Measure Applications Partnership

Coordinating Committee Meeting

January 7-8, 2013

Welcome, Review Meeting Objectives, and MAP Pre-Rulemaking Approach

Meeting Objectives

- Review progress on measure alignment and measure gaps
- Finalize recommendations to HHS on measures for use in federal programs for the clinician, hospital, and post-acute-care/long-term care settings
- Finalize plan for MAP off-cycle measure review
- Finalize recommendations to HHS on the structure and measures in the Health Insurance Marketplace Quality Rating System
- Provide early input on the MAP Affordability, Person- and Family-Centered Care, and Population Health Families of Measures
- Provide input on determining potential measure impact and improving MAP's processes

Measure Applications Partnership

Statutory Authority

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

MAP Purpose

In pursuit of the NQS, MAP informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all

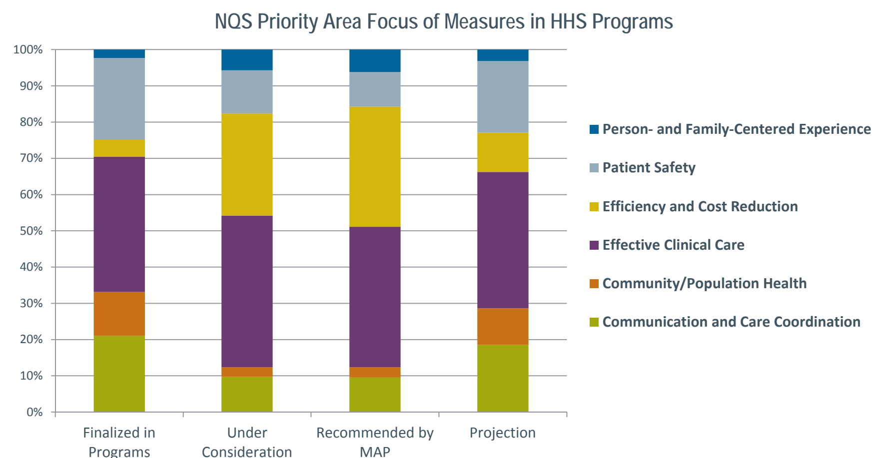
- MAP Objectives:
  1. Improve outcomes in high-leverage areas for patients and their families
  2. Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value
  3. Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden

MAP Pre-Rulemaking Strategic Issues: Alignment, Measure Gaps, and Measure Selection

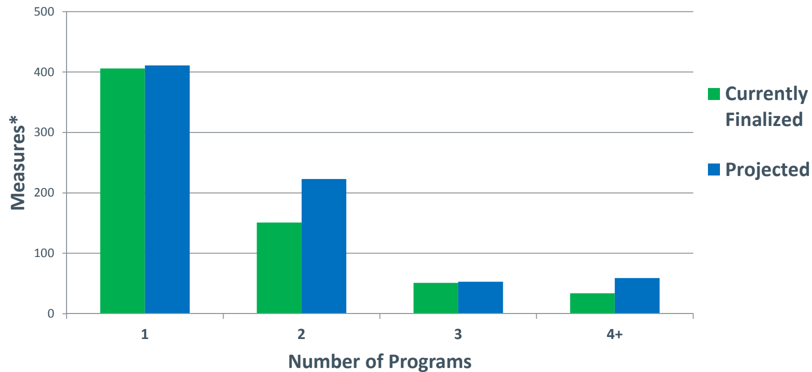
Measure Alignment

- MAP has placed a high priority on alignment of measure applications, as indicated in the MAP Strategic Plan and Measure Selection Criteria
- Alignment can be demonstrated in a variety of ways, including:
  - Choosing measures that address the aims and priorities of the National Quality Strategy
  - Applying the same or related measures in multiple HHS programs
  - Using the same or related measures across public- and private-sector initiatives

Progress on Measure Alignment



Progress on Measure Alignment



*Estimated count of measures in one or more HHS program measure sets that MAP reviews or considers. Projections based on preliminary workgroup recommendations.

