

# Measure Applications Partnership

## Clinician Workgroup Web Meeting



NATIONAL  
QUALITY FORUM

*December 18-19, 2013*

## ***Welcome, Introductions, Review of Meeting Objectives, and Pre- Rulemaking Approach***

## Agenda-Day 1

- Welcome, Introductions, Review Meeting Objectives, and Pre-Rulemaking Approach
- Pre-Rulemaking Input on Measures Under Consideration for Individual Clinician Reporting
- Core Measures for Individual Clinician Reporting
- Opportunity for Public Comment
- Summary of Day and Adjourn

## Clinician Workgroup Membership

**Workgroup Chair:** Mark McClellan, MD, PhD

### Organizational Members

American Academy of Family Physicians	<i>Amy Mullins, MD</i>
American Association of Nurse Practitioners	Anne Norman, DNP, APRN, FNP-BC
American College of Cardiology	Paul Casale, MD, FACC
American College of Emergency Physicians	Bruce Auerbach, MD
American College of Radiology	David Seidenwurm, MD
American Speech-Language-Hearing Association	Janet Brown, MA, CCC-SLP
Association of American Medical Colleges	Joanne Conroy, MD
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	David M. Ferriss, MD, MPH
Consumers' CHECKBOOK	Robert Krughoff, JD
Kaiser Permanente	Amy Compton-Phillips, MD
March of Dimes	Cynthia Pellegrini
Minnesota Community Measurement	Beth Averbeck, MD
National Business Coalition on Health	Representative TBD
Pacific Business Group on Health	David Hopkins, PhD
Physician Consortium for Performance Improvement	Mark Metersky, MD
The Alliance	Cheryl DeMars

## Clinician Workgroup Membership

### Subject Matter Experts

Disparities	Luther Clark, MD
Palliative Care	Constance M. Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN
Population Health	Eugene Nelson, MPH, DSc
Surgical Care	Eric B. Whitacre, MD, FACS
Shared Decision Making	Karen Sepucha, PhD
Team-Based Care	Ronald Stock, MD, MA

### Federal Government Members

Agency for Healthcare Research and Quality (AHRQ)	Darryl Gray, MD, ScD
Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Kate Goodrich, MD
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP
Veterans Health Administration	Joseph Francis, MD, MPH

## Meeting Objectives

- Review and provide input on finalized measures for federal programs applicable to clinician measurement
- Review and provide input on measures under consideration for federal programs applicable to clinician measurement
- Discuss characteristics of core measures and identify high-priority measure gaps
- Finalize input to the MAP Coordinating Committee on measures for use in federal programs

## MAP Pre-Rulemaking Timeline

- **December 1:** HHS list of measures under consideration provided to MAP
- **December 4:** All MAP Web Meeting to preview list of measures under consideration
- **December 10-20:** MAP workgroup meetings to provide input on program measure sets and measures under consideration
- **January 7-8:** MAP Coordinating Committee Meeting in-person to finalize MAP's recommendations to HHS
- **Mid-January:** 2-week public comment period on draft Pre-Rulemaking Report
- **February 1:** Pre-Rulemaking Report due to HHS

## *MAP Pre-Rulemaking Approach*

## Pre-Rulemaking Approach

1. Build on MAP's prior recommendations
2. Evaluate each finalized program measure set using MAP Measure Selection Criteria
3. Evaluate measures under consideration for what they would add to the program measure sets
4. Identify high-priority measure gaps for programs and settings

## 1. Build on MAP's Prior Recommendations

### **MAP's prior efforts serve as guidance for pre-rulemaking decisions**

- Coordination Strategies
  - Key recommendations included in Discussion Guide
- Gaps identified across all MAP efforts
  - MAP Previously Identified Gaps list in background materials
- 2012 and 2013 pre-rulemaking decisions
  - Measure charts and Discussion Guide note prior pre-rulemaking decisions
- Families of measures
  - Measure charts note measures that are included in families

## 2. Evaluate Finalized Program Measure Set Using MAP Measure Selection Criteria

**Through discussion, MAP identifies:**

- Potential measures for inclusion
- Potential measures for removal
- Gaps—implementation gaps (measures in a family not in the set) and other gaps (e.g., development, endorsement) along the measure lifecycle
- Additional programmatic considerations (e.g., guidance on implementing MAP recommendations, data collection and transmission, attribution methods)

## 3. Evaluate Measures Under Consideration

**MAP will indicate a decision and rationale for each measure under consideration:**

MAP Decision Category	Decision Description	Rationale (Example)
Support	Indicates measures under consideration that should be added to the program measure set during the current rulemaking cycle.	<ul style="list-style-type: none"> <li>• NQF-endorsed measure</li> <li>• Addresses National Quality Strategy aim or priority not adequately addressed in program measure set</li> <li>• Addresses program goals/requirements</li> <li>• Addresses a measure type not adequately represented in the program measure set</li> <li>• Promotes person- and family-centered care</li> <li>• Provides considerations for healthcare disparities and cultural competency</li> <li>• Promotes parsimony</li> <li>• Promotes alignment across programs, settings, and public and private sector efforts</li> <li>• Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries</li> <li>• Included in a MAP family of measures</li> </ul>

### 3. Evaluate Measures Under Consideration

MAP will indicate a decision and rationale for each measure under consideration:

