Measure Applications Partnership

Clinician Workgroup Web Meeting

NATIONAL QUALITY FORUM

October 3, 2014

Meeting Agenda

- **Welcome and Review of Meeting Objectives**
- Meet the Team and Workgroup Introductions
- MAP Process Improvements
- Overview of Clinician Measurement Programs
- Opportunity for Public Comment
- Summary and Next Steps

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MAP Clinician Team

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Alexandra Ogungbemi, Project Analyst

Clinician Workgroup Membership

Workgroup Chair: Mark McClellan, MD, PhD

Organizational Members

American Academy of Family Physicians	Amy Mullins, MD, FAAFP
American Association of Nurse Practitioners	Diane Padden, PhD, CRNP, FAANP
American Academy of Pediatrics	Terry Adirim, MD, MPH
American College of Cardiology	Paul Casale, MD, FACC
American College of Emergency Physicians	Jay Schuur, MD, MHS
American College of Radiology	David Seidenwurm, MD
Association of American Medical Colleges	Janis Orlowski, MD
Center for Patient Partnerships	Rachel Grob, PhD
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	Bruce Sherman, MD, FCCP, FACOEM
National Center for Interprofessional Practice and Education	James Pacala, MD, MS
Pacific Business Group on Health	David Hopkins, PhD
Patient-Centered Primary Care Collaborative	Marci Nielsen, PhD, MPH
Physician Consortium for Performance Improvement	Mark Metersky, MD
The Alliance	Amy Moyer, MS, PMP
WellPoint	Catherine MacLean, MD, PhD

Clinician Workgroup Membership

Subject Matter Experts

Disparities	Luther Clark, MD
Palliative Care	Constance M. Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN
Surgical Care	Eric B. Whitacre, MD, FACS

Federal Government Members

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)	Girma Alemu, MD, MPH

Duals Workgroup Liaison

Human	George Andrews, MD, MBA, CPE, FACP, FACC, FCCP

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Background on MAP Process Improvement Efforts

- Based on feedback from MAP members, external stakeholders, NQF members, and staff, NQF undertook an intensive improvement effort on MAP.

- Our goal was to develop a streamlined and manageable process for MAP stakeholders and staff resulting in an improved product.