Progress on Measure Alignment

Public- and Private-Sector Alignment

- The analysis of alignment among various state and regional measure sets completed for the **Buying Value** initiative earlier this year demonstrated wide variation in measure use
- While a number of recommendations were made to address this challenge, it was also recognized that there may be situations where alignment is not feasible or desirable

MAP Approach to Measure Alignment

MAP continues to promote alignment through:

- Creation of families of measures to identify related groups of the best available measures that address topics related to the NQS priority areas
- Review of the existing use of measures within public and private programs before making recommendations on the selection of measures under consideration

Measure Alignment

However, alignment is only one piece of the puzzle…

Measure Gap-Filling

- The importance of filling measure gaps is also emphasized in the MAP Strategic Plan
- Many stakeholders, including MAP, have justifiably pushed for more rapid development and implementation of performance measures to fill these gaps
- A number of often competing factors need to be considered when choosing measures to fill gaps

MAP Measure Selection Criteria and Gap-Filling

- The **Measure Selection Criteria (MSC)** were recently revised to incorporate MAP's experience over its first two years
- Changes included addition of a preamble, emphasizing critical gap-filling and alignment, and that the criteria are meant as guidance rather than rules
- Some criteria were generalized to be more inclusive, such as focusing on how well potential measures under consideration are "**fit for purpose**" of the program within which they may be used

MAP Measure Selection Criteria and Gap-Filling

Measure Selection Criterion #1 was also updated:

From: **Measures within the program measure set are NQF endorsed or meet the requirements for expedited review**

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

Did the revised criterion #1 adequately serve MAP's objectives during pre-rulemaking?

Progress on Gap-Filling

- MAP has previously supported both NQF-endorsed and non-endorsed measures that HHS subsequently adopted to address high-priority gap areas; for example:
  - NQF #0258 (**CAHPS In-Center Hemodialysis Survey**) is a patient-reported outcome measure that MAP supported last year, and HHS plans to use it in the future for the ESRD Quality Incentive program. It addresses gaps in assessing the patient's experience of care.
  - MAP supported the **Medicare Spending per Beneficiary** measure for the Hospital IQR and VBP programs, which are required by statue to include cost measures. The measure was not endorsed at the time of initial support by MAP, but it was subsequently endorsed and finalized by HHS for both programs.

Progress on Gap-Filling

- In the current pre-rulemaking cycle, MAP workgroups continued to show a preference for endorsed measures
- However, a variety of non-endorsed measures that addressed critical gap areas were also supported; for example:
  - The **Hospital Workgroup** supported a non-endorsed measure for the Inpatient Psychiatric Facility Quality Reporting program measuring how often facilities routinely assess patient experience of care
  - The **PAC/LTC Workgroup** supported a non-endorsed measure for Ventilator-Associated Events in LTCHs, noting it was important and helps address an NQS priority not adequately covered in the set
  - The **Clinician Workgroup** fully supported several non-endorsed measures for PQRS related to mental/behavioral health

MAP Conditional Support Recommendations

- MAP also revised one of its decision categories from **Support Direction** to **Conditional Support** for the current cycle to allow MAP to provide more specificity in what conditions needed to be met before full support could be provided
- The category was used frequently by the workgroups – **about one-fourth of Clinician, one-third of Hospital, and one-half of PAC/LTC decisions were to conditionally support a measure**
- **Endorsement** was one of the most common conditions indicated as necessary for full support
- This approach allows MAP to **promote faster gap-filling** because conditionally supported measures become fully supported when the specified condition(s) are met

Ongoing NQF Efforts to Address Measure Gaps

NQF is also taking broader strides to speed gap-filling:

- **Decreased average time** for a measure to make it through the endorsement process
- **More frequent measure submission and endorsement review** opportunities
- **Kaizen event** to explore opportunities for further potential enhancements to endorsement, including:
  - Connecting measure developers to promote collaborative efforts; e.g., facilitator role of NQF via a measure "incubator"
  - Standardized forms and approaches to submission/testing
  - Standing steering committees
- Consideration for **new approaches**, such as different levels of endorsement depending on application

Questions for the Committee

- Is MAP making sufficient progress on its strategic objectives to promote measure alignment and fill critical measurement gaps?
- How much did changes to the Measure Selection Criteria affect MAP workgroup selection recommendations? Are additional changes needed?
- How effective is the new Conditional Support category at allowing more specific and efficient recommendations by MAP 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	Pre-Rulemaking Use
Coordination Strategies **(i.e., Safety, Clinician, PAC-LTC, Dual Eligible Beneficiaries Cross-Cutting Input)**	• Provides setting-specific considerations that will serve as background information for MAP's pre-rulemaking deliberations. • Key recommendations from each coordination strategy will be compiled in background materials.
Gaps Identified Across All MAP Efforts	• Provides historical context of MAP gap identification activities. • Will serve as a foundation for measure gap prioritization. • A universal list of MAP's previously identified gaps will be compiled and provided in background materials.