MAP Decision Category	Decision Description	Rationale (Example)
Do Not Support	Indicates measures that are not recommended for inclusion in the program measure set.	<ul style="list-style-type: none"> <li>• Measure does not adequately address any current needs of the program</li> <li>• A finalized measure addresses a similar topic and better addresses the needs of the program</li> <li>• A 'Supported' measure under consideration addresses as similar topic and better addresses the needs of the program</li> <li>• NQF endorsement removed (the measure no longer meets the NQF endorsement criteria)</li> <li>• NQF endorsement retired (the measure is no longer maintained by the steward)</li> <li>• NQF endorsement placed in reserve status (performance on this measure is topped out)</li> <li>• Measure previously submitted for endorsement and was not endorsed</li> </ul>
Conditionally Support	Indicates measures, measure concepts, or measure ideas that should be phased into program measure sets over time, subject to contingent factor(s).	<ul style="list-style-type: none"> <li>• Not ready for implementation; measure concept is promising but requires modification or further development</li> <li>• Not ready for implementation; should be submitted for and receive NQF endorsement</li> <li>• Not ready for implementation; data sources do not align with program's data sources</li> <li>• Not ready for implementation; measure needs further experience or testing before being used in the program</li> </ul>

### 4. Identify High-Priority Measure Gaps for Programs and Settings

**Process for the meeting:**

- Workgroup will identify gaps in the program measure set
  - Staff will capture any new gaps raised during the course of discussion
- Workgroup will discuss gap priorities for the program

## MAP Measure Selection Criteria

### Background

- MAP initially developed the Measure Selection Criteria (MSC) prior to the first round of pre-rulemaking activities in 2011, primarily to guide decisions on recommendations for measure use in federal programs, with an emphasis on *measure sets*
- Per HHS' request, the MAP Strategy Task Force was re-convened this summer as the MAP Measure Selection Criteria and Impact Task Force to advise the Coordinating Committee about potential refinements to the MSC, emphasizing the following:
  - Applying lessons learned from the past two years
  - Integrating the Guiding Principles developed by the Clinician and Hospital Workgroups during the 2012-13 pre-rulemaking cycle

## Revisions to the Measure Selection Criteria

### Overarching Changes

- Added a preamble to emphasize that the criteria are meant as guidance rather than rules; application should be to *measure sets*, not individual measures; and focus should be placed on filling important measure gaps and promoting alignment
- More consistent use of terminology and formatting
- Removed extraneous content, including the "Response Option" rating scales for each criterion or sub-criterion



## Revised MAP Measure Selection Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

*Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.*

**Sub-criterion 1.1** Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

**Sub-criterion 1.2** Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

**Sub-criterion 1.3** Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

### Clinician workgroup application of this criterion:

- Balance the importance of the endorsement and filling the measurement gaps
- Preference for NQF-endorsed measures in public reporting and payment programs

## Revised MAP Measure Selection Criteria

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

*Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:*

**Sub-criterion 2.1** Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

**Sub-criterion 2.2** Healthy people/healthy communities, demonstrated by prevention and well-being

**Sub-criterion 2.3** Affordable care

## Revised MAP Measure Selection Criteria

### 3. Program measure set is responsive to specific program goals and requirements

*Demonstrated by a program measure set that is “fit for purpose” for the particular program.*

**Sub-criterion 3.1** Program measure set includes measures that are applicable to and appropriately tested for the program’s intended care setting(s), level(s) of analysis, and population(s)

**Sub-criterion 3.2** Measure sets for public reporting programs should be meaningful for consumers and purchasers

**Sub-criterion 3.3** Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

**Sub-criterion 3.4** Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program.

**Sub-criterion 3.5** Emphasize inclusion of endorsed measures that have eMeasure specifications available

## Revised MAP Measure Selection Criteria

### 4. Program measure set includes an appropriate mix of measure types

*Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program.*

**Sub-criterion 4.1** In general, preference should be given to measure types that address specific program needs

**Sub-criterion 4.2** Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

**Sub-criterion 4.3** Payment program measure sets should include outcome measures linked to cost measures to capture value

## Revised MAP Measure Selection Criteria

### 5. Program measure set enables measurement of person- and family-centered care and services

*Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration*

**Sub-criterion 5.1** Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

**Sub-criterion 5.2** Measure set addresses shared decision-making, such as for care and service planning and establishing advance directives

**Sub-criterion 5.3** Measure set enables assessment of the person's care and services across providers, settings, and time