New for 2014-2015 Pre-Rulemaking

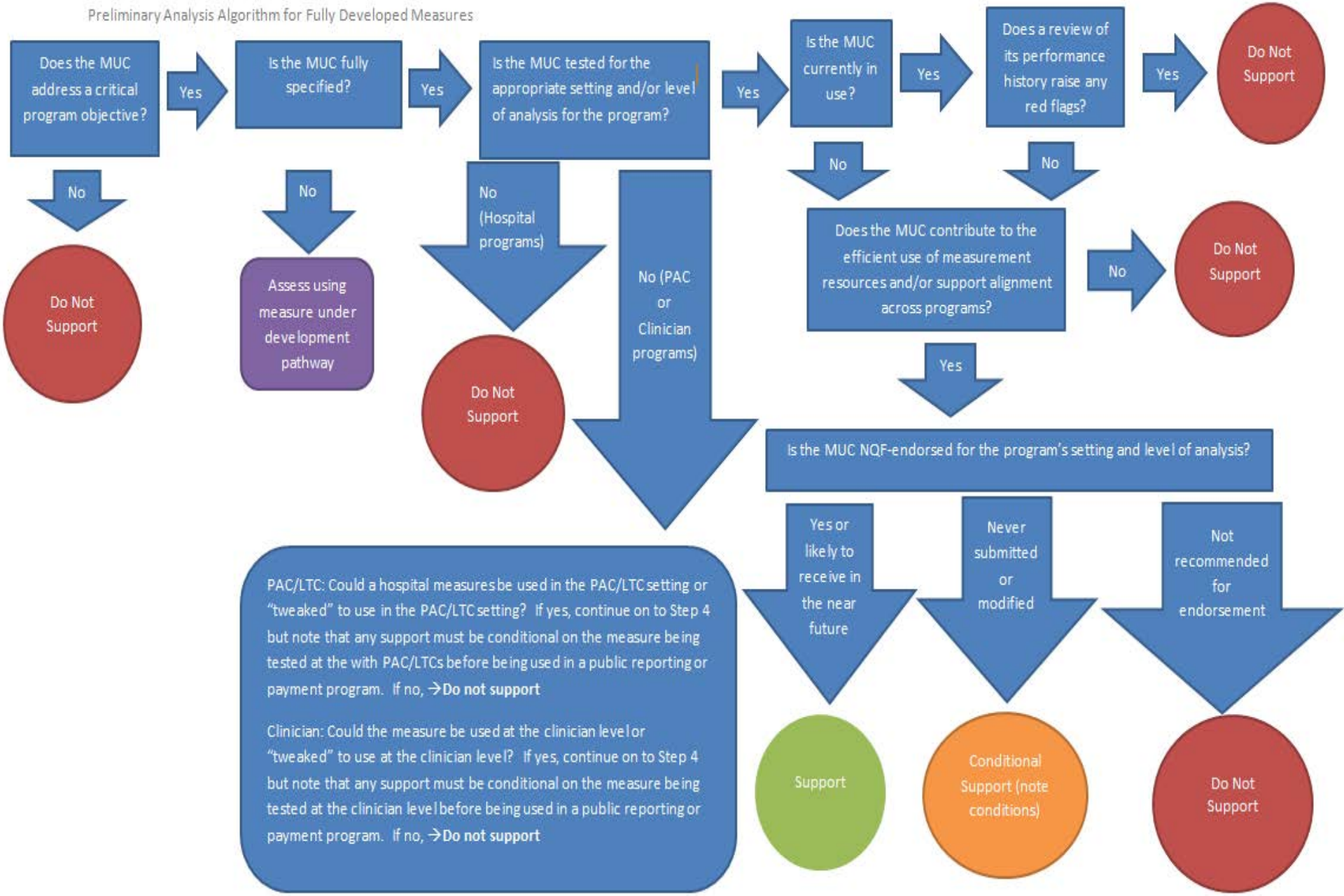
- Expanded opportunities to gather public feedback
- Easier access to information through focused products
- Centering decisions on critical program needs and objectives
- Better navigation and focused analysis in meeting materials
- More consistent and transparent deliberations process

Approach to decision-making – Supporting deliberations with preliminary analysis

Standardized approach across all workgroups:

- The measures under consideration will be divided into related groups for the purposes of discussion and voting
- Each measure under consideration will undergo a preliminary analysis by staff based on a standard decision algorithm applying the MAP measure selection criteria
- Discussion guide will note the result of the preliminary analysis and provide rationale to support how that conclusion was reached

New for 2014-2015 Pre-Rulemaking: Preliminary analysis of measures with MAP measure selection criteria



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Physician Quality Reporting System (PQRS)

- **Program Type:** Incentive
- **Incentive Structure:** Beginning in 2015, a downward payment adjustment of -2 percent will apply to eligible professionals (EP) who do not satisfactorily report data on quality measures for covered professional services or satisfactorily participate in a qualified clinical data registry.
- **Program Goal**: Encourage widespread participation by eligible professionals to report quality information.

Physician Quality Reporting System (PQRS)

Program Updates (Proposed PFS Rule for 2015):

- 18 cross-cutting measures that can be used by all EPs – based on the recommendation of a core set from the MAP.
- Measure turnover:
  - Add 28 new individual measures and two measures groups:
    - Sinusitis Measures Group
    - Acute Otitis Externa Measures Group
  - Remove 73 measures for a variety of reasons:
    - Measure steward will no longer maintain the measure: 18
    - Performance rates consistently close to 100%, i.e., “topped out”: 27
    - Measure does not add clinical value to PQRS: 6
    - Measures a standard of care: 14
    - Evidence and guideline change: 2
    - Duplicative measures: 6

Physician Compare

- **Program Type**: Public Reporting
- **Incentive Structure**: None
- **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.