***While MAP's prior efforts serve as guidance for this work, pre-rulemaking decisions are not restricted to measures identified within these efforts.**

1. Build on MAP's Prior Recommendations

MAP's Prior Efforts	Pre-Rulemaking Use
2013 Pre-Rulemaking Decisions	• Provides historical context and represents a starting place for pre-rulemaking discussions. • Prior MAP decisions will be noted in the individual measure information.
Families of Measures **NQS priorities (safety, care coordination)** **Vulnerable populations (dual eligible beneficiaries, hospice)** **High-impact conditions (cardiovascular, diabetes, cancer)**	• Represents a starting place for identifying the highest-leverage opportunities for addressing performance gaps within a particular content area. • Setting- and level-of-analysis-specific core sets will be compiled, drawing from the families and population cores. Core measures will be flagged in the individual measure information. • MAP will compare the setting and level-of-analysis cores against the program measure sets.

Families of Measures and Core Measure Sets

Families of Measures

"Related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS " (e.g., care coordination family of measures, diabetes care family of measures)

Core Measure Sets

"Available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., ambulatory clinician measure set, hospital core measure set, dual eligible beneficiaries core measure set)

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

MAP identifies:

- Potential measures for inclusion
- Potential measures for removal
- Gaps—implementation gaps (measures not in the set that should be) 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 program measure sets during the current rulemaking cycle.	• Measure addresses an NQS aim or priority • Measure promotes person- and family-centered care • Measure promotes parsimony and alignment across public and private sectors
Do Not Support	Indicates measures that are not recommended for inclusion in program measure sets.	• Measure is not appropriately specified or tested for the population, setting, or level of analysis • A different measure better address a similar topic • Measure is topping out
Conditionally Support	Indicates measures, measure concepts, or measure ideas that should be phased into program measure sets over time, subject to contingent factor(s).	• Measure should receive NQF endorsement before being used in the program • Measure needs a modification before used in the program • Measures needs further experience or testing before used in the program

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

MAP's Previously Identified Gaps

- Compiled from all of MAP's prior reports and recent MAP activities
- Categorized by NQS priority and high-impact conditions
- Compared with gaps identified in other NQF efforts (e.g., NPP, endorsement reports)

MAP will:

- Identify priorities for filling gaps across settings and programs
- Present measure ideas to spur development
- Capture barriers to gap filling and potential solutions

Federal Program for MAP Pre-Rulemaking Input	MAP Workgroup
Physician Feedback/Value-Based Payment Modifier	Clinician Workgroup
Physician Quality Reporting System	
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	
Medicare Shared Savings Program	
Physician Compare	
Hospital Inpatient Quality Reporting	Hospital Workgroup
Hospital Value-Based Purchasing	
Hospital Outpatient Quality Reporting	
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	
Inpatient Psychiatric Facility Quality Reporting	
Hospital Readmission Reduction Program	
Hospital-Acquired Conditions Payment Reduction	
Medicare Shared Savings Program	
Ambulatory Surgical Center Quality Reporting	
Home Health Quality Reporting	PAC/LTC Workgroup
Inpatient Rehabilitation Facility Quality Reporting	
Long-Term Care Hospital Quality Reporting	
Hospice Quality Reporting	
Nursing Home Quality Initiative and Nursing Home Compare	
Home Health Quality Reporting	
End Stage Renal Disease Quality Management	

MAP Dual Eligible Beneficiaries Workgroup Liaisons for 2013-2014 Pre-Rulemaking

- Workgroup liaisons participated in setting-specific MAP workgroup meetings to represent the perspective of vulnerable beneficiaries.
- Liaisons reported back to the MAP Dual Eligible Beneficiaries Workgroup during their December 20 web meeting.
- Workgroup Chair, Alice Lind, will represent the workgroup during today's meeting.

Established an Early Public Comment Period for Measures Under Consideration

- MAP held an early public comment period from December 2 to December 9.
- Comments received served as input to the MAP workgroup discussions.
- Type of input sought:
  - Would the measure add value to the program measure set? Is a better measure available or is a measure addressing the particular program objective already in the measure set?
  - If the measure is being used, for what purpose? Are there implementation challenges?

Next Steps

Public comment on Draft Pre-Rulemaking Report

January 13-27, 2014

Pre-Rulemaking Final Report Due to HHS

February 1, 2014

MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for Clinician Programs, Including Medicare Shared Savings

Meeting Binder: Tab 2

Finalize Pre-Rulemaking Recommendations for System-Level Programs

Meeting Binder: Tab 2,
MSSP and GPRO Excel

Key Issues: System-Level Programs

- One of MAP's goals is to promote alignment across all programs and levels of analysis
- Clinician Workgroup generally supported measures for MSSP that are used in other system-level programs (e.g., Medicare Advantage 5-Star Quality Rating System) and measures of population health
- Workgroup recommends that system-level program measure sets align with measures used for setting-specific performance measurement programs, as harmonized measures can enhance focus on care delivery goals and reduce data collection burden