## Revised MAP Measure Selection Criteria

### 6. Program measure set includes considerations for healthcare disparities and cultural competency

*Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).*

**Sub-criterion 6.1** Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

**Sub-criterion 6.2** Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

## Revised MAP Measure Selection Criteria

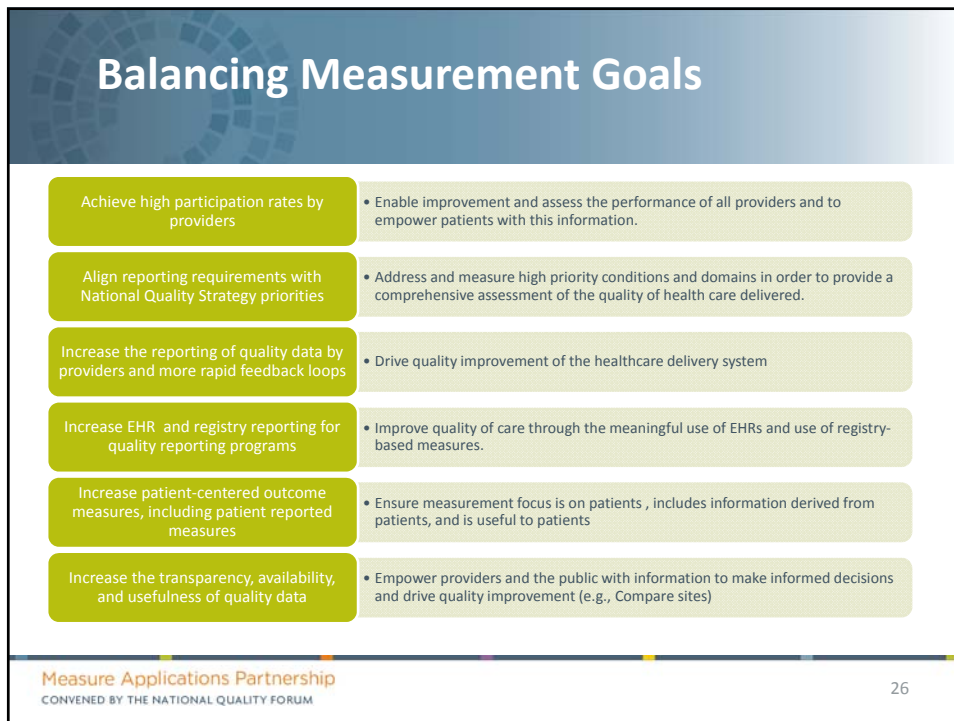
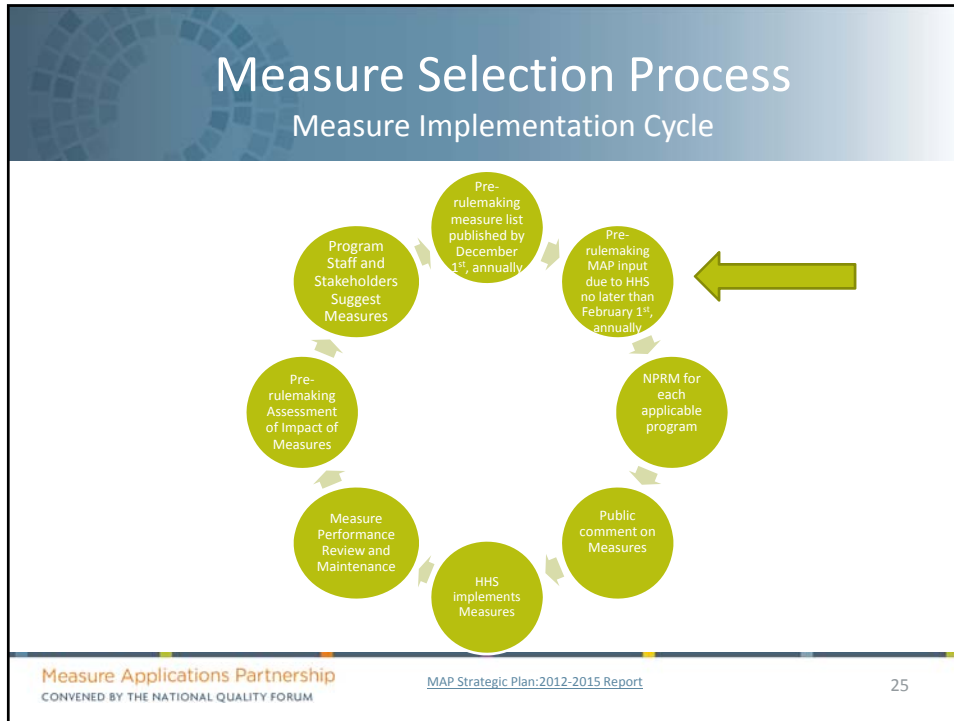
### 7. Program measure set promotes parsimony and alignment

*Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.*

**Sub-criterion 7.1** Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

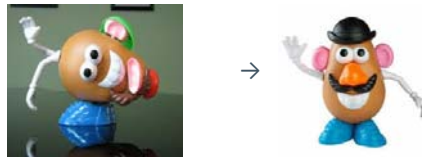
**Sub-criterion 7.2** Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

## 2013 Pre-Rulemaking Measures Under Consideration List



## Major Changes in the last 2 years (Future vs. Current)

- Process improvement - LEAN
  - Transparent and collaborative
  - Communication early and often
- MAP developed Guiding Principles and categories for support which has been incredibly helpful
- Incorporated MAP feedback into CMS processes



## LEAN Improvements

Wastes	Improved Process	Benefits
Defects : 23 clearance reviews & List Revisions*	<b>Early engagement:</b> Convene two federal stakeholder meetings to obtain (1) consensus on needs/priorities and (2) approval of final measures under consideration (MUC) list.	<b>Reduced or removal of clearance process; 5 months saved</b>
<b>Confusion:</b> Non-concurrence from certain agencies during HHS clearance due to misunderstanding of requirements	<b>Early education</b> regarding MUC list process	Reduced number of revisions and re-reviews
<b>Waiting:</b> HHS & OMB clearance 1 week and 2 weeks over project timeline, respectively.	Implement <b>open source issue and project tracking</b> via a web based interface (i.e. JIRA software) for expedited review; Measurement Policy Council (MPC) provides HHS Clearance; and Quality Measures Task Force (QMTF) provides CMS Clearance	6 weeks saved
Over processing: Public call for measures without criteria resulting in > 500 measures on the list	Public call for measures based on <b>explicit criteria</b> identified during first stakeholder meeting	Reduced number of measures; more meaningful & parsimonious measures list; reduced burden to reviewers
<b>Discordant policy</b> decisions within CMS	<b>All federal stakeholder meeting</b> includes Office of General Counsel, Office of Legislation, Office of Strategic Operations and Regulatory Affairs; Office of Management and Budget; and others.	Increased transparency and stakeholder engagement
<b>Motion:</b> Continuous access and changes	<b>"Pens down"</b> deadline for changes to the list	Reduced number of revisions and re-reviews

