noted that while most federal programs are focused on the Medicare population, the Medicaid EHR Incentive program also needs eMeasures applicable to children, young adults, and pregnancy.

MAP's perspectives on critical objectives for the EHR Incentive Programs include:

- Include endorsed measures that have eMeasure specifications available.
- Alignment with other federal programs, particularly PQRS.
- As health IT becomes more effective and interoperable, focus on:
  - Measures that reflect efficiency in data collection and reporting through the use of health IT
  - Measures that leverage health IT capabilities (e.g., measures that require data from multiple settings/providers, patient-reported data, or connectivity across platforms to be fully operational)
  - Innovative measures made possible by the use of health IT

MAP noted that the eMeasures under consideration tend to be limited by today's EHR environment rather than pushing towards a system of greater interoperability and health information exchange in which measurement is readily performed without additional burden on the providers. MAP was interested in seeing more forward-thinking eMeasures for consideration.

APPENDIX A:
Program Summaries

Physician Quality Reporting System (PQRS)

Program Type

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

Incentive Structure

In 2012-2014, EPs could receive an incentive payment equal to a percentage (2% in 2010, gradually decreasing to 0.5% in 2014) of the EP's estimated total allowed charges for covered Medicare Part B services under the Medicare Physician Fee Schedule. Beginning in 2015, EPs and group practices that do not satisfactorily report data on quality measures will receive a reduction (1.5% in 2015 and 2% in subsequent years) in payment.

Program Goals

The goal of the PQRS program is to encourage widespread participation by EPs to report quality information. In 2012, only 36% of EPs satisfactorily submitted quality information to PQRS.

Program Update

For 2014 the PQRS program has 285 measures that may be submitted through a variety of mechanisms: claims, qualified registry, EHRs and the group reporting web interface (GPRO).

The most recent 2012 PQRS participation report reported:

- Participation increased from 29% of EPs in 2011 to 36% of EPs in 2012.
- PQRS participation is highest among EPs who see the most Medicare patients.
- Emergency physicians (64%) and anesthesiology (57%) had the high participation rates among the specialties using the individual claims reporting mechanism.
- Internal medicine and family practice had the highest numbers of EPs participating via the registry mechanism.
- Family practice, internal medicine, nurse practitioner, and cardiology were also the top four specialties using the EHR reporting mechanism.

The final 2015 Physician Fee Schedule rule includes the following updates:

- Beginning in 2015, a downward payment adjustment of -2 percent will apply to EPs who do not satisfactorily report data on quality measures for covered professional services or satisfactorily participate in a qualified clinical data registry
- Identification of 19 cross-cutting measures that can be used by all EPs – based on the recommendation of a core set from the MAP.
- For the 12-month reporting period (2015) for the 2017 PQRS payment adjustment EPs reporting by claims, EHR or registry would report at least 9 measures, covering at least 3 of the National Quality Strategy domains.
  - For individual EPs reporting via EHR: if the EHR does not contain data for 9 measures, then report on all measures with Medicare patient data (aligns with Medicare EHR Incentive Program).
  - Qualified Clinical Data Registries (QCDRs) must report at least 2 outcome measures or 1 outcome and 1 other (resource use, patient experience with care, efficiency/appropriate use or patient safety) measure; QCRDs may report up to 30 non-PQRS measures; QCRDs must public report measure results beginning in 2015 (except new measures

that are not required to report in the first year)

  - Group practices of 100 or more EPs that report via PQRS must report CAHPS for PQRS GPRO

- Changes to the total number of PQRS measures:
  - Addition of 20 new individual measures and two measures groups to fill existing measure gaps;
  - Removal of 50 measures for a variety of reasons:
    - » Measure steward will no longer maintain the measure
    - » Performance rates consistently close to 100%, i.e., "topped out"
    - » Measure does not add clinical value to PQRS
    - » Measures a standard of care
    - » Evidence and guideline change
    - » Duplicative measures
  - The measures to be removed include 8 hypertension measures, 3 stroke measures, 4 back pain measures, , 4 inflammatory bowel disease measures, 3 emergency medicine measures

CMS has an ongoing Call for Measures to solicit new measures for possible inclusion in PQRS. Aside from NQF endorsement, submitters are asked to consider the following:

- Measures that are not duplicative of existing or proposed measures.
- Measures that are further along in development than a measure concept.
- CMS is not accepting claims-based-only reporting measures.
- Measures that are outcome-based rather than clinical process measures.
- Measures that address patient safety and adverse events.
- Measures that identify appropriate use of diagnosis and therapeutics.
- Measures that include the NQS domains of care coordination, communication, patient experience and patient-reported outcomes.
- Measures that address efficiency, cost and resource use.