Physician Compare

Program Update (Proposed PFS Rule for 2015):

- All PQRS measures are available for public reporting.
- Measures will be publicly reported in two ways:
  - Measures of specific interest to consumers and beneficiaries will be posted on the physician's webpage
  - Other measures in a downloadable format
- PQRS measures will be tested for reliability and validity prior to being reported on Physician Compare

Value-Based Payment Modifier and Physician Feedback Programs

- **Program Type**: Incentive
- **Incentive Structure**: In order to avoid an automatic negative two percent ("-2.0%") Value Modifier payment adjustment in CY 2016, Eligible Professionals (EPs) in groups of 10 or more must participate in and satisfy the PQRS requirements as a group or as individuals in CY 2014
- **Program Goals:** The Physician Feedback/Value-Based Modifier Program provides comparative performance information to physicians as one part of Medicare's efforts to improve the quality and efficiency of medical care and payment adjustment of Medicare FFS reimbursement based on performance on quality and cost measures.

Value-Based Payment Modifier and Physician Feedback Programs

Program Updates:

- Physicians in group practices of 100 or more eligible professionals (EPs) who submit claims to Medicare will be subject to the value modifier in 2015, based on their performance in calendar year 2013.
- Physicians in group practices of 10 or more EPs will be subject to the value modifier in 2016, based on their performance in calendar year 2014.
- For 2015 and 2016, the Value Modifier does not apply to groups of physicians in which any of the group practice's physicians participate in the Medicare Shared Savings Program, Pioneer ACOs, or the Comprehensive Primary Care Initiative.

Value-Based Payment Modifier and Physician Feedback Programs

Program Updates:

- All physicians who participate in Fee-For-Service Medicare will be affected by the value modifier starting in 2017.
- Quality-tiering is the methodology that is used to evaluate a group's performance on cost and quality measures for the Value Modifier. Cost and quality measures are used to determine the payment modifier. Measures are collected for one year to establish benchmarks prior to use in determining the payment modifier.
- The 2015 PFS Proposed Rule proposes increasing the amount of payment at risk under the Value Modifier from 2% in CY2016 to 4% in CY 2017.

PQRS: Critical Program Objectives

- To encourage widespread participation many measures are needed for the variety of eligible professionals, specialties and sub-specialties.
- Measures chosen by EPs for PQRS will be reported on Physician Compare and used for the Value Based Payment Modifier.
- 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.

PQRS: Critical Program Objectives (con't)

- 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
- 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.

PQRS: Critical Program Objectives (con't)

Specific to public reporting:

- Include measures that focus on outcomes and 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.
- To generate a comprehensive picture of quality, measure results should be aggregated (e.g., composite measures), with drill-down capability for specific measure results

PQRS: Critical Program Objectives

Specific to payment:

- 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).

Medicare and Medicaid EHR Incentive Program

- **Program Type**: Incentive
- **Incentive Structure**:
  - **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 CEHRT by providers
  - Incentivize “meaningful use” of EHRs by providers

Medicare and Medicaid EHR Incentive Program

Program Update:

- For Stage 1 (2014):
  - New objective –"Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the eligible professional."
  - The separate objective to report clinical quality measures (CQMs) will no longer be required for Stage 1 for eligible professionals, eligible hospitals, and CAHs. Reporting CQMs will still be required in order to achieve meaningful use.

Medicare and Medicaid EHR Incentive Program

Program Update:

- For Stage 2 (2014):
  - 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.

Medicare and Medicaid EHR Incentive Program-Critical Program Objectives

- Include endorsed measures that have complete 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.

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Upcoming MAP Pre-Rulemaking Meetings

October/November Strategic Web Meetings

- **Clinician Workgroup - October 3**
- Hospital Workgroup - **October 8**
- Dual Eligible Workgroup - **October 10**
- PAC/LTC Workgroup - **October 17**
- Coordinating Committee - **November 10**

December In-Person Workgroup Meetings

- Hospital Workgroup - **December 8-9**
- PAC/LTC Workgroup - **December 12**
- Clinician Workgroup - **December 15-16**

January In-Person Meeting

- Coordinating Committee **January 26-27**