## 2013 Highlights

1. New CMS LEAN Process for the MUC list.
2. 234 new measures under consideration; however, many are being considered for multiple programs.
3. These measures are being considered for 20 Medicare programs.
4. If CMS chooses not to adopt a measure under this list for the current rulemaking cycle, those measures remain under consideration by the Secretary and may be considered in future rulemaking cycles.
5. External stakeholders contributed to and supported the majority of measures on this list.
6. Many of the measures contained in this list are NQF endorsed or pending NQF endorsement.
7. Balance of measure types tilted more towards high value measures (outcome, cost, appropriateness, safety)

## 2013 Measures Under Consideration List

CMS Program	Number of Measures
Ambulatory Surgical Center Quality Reporting	3
End Stage Renal Disease Quality Improvement Program	20
Home Health Quality Reporting	4
Hospice Quality Reporting	0
Hospital Acquired Condition Payment Reduction (ACA 3008)	4
Hospital Inpatient Quality Reporting	11
Hospital Outpatient Quality Reporting	6
Hospital Readmission Reduction Program	3
Hospital Value-Based Purchasing	14
Inpatient Psychiatric Facility Quality Reporting	10
Inpatient Rehabilitation Facility Quality Reporting	8
Long-Term Care Hospital Quality Reporting	3
<b>Medicare and Medicaid EHR Incentive Program for Eligible Professionals</b>	<b>37</b>
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	6
<b>Medicare Shared Savings Program</b>	<b>100</b>
<b>Medicare Physician Quality Reporting System (PQRS)</b>	<b>110</b>
<b>Physician Feedback/Quality and Resource Utilization Reports</b>	<b>161</b>
<b>Physician Value Based Payment Modifier</b>	<b>161</b>
<b>Physician Compare</b>	<b>110</b>
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	6

## 2014 Measure Reporting Changes

- Emphasis on 2014 Incentive **AND** avoiding 2016 Payment Adjustment
- New satisfactorily reporting requirements via claims, registry and EHR to receive incentive: **9 measures across 3 National Quality Strategy domains** (this will also allow EPs to avoid the payment adjustment)
- Registries can report **less than 9** measures for EPs to potentially receive incentive and report less than 3 measures for EPs to avoid the payment adjustment.
  - Due to this requirement, a **new registry MAV process** will be implemented
- All measures Groups reportable via **Registry Only**
- Measures Changing Reporting Options
  - EHR reporting option **removed** from 6 measures
  - EHR reporting option **added** to 11 measures
  - Claims-based reporting option **removed** from 17 individual measures

## 2014 Measure Reporting Changes

- **Added EHR Reporting** for group practices
- **Elimination of Administrative claims** for purposes of avoiding the 2016 PQRS payment adjustment
- **Certified Survey Vendor Option** for purposes of reporting the CG-CAHPS measures, available to group practices that register to participate in the Group Practice Reporting Option (GPRO)
  - CG-CAHPS measures are required for group practices of 100+ reporting measures via the GPRO Web Interface



## Qualified Clinical Data Registry

- **New Qualified Clinical Data Registry (QCDR) reporting option**
- A QCDR is a CMS-approved entity that has self-nominated and successfully completed a qualification process that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. A qualified clinical data registry must perform the following functions:
  - (1) Submit quality measures data or results to CMS
    - » Must have in place mechanisms for the transparency of data elements, specifications, risk models, and measures.
  - (2) Submit to CMS quality measures data on multiple payers
  - (3) Provide timely feedback (4 times a year)
  - (4) Possess benchmarking capacity
  - (5) Must have at least 9 measures, covering at least 3 of the 6 NQS domains, available for reporting
  - (6) Must have at least 1 outcome measure available for reporting

## PQRS Integration of Inpatient Quality Reporting (IQR) Measures

- CMS is exploring the integration of the IQR measures with PQRS
  - Goal: increases the ability for hospital-based eligible professionals (EPs) to participate in PQRS
- Two options proposed for 2014 rulemaking but deferred for finalization
  - Retooling IQR measures from hospital-level to individual EP-level
  - Attributing a hospital's IQR performance score to an individual EP
- CMS has received initial comments for this alignment
  - Seeking input from MAP on specific IQR measures CMS should consider in future rulemaking

## Measure Counts

Totals	2013	Proposed 2014 (Combined with Finalized in 2013 for 2014)	Final 2014
Measures	258	296	284
Measures Removed	N/A	46	45

Reporting Option	Total 2013 Count	Total 2014 Count
Claims Measures	137	110
Registry Measures	203	201
EHR Measures	51	64
GPRO Web Interface Measures	22 (Includes subcomponents of composite measures)	22 (Includes subcomponents of composite measures)
Certified Survey Vendor	N/A	CG-CAHPS (12 Summary Survey Modules)
Measures Groups	22	25

## Questions for Consideration (recap from October meeting)

- For NQF and MAP, how do we focus on the measure science and “leave our organizational interests at the door” in decision-making processes?
- Help us prioritize how we fill gaps (so many gaps – where do we start and who/how are gaps filled?)
- In making recommendations, give explicit consideration to vulnerable populations
- Tiered recommendations and rationale is helpful – will need to continue to refine approach
- For clinicians, what measures could or should be reported by ALL clinicians? And/Or should there be core common sets for each major specialty?
- What are some “leading edge” measures or concepts that should be considered in CMS programs or Innovation center models?
- We would value MAP’s feedback on the LEAN process and the quality of the end product (MUC list). How else could we improve?