MAP's Suggested Critical Program Objectives

- To encourage widespread participation many measures are needed for the variety of EPs specialties and sub-specialties.
- The measures chosen by EPs to submit for PQRS will be reported on Physician Compare and used to determine the Value Based Payment Modifier; therefore all PQRS measures will be used for accountability purposes.
- Include more high value measures, e.g., outcomes, patient-reported outcomes, composites, intermediate outcomes, process measures close to outcomes, cost and resource use measures, appropriate use measures, care coordination measures, patient safety, etc.
- Include NQF-endorsed measures relevant to clinician reporting to encourage engagement Measures selected for the program that are not NQF-endorsed should be submitted for endorsement.
- For measures that are not endorsed, include measures under consideration that are fully specified and that:
  - Support alignment (e.g., measures used in other programs, registries)
  - Are outcome measures that are not already addressed by outcome measures included in the program
  - Are clinically relevant to specialties/ subspecialties that do not currently have clinically relevant measures

Value-Based Payment Modifier and Physician Feedback of Quality Resource and Use Reports (QRURs)

Program Type

Physician Feedback of QRURs provides comparative performance information via Quality Resource and Use Reports (QRURs) to physicians as one part of Medicare's efforts to improve the quality and efficiency of medical care.

Value Based Payment Modifier assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule. High-quality and/or low-cost groups can qualify for upward adjustments. Low- quality and/or high-cost groups and groups that fail to satisfactorily report PQRS are subject to downward adjustments

Incentive Structure

The Physician Value Based Payment Modifier is being phased in over the three years 2015-2017:

CY 2015: VM will apply to physicians in groups with 100 or more eligible professionals (EPs) based on 2013 performance.

CY 2016: VM will apply to physicians in groups with 10 or more EPs based on 2014 performance.

CY 2017: VM will apply to physician solo practitioners and physicians in groups with 2 or more EPs based on 2015 performance. An estimated 900,000 physicians will be affected.

CY 2018: VM will apply to physicians **and non-physician** EPs who are solo practitioners or are in groups with 2 or more EPs based on 2016 performance

Program Goals

- The QRURs provide information about performance on the quality and cost measures used to calculate the Value Modifier. They allow eligible professionals to understand and improve the care they provide to Medicare beneficiaries and their performance under the Value Modifier Program.
- The VM is an adjustment made on a per claim basis to Medicare payments for items and services furnished under the Medicare Physician Fee Schedule, based on performance on cost and quality measures during a performance period. The goal of the program is to encourage and reward physicians for furnishing high-quality, efficient, patient-centered clinical care.
- Alignment of federal programs – the VM is aligned with the Physician Quality Reporting System (PQRS) and provides an additional incentive to physicians and groups to report quality measures through PQRS.
- The program also seeks to align measures, and consequently align incentives to improve care, with the Hospital VBP Program in the future, to the extent possible.

Program Update

- In 2017, the Value Modifier applies to all physician solo practitioners and physicians in groups of all sizes.
- In 2018, the Value Modifier applies to all physician and non-physician eligible professionals.
- Quality tiering is the method by which quality and cost performance that is substantially better than or worse than average is recognized through payment adjustments. Quality tiering is mandatory for all groups and solo practitioners subject to the 2017 Value Modifier but smaller groups of one to nine eligible professionals can only earn upward or neutral (no) payment adjustments under this methodology.

MAP's Suggested Critical Program Objectives

- NQF-endorsed measures are strongly preferred for pay-for-performance programs; measures that are not NQF-endorsed should be submitted for endorsement or removed.
- Include measures that have been reported in a national program for at least one year

(e.g.,PQRS) and ideally can be linked with particular cost or resource use measures to capture value.

- Focus on outcomes, composites, process measures that are proximal to outcomes, appropriate care (e.g., overuse), and care coordination measures (measures included in the MAP Families of Measures generally reflect these characteristics).
- Monitor for unintended consequences to vulnerable populations (e.g., through stratification).

Physician Compare Initiative

Program Type

Physician Compare is the federal website that reports information on physicians and other clinicians. The purpose of the web site is public reporting of information and quality measures that are meaningful to patients.

Incentive Structure

There is no incentive specific to public reporting. The information reported on the web site is derived from other programs that have various incentives.

Program Goals

- Providing consumers with quality of care information that will help them make informed decisions about their health care.
- Encourage clinicians to improve the quality of care they provide to their patients and create incentives to maximize performance.

Program Update

The website was launched on December 30, 2010 providing information about Medicare physicians and other health care professionals including an indication of participation in Physician Quality Reporting System (PQRS). Public reporting of performance measure results is being employed via a phased approach. In February 2014, the first set of measure data were posted on Physician Compare. These data included a sub-set of the 2012 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) Diabetes Mellitus (DM) and Coronary Artery Disease (CAD) measures for the 66 group practices and 141 Accountable Care Organizations (ACOs) that successfully reported via the Web Interface. In late 2014, a similar subset of 2013 group-level measures will be reported. In 2015, the first individual eligible professional-level measures available for public reporting will be a sub-set of twenty 2014 PQRS measures and measures from the Cardiovascular Prevention measures group in support of the Million Hearts campaign.