## *MAP's Prior Input on Clinician Measurement Programs*

### PQRS Guiding Principles

- For NQF-endorsed measures (finalized or under consideration):
  - Include NQF-endorsed measures relevant to clinician reporting to encourage engagement
- For measures that are not NQF-endorsed:
  - Measures currently finalized for the program
    - ❖ Remove measures that have had endorsement removed or have been submitted for endorsement and were not endorsed
    - ❖ Remove measures that are in endorsement reserve status (i.e., topped out), unless the measures are clinically relevant to specialties/subspecialties that do not currently have relevant measures
  - Include measures under consideration that are fully specified and that:
    - ❖ Support alignment (e.g., measures used in MOC 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
  - Measures selected for the program that are not NQF-endorsed should be submitted for endorsement

## CMS Medicare and Medicaid EHR Incentive Program for Eligible Professionals Guiding Principles

- Include endorsed measures, whether currently finalized for the program or under consideration, that have eMeasure specifications available (the endorsement process addresses issues of harmonization and competing measures)
- 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

## Physician Compare Guiding Principles

- 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
- Include measures that focus on outcomes and are meaningful to consumers and purchasers
- Focus on patient experience, patient-reported outcomes, care coordination, population health, and appropriate care measures
- To generate a comprehensive picture of quality, measure results should be aggregated, with drill-down capability for specific measure results

## Value-Based Payment Modifier Guiding Principles

- 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 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
- Monitor for unintended consequences to vulnerable populations (e.g., through stratification)

## Gaps

### Key gaps across clinician programs

- Overarching gaps
  - Clinically relevant measures for all sub-specialties
  - Composites of process measures addressing a particular condition
  - Outcome measures, including patient-centered outcome measures, and cross-cutting measures (e.g., patient experience, shared decision-making, and goal attainment, functional status, care coordination)
- All MAP Previously Identified Gaps available in reference materials

## *Pre-Rulemaking Input on Measures Under Consideration for Individual Clinician Reporting*

## Physician Quality Reporting System (PQRS)

- **Program Type:** Pay for Reporting
- **Incentive Structure:**
  - In 2012-2014: incentive payment equal to a percentage of the eligible professional's estimated total allowed charges for covered Medicare Part B services under the Medicare Physician Fee Schedule.
    - » 2% in 2010, gradually decreasing to 0.5% in 2014
  - In 2015, eligible professionals and group practices that do not satisfactorily report data on quality measures will receive a reduction in payment.
    - » 1.5% in 2015, and 2% in subsequent years
- **Statutory Requirements for Measures:**
  - Individual clinician reporting and groups of 2-25: select 9 measures that address at least 3 NQS domains, or reporting a specified measure group
    - » 25 measure groups- two new Optimizing Patient Exposure to Ionizing Radiation Group and General Surgery Group
  - Clinician groups 25+ : report a set of 18 measures and CG-CAHPS (for groups 100 or more)

Individual Clinician Reporting Criteria for Satisfactory Reporting in PQRS for 2014		
Measure Type	Reporting Mechanism	Criterion
Individual Measures	Claims	<ul style="list-style-type: none"> <li>Report at least 9 measures covering 3 NQS domains</li> <li>If less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1-8 measures covering 1-3 NQS domains, AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies</li> <li>If an eligible professional's EHR system does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data</li> </ul>
	Qualified Registry	
	EHR	
Measures Groups	Qualified Registry	<ul style="list-style-type: none"> <li>Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients</li> </ul>
Measures Selected by Qualified Clinical Data Registry	Qualified Clinical Data Registry	<ul style="list-style-type: none"> <li>Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50 percent of the eligible professional's applicable patients seen during the reporting period to which the measure applies.</li> <li>Must select 1 outcome measure</li> </ul>

## CMS Medicare and Medicaid EHR Incentive Program for Eligible Professionals (Meaningful Use)

- **Program Type:** Incentive Program
- **Incentive Structure:**
  - Medicare- Up to \$44,000 from 2011- 2014; penalties begin in 2015
  - Medicaid- Up to \$63,750 from 2011- 2021
- **Statutory Requirements for Measures:**
  - Processes, experience, and/or outcomes of patient care
  - Observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care
  - Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries
  - Preference should be given to quality measures endorsed by NQF

## Physician Compare

- **Program Type:** Public Reporting
- **Incentive Structure:** None
- **Statutory Requirements for Measures:**
  - Generally measures from PQRs with a focus on:
    - » Patient health outcomes and functional status
    - » Continuity and coordination of care and care transitions
      - *Episodes of care*
      - *Risk adjusted resource use*
    - » Efficiency
    - » Patient experience and patient, caregiver, and family engagement
    - » Safety, effectiveness, and timeliness of care
  - Clinician group reporting: All measures collected through GPRO web interface and CG-CAHPS

## Value-Based Payment Modifier (VBPM)

- **Program Type:** Pay for Performance
- **Participation:** In 2015 begins with groups of physicians of 100 or more eligible professionals, in 2016 expands to 10 or more eligible professionals
- **Incentive Structure:** Payment adjustment amount is built on satisfactory reporting through PQRs
  - Successfully reporting through PQRs:
    - » Option for no quality tiering: 0% adjustment
    - » Option for quality tiering: for poor performance up to -1% in 2015, up to -2% in 2016, reward for high performance to be determined
  - Not successfully reporting through PQRs: -1% adjustment in 2015,
  - 2015 performance period will be used for the 2017 value-based payment modifier
- **Statutory Requirements for Measures:**
  - Must include a composite of appropriate, risk-based quality measures and a composite of appropriate cost measures
- Final rule indicated, for 2013 and beyond, the use of all individual measures under PQRs



## Process for Review of Measures

1. Assigned workgroup members will provide an overview of the condition/topic
2. Provide input on measures under consideration (blue sections in discussion guide)
  - Staff will summarize any public comments received
  - Workgroup to determine Support, Do Not Support, Conditionally Support
3. Revisit finalized set
  - For measures not previously discussed (grey sections) determine if measure should be included in Physician Compare and VBPM
  - Workgroup members can request discussion on finalized measures previously discussed (green, yellow, red sections)
4. Discuss gaps
  - Consider adding any staff-identified gap-filling opportunities (purple sections)
  - Identify remaining gaps

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## Process for Review of Measures

Time	Condition	# Finalized	# MUC
10:00- 10:10 am	CAHPS	2	1
10:10- 10:25 am	Care Coordination	5	13
10:25- 10:30 am	Cost	2	1
10:35- 10:50 am	Behavioral Health	13	12
10:50- 11:15 am	Infectious Disease	17	12
11:15- 12:45 am	Cardiovascular	33	21
11:45- 12:00pm	Respiratory	20	7
12:00- 12:30pm	LUNCH		

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## Process for Review of Measures

Time	Condition	# Finalized	# MUC
12:30 am- 12:45pm	Endocrine/Renal	27	4
12:45- 1:00pm	Cancer	36	11
1:00- 1:20pm	Head, Eyes, Ears, Nose and Throat	14	10
1:20- 1:30pm	Inflammatory Bowel Disease	7	0
1:30- 1:50pm	Musculoskeletal	29	19
1:50- 2:10pm	Neurological	23	3
2:10- 2:30pm	Imaging	11	13
2:30- 2:40pm	Obesity	11	0
2:40- 2:45pm	Perinatal, Reproductive Health	6	0
2:45- 3:00pm	Safety	17	3
3:00- 3:15pm	Surgery- Cardio	21	3
3:15-3:30pm	Surgery- Other	42	2

## *Core Measures for Individual Clinician Reporting*

## Core Measures for Individual Clinician Reporting

### Input to HHS

- Define the objectives for a core measure set
- Provide input on options for operationalizing a core measure set
- Discuss the types of measures that could be included in a core

## Core Measures for Individual Clinician Reporting

### Purpose

- Allow comparability across multiple clinicians
- Encourage focus on critical improvement gaps
- Align payment incentives across clinician types
- Reduce data collection requirements
- Other?

## Core Measures for Individual Clinician Reporting

### Measures

- The MAP Clinician Workgroup has previously noted the following types of cross-cutting measures should be adopted as core measures:
  - Patient-reported outcomes (e.g., health-related quality of life, experience with care, shared decision-making)
  - Care coordination; medication management
  - Population health
  - Health disparities; cultural competence
  - Prevention; wellness
  - Cost
  - Other?

## Core Measures for Individual Clinician Reporting

### Structure

- Option 1: Identify measures that could be reported by all clinician specialties
- Option 2: Identify a core measure set for each specialty (or groups of specialties)
- How can each option be operationalized?
  - Should the core be a suite of measures that clinicians can select?
    - » E.g., clinicians select 1-3 measures from 7-12 core measures
  - Should the core be a required set of measures?
    - » E.g., 1-3 core measures required for all clinicians
  - How can registries be encouraged to adopt core measures?
  - What information can be leveraged from existing measures and registries?

## *Opportunity for Public Comment*

## *Summary of Day and Adjourn*

## *Adjourn*

## Agenda-Day 2

- Welcome, Review of Day 1
- Pre-Rulemaking Input on Hospital Measures Under Consideration for Clinician Performance Measurement Programs
- Pre-Rulemaking Input on Measures Under Consideration for Clinician Group Reporting
- Opportunity for Public Comment
- Pre-Rulemaking Input on Measures under Consideration for the Medicare Shared Savings Program
- Gap-Filling Opportunities
- Opportunity for Public Comment
- Adjourn

## ***Welcome, Review of Day 1***

## ***Pre-Rulemaking Input on Hospital Measures Under Consideration for Clinician Performance Measurement Programs***

## Application of Hospital Measures for Clinician Programs

- Measures in PQRS do not adequately capture hospital-based physicians
- Proposed rule highlighted two options:
  - Re-specify existing measures for application to clinicians
    - » Proposed rule identified measures available under the Hospital IQR Program that have been retooled to be reported under the PQRS
  - Apply hospital performance rate to clinicians
- Final rule deferred incorporating the IQR measures in PQRS until 2015 due to operational issues with implementation

## Process for Review of Measures

1. Discuss options for application of hospital measures to clinicians
  - Re-specify existing measures
  - Apply hospital performance rate to clinicians
2. Discuss existing Hospital IQR and Hospital OQR measures and their potential application to clinicians
  - High-level review of each measure chart



## *Pre-Rulemaking Input on Measures Under Consideration for Clinician Group Reporting*

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### Clinician Group Reporting Criteria for Satisfactory Reporting in PQRS for 2014

Reporting Mechanism	Group Practice Size	Criterion
GPRO Web Interface	25-99 EPs	<ul style="list-style-type: none"> <li>Report on all measures included in the web interface</li> </ul>
	100+ EPs	<ul style="list-style-type: none"> <li>Report on all measures included in the web interface</li> <li>Report all CG-CAHPS measures</li> </ul>
Qualified Registry	2+ EPs	<ul style="list-style-type: none"> <li>Report at least 9 measures covering at least 3 of the NQS domains OR</li> <li>If less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1-8 measures covering 1-3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies</li> </ul>
EHR	2+ EPs	<ul style="list-style-type: none"> <li>Report 9 measures covering at least 3 of the NQS domains</li> <li>If a group practice's EHR system does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data</li> </ul>