By statute, the following types of measures are encouraged to be included for public reporting:

- PQRS measures
- Patient health outcomes and functional status of patients
- Continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use
- Efficiency
- Patient experience and patient, caregiver, and family engagement
- Safety, effectiveness, and timeliness of care

The final 2015 Physician Fee Schedule rule notes that beginning in 2015 all PQRS measures and all QCDR measures will be available for public reporting. Measures that are new to PQRS or a QCDR will not be publicly reported in the first year. All valid and reliable measures will be available in a downloadable file. Only those measures that are accurately understood and interpreted by consumers will be available on Physician Compare profile pages. Measures from QCDRs will be held to the same qualifications as PQRS measures, i.e., a minimum sample size of 20 and successful testing for reliability and validity.

For data collected in 2015, for publication on Physician Compare in 2016:

- PQRS, PQRS GPRO, EHR and Million

Hearts: include an indicator of satisfactory participation

- PQRS GPRO and ACO GPRO: all PQRS GPRO measures for groups of 2 or more; all measures reported by ACOs with minimum sample size of 20.
- CAHPS for PQRS for all groups of 2 or more and CAHPS for ACOs for all measures that meet sample size
- PQRS: All PQRS measures for individual EPs collected through registry, EHR or claims.
- QCRD data: All individual EP-level 2015 QCDR data.

CMS has indicated an interest in MAP identifying those PQRS measure that are most meaningful to consumers.

MAP's Suggested Critical Program Objectives

- Focus on outcome measures and measures that are meaningful to consumers (i.e., have face validity) and purchasers.
- Focus on patient experience, patient-reported outcomes (e.g., functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care measures.
- Public reporting of PQRS measures for:
  - Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
  - Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
  - Therapists—physical therapist, occupational therapist, qualified speech-language therapist
  - Reporting of physicians in groups and ACOs is included.
- NQF-endorsed measures are preferred for public reporting programs over measures that are not endorsed or are in reserve status (i.e., topped out); measures that are not NQF-endorsed should be submitted for endorsement or removed.
- To generate a comprehensive picture of quality, measure results should be aggregated (e.g., composite measures), with drill-down capability for specific measure results.
- Alignment of measures in federal programs.

Medicare and Medicaid EHR Incentive Programs for Eligible Professionals

Program Type

The Medicare and Medicaid Electronic Health Care Record (EHR) Incentive Programs provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Incentive Structure

The incentive structure varies by program:

- Medicare: Up to $44,000 over 5 continuous years. The last year to begin the program is 2014. Penalties take effect in 2015 and in each year hereafter where EPs are eligible but do not participate.
- Medicaid: Up to $63,750 over 6 years. The last year to begin the program is in 2016. Payment adjustments do not apply to Medicaid.

Program Goals

- Promote widespread adoption of certified EHR technology by providers.
- Incentivize "meaningful use" of EHRs by providers to:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and family

  - Improve care coordination, and population and public health
  - Maintain privacy and security of patient health information

Program Update

- The three main components of Meaningful Use:
  - The use of a certified EHR in a meaningful manner, such as e-prescribing;
  - The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and
  - The use of certified EHR technology to submit clinical quality and other measures.
- Meaningful Use Stage 2:
  - The earliest providers will demonstrate Stage 2 of meaningful use is 2014.
  - For Stage 2 (2014 and beyond): Eligible Professionals must report on 9 total clinical quality measures that cover 3 of the National Quality Strategy Domains (selected from a set of 64 clinical quality measures).
  - CMS is not requiring the submission of a core set of electronic CQMs (eCQMs). Instead, CMS has identified two recommended core sets of eCQMs—one for adults and one for children—that focus on high-priority health conditions and best-practices for care delivery.
- The program has several options that align with other programs:
  - Report individual eligible professionals' eCQMs through PQRS Portal
  - Report group's eCQMs through PQRS Portal
  - Report group's eCQMs through Pioneer ACO participation or Comprehensive Primary Care Initiative participation.
- Measures under consideration for the current pre-rulemaking cycle are for Meaningful Use Stage 3. CMS has determined that the measures under consideration (MUC) for the EHR Incentive Programs are appropriately specified as "electronic Clinical Quality Measures (eCQMs)" or "eMeasures". While some testing may have been done, the eMeasures under consideration are being revised to meeting the most recent standards and have not been used in the field. CMS agrees the eCQMs on the MUC list are "Measures Under Development".

MAP's Suggested Critical Program Objectives

- Include endorsed measures that have eMeasure specifications available.
- Over time, as health IT becomes more effective and interoperable, focus on:
  - Measures that reflect efficiency in data collection and reporting through the use of health IT
  - Measures that leverage health IT capabilities (e.g., measures that require data from multiple settings/providers, patient-reported data, or connectivity across platforms to be fully operational)
  - Innovative measures made possible by the use of health IT
- Alignment with other federal programs, particularly PQRS.

APPENDIX B:
Measure Applications Partnership (MAP) Rosters

MAP Clinician Workgroup

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