## Process for Review of Measures

1. Discuss current measure set (green, yellow areas)
2. Discuss expansion of GPRO-web interface option
  - Review prior expansion recommendations (purple areas)
  - Identify additional measures (see individual clinician reporting discussion guide)
3. Discuss gaps
  - Identify remaining gaps

## *Opportunity for Public Comment*

## *Pre-Rulemaking Input on Measures Under Consideration for the Medicare Shared Savings Program*

### Medicare Shared Savings Program

- **Program Type:** Performance-Based Payment with Public Reporting
- **Incentive Structure Options:**
  - One-sided risk model, with sharing of savings only for the first two years and sharing of savings and losses in the third year
  - Two-sided risk model, with sharing of savings and losses for all three years
- **Statutory Requirements for Measures:**
  - Appropriate clinical processes and outcomes measures
  - Patient, and wherever practicable, caregiver experience of care measures
  - Utilization measures, such as rates of hospital admission for ambulatory-sensitive conditions

## MSSP Discussion

- Brookings Institute Roundtable: Accountable Care Organizations 2.0 Measurement, Data, and Related Issues
  - *Mark McClellan*
- Measurement systems: quality improvement measures to support achievement of accountability measures
  - *Woody Eisenberg, PQA*
  - See MAP-Quality Measures Crosswalk
- Review measures under consideration and discuss alignment with PQRS group reporting

## Improving Medication Use in a Quality Measurement & Improvement System

### Task Force for Advanced Payment Models

Measure Applications Partnership (MAP) Clinician Workgroup

*December 18-19, 2013*



## Objectives



- Illustrate a *Quality Measurement & Improvement System* including Medication Use Measures.
- Demonstrate how medication quality measures can support performance improvement of NQS measure domains and NQF families of measures.
- Provide examples of how medication therapy management has been integrated into health systems and with providers participating in Advanced Payment Models.

***Ultimate Goal: Improving Patient Care and Outcomes through Appropriate Medication Use***

Improving Medication Use in a Quality Measurement & Improvement System 2

## What is a Quality Measurement and Improvement System?



Must Have:	Must Support:	To Facilitate:
<ul style="list-style-type: none"> <li>Data collection and analytics</li> <li>Measures based on data for QI</li> <li>Tools for practice support and improvement</li> <li>Reporting capabilities for use of measures in payment, public reporting, evidence development</li> </ul>	<ul style="list-style-type: none"> <li>Delivery</li> <li>Improvement</li> <li>Accountability</li> </ul>	<ul style="list-style-type: none"> <li>Aligning reporting requirements with data collection for improvement and information flows for delivery</li> <li>Reducing burden of redundant reporting of measures and mechanisms</li> <li>Maintaining data security outside of systems used in care delivery</li> </ul>

Improving Medication Use in a Quality Measurement & Improvement System 3




## Medication Use in a Quality Measurement & Improvement System

- **Align with Key National Quality Strategy Priorities**
  - Effective practices for the leading causes of mortality
  - Making care safer
  - Ensuring person- and family-centered care
  - Promoting effective communication and care coordination
- **Expand Data Systems to Include:**
  - Pharmacy claims and prescription drug event data
  - Minimum Data Set (MDS)
  - e-Prescribing
  - Dispensing
  - EQuIPP
  - MTM and DUR

Improving Medication Use in a Quality Measurement & Improvement System

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## Medication Use Measures Contribute to NQF Families of Measures

**Prevention and Treatment of Diabetes**

- Appropriate Treatment of HTN
- Diabetes Medication Dosing
- Adherence – Diabetes Medications

**Cardiovascular Conditions**

- Cholesterol Management in CAD
- Adherence – Calcium Channel Blockers
- Adherence – RAS Antagonists
- Adherence – Beta Blockers

**Care Coordination**

- Comprehensive Medication Review

**Safety**

- High Risk Medications in Elderly
- Drug-Drug Interactions
- Antipsychotics in Dementia
- Antipsychotics in Children <5

Improving Medication Use in a Quality Measurement & Improvement System

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## EQuIPP – a Practice Support and Improvement Tool

Measure	Trend	Pharmacy	Variance	Goal	Variance	Others
ACIAMS in Diabetes	↑	84	<b>86.9%</b>	87%	0.1%	81.0% 79.7%
ACIAMS PDC	↑	129	<b>77.5%</b>	79%	1.5%	86.2% 80.0%
Diabetes PDC	↑	72	<b>62.4%</b>	75%	12.6%	82.4% 76.7%
Diabetes PDC	↑	44	<b>59%</b>	77%	18%	84.1% 78.0%
Drug-Drug Interactions	↑	73	<b>8.2%</b>	5.5%	2.7%	4.6% 4.8%
High Risk Prescriptions	↑	205	<b>3.9%</b>	3%	0.9%	7% 7.4%

**Link to resources to support improvement on measures**

**Multi-disciplinary Collaboration and Alignment**

**performance benchmarking**



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## Tying it all together...

Measure Type	Measure Sub-Type	ACO Measure Sub-Type (example)	Medication Measures (example)
Clinical Composite	Clinical Care	DM Composite: HbA1c Control	DM Medication Dosing
	Patient Experience	DM: LDL Control	PDC: Oral DM Medications by Class
	Pop. / Comm. Health	DM Composite: BP Control	PDC: Oral DM Meds - All Class
	Patient Safety	DM: A1c Poor Control	
	Care Coordination	HTN: Controlling BP	
	Efficiency / Affordability	CAD Composite: Lipid Control	
		IVD: Controlling LDL	

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## Questions

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Improving Medication Use in a Quality Measurement & Improvement System 8

## Process for Review of Measures

1. Discuss current measure set (grey section)
2. Provide input on measures under consideration (blue section)
  - Staff will summarize any public comments received
  - Workgroup to determine Support, Do Not Support, Conditionally Support
3. Discuss expansion of MSSP measure set
  - Consider alignment with GPRO-Web (see GPRO discussion guide)
4. Discuss gaps
  - Identify remaining gaps

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## *Gap-Filling Opportunities*

### Gaps

#### Key gaps across clinician programs

- Overarching gaps
  - Clinically relevant measures for all sub-specialties
  - Composites of process measures addressing a particular condition
  - Outcome measures including patient-centered outcome measures and cross-cutting measures (e.g., patient experience, shared decision-making, and goal attainment, functional status, care coordination)
- All MAP Previously Identified Gaps available in reference materials

## The Affordable Care Act: A Framework and Resources for Measurement-Based Improvement

- Section 3014 amended Section 1890 of the Social Security Act requiring the consensus-based entity (NQF) to “synthesize evidence and convene key stakeholders to make recommendations...on...priorities for health care performance measurement in all applicable settings,” to include:
  - gaps in endorsed quality measures, including measures within priority areas identified by the Secretary under the national strategy;
  - areas in which quality measures are unavailable or inadequate to identify or address such gaps; and
  - areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary.

## The National Quality Strategy: Three Aims and Six National Priorities



## Priority Setting for Health Care Performance Measurement: 2013 Focus Areas

- Adult Immunizations
- Alzheimer's Disease and Related Dementias
- Care Coordination
- Health Workforce
- Person-Centered Care and Outcomes

## Project Purpose and Objectives

To provide HHS with recommendations on priorities for performance measurement by:

- Providing multistakeholder guidance on high-leverage measurement areas in each topic area
- Identifying existing measures and measure concepts that may be useful for performance measurement
- Prioritizing opportunities and next steps for measure development and endorsement

## 1. Convene Multistakeholder Committee

- For each topic area, NQF will convene a multistakeholder committee (15-20 members) to provide expertise and guidance to meet the project objectives

## 2. Identify and/or Modify Conceptual Measurement Framework

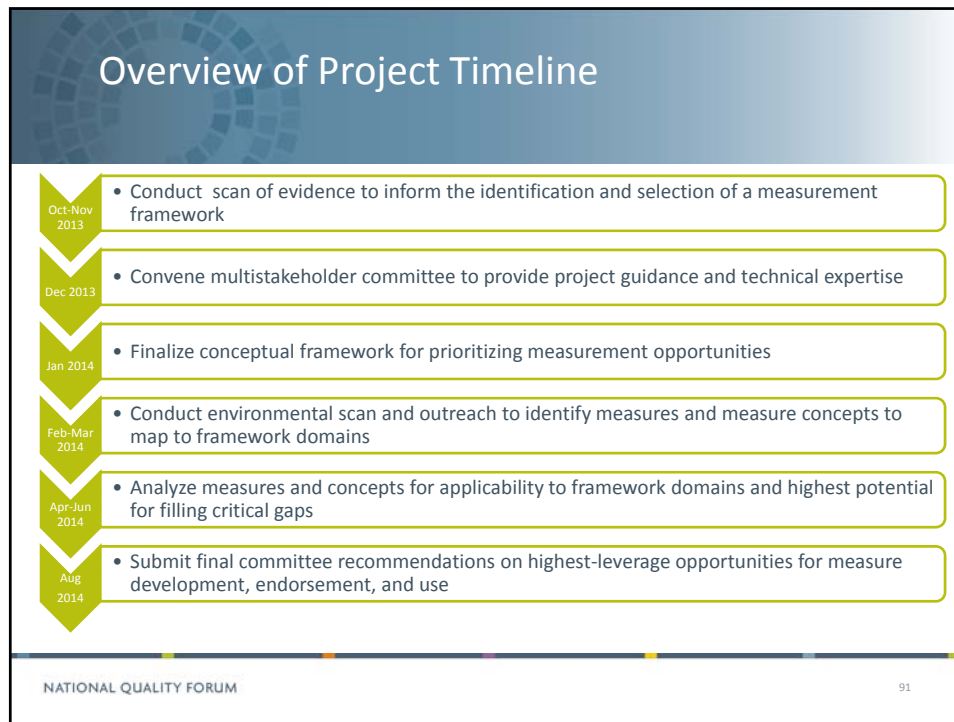
- NQF will conduct an environmental scan and propose relevant conceptual frameworks for each topic area
- The identified framework will offer measure domains and subdomains that align with the triple aim of improving health, quality and cost
- Key leaders will provide guidance to staff on the draft framework

### 3. Conduct Measure Gap Analysis

- NQF staff will conduct an environmental scan of evidence, measures, and measure concepts that map to the domains and subdomains of the identified conceptual framework
- Each committee will consider high-priority opportunities for measure development and endorsement and will assist with identifying potential measures and concepts for consideration
- Each committee will consider the applicability of identified measures and concepts

### 4. Develop Committee Recommendations

- Each committee will prioritize opportunities for performance measure development, endorsement, and use, considering importance, level of evidence, feasibility of measurement
- Each committee will develop recommendations for submission to HHS



## For More Information

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## *Opportunity for Public Comment*

## Pre-Rulemaking Timeline

- **December 1:** HHS list of measures under consideration provided to MAP
- **December 4:** All MAP Web Meeting
- **December 18-19:** PAC-LTC Workgroup In-Person Meeting
- **January 7-8:** Coordinating Committee In-Person Meeting
- **Mid-January:** 2-week public comment period on draft Pre-Rulemaking Report
- **February 1:** Pre-Rulemaking Report due to HHS

*Adjourn*