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

Clinician Workgroup Recommendations for the Medicare Shared Savings Program

- Measures that the workgroup supported or conditionally supported address cross-cutting issues (e.g., Follow-up after Hospitalization for Mental Illness) or patient-reported outcomes (e.g., Patient Activation measure)
- Workgroup did not support the majority of the measures under consideration noting that the set should remain parsimonious
- Most of the measures under considerations were not reflective of the workgroup's stated preference for outcome measures, measures of functional status, avoiding duplicative/competing measures, and supporting measures for medically complex patients

Clinician Workgroup Recommendations for the Medicare Shared Savings Program

- Although the workgroup views the MSSP measure as close to an ideal set, it could be enhanced with:
  - Other patient-reported outcome measures in the areas of depression remission, functional status, smoking, and medically complex patients (e.g., chronically ill or those with multiple chronic conditions)
  - Measure of health risks with follow-up interventions
- Workgroup was split on the inclusion of additional cost measures:
  - **Members in support**: noted that consumers need cost information to supplement quality data for this program; however, the current MSSP cost calculation only includes Medicare services, thus a complete picture of total Medicare and private payer costs is not possible at this time
  - **MAP members who did not support:** did not want to increase the reporting burden for ACOs and suggested that the existing ACO cost calculations be made publicly available for consumers

Finalize Pre-Rulemaking Recommendations for Clinician-Level Programs

Clinician Programs with Measures Under Consideration

Program	Number of Measures under Consideration
Physician Quality Reporting System (PQRS)	89
Medicare and Medicaid EHR Incentive Program for Eligible Professionals (MU-EP)	38
Physician Compare	425
Value-Based Payment Modifier (VBPM)	471

Review Process for Clinician-Level Programs

- All finalized measures and measures under consideration for PQRS and MSSP are also under consideration for Physician Compare and VBPM
- The Clinician Workgroup integrated its review of all four programs, considering the following:
  - If measures should be used for clinician reporting (i.e., should be included in PQRS)
  - If measures are e-specified or leverage HIT capabilities (i.e., should be included in Meaningful Use)
  - If measures should be publicly reported (i.e., should be included in Physician Compare)
  - If measures should be used for payment incentives and penalties (I.e., should be included in VBPM)

Meeting Binder: Tab 2,
Clinician Excel

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)

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Clinician Excel

Clinician Workgroup's Guiding Principles for PQRS

- 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

Meeting Binder: Tab 2,
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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

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Clinician Excel

Clinician Workgroup's Guiding Principles for Meaningful Use for Eligible Professionals

- 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

- **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

Clinician Workgroup's Guiding Principles for Physician Compare

- 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 (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
    - » 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 clinician measures under PQRS

Clinician Workgroup's Guiding Principles for the Value-Based Payment Modifier

- 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)

Key Issues: Finalized Measures for Clinician Programs

- The Clinician Workgroup utilized its Guiding Principles in addition to the MAP Measure Selection Criteria to review measures
- Workgroup began its review of finalized measures prior to the winter pre-rulemaking cycle to identify measures to:
  - Remain in PQRS
  - Remain in PQRS and be included in Physician Compare and VBPM
  - Measures for removal from PQRS

Key Issues: Measures Under Consideration for Clinician Programs

- Majority of measures under consideration reviewed were measure concepts or are being specified or tested for the clinician-level of analysis
- MAP supported or conditionally supported 74 measures for PQRS; MAP did not support most (52) of these measures for Physician Compare and VBPM (NQF-endorsed measures and measures used in PQRS were strongly preferred)

Key Issues: Episode Groupers for Clinician Programs

- The Clinician Workgroup reviewed a large number of condition-specific episode grouper measure concepts
- Workgroup conditionally supported these measures, recognizing that cost measures are critical to the implementation of VBPM
  - Once fully-specified and tested, groupers should be submitted for and receive NQF-endorsement, and then be paired with relevant clinical outcome measures

Key Issues: Episode Groupers continued…

- The Clinician Workgroup requested that the measure developer explore how patients with multiple chronic conditions are attributed to these measures
- Workgroup raised questions about how the episode grouper measures are attributed to clinicians
- Workgroup requested clarification about the spectrum of a conditions that episode groupers might cover

Measure Gaps for Clinician Programs

The Clinician Workgroup identified priority gaps:

- Overarching gaps
  - Measures that lead to improved outcomes and the overall health and well-being of patients across the care continuum
  - Related process measures should be rolled up into composites to illustrate a more comprehensive picture of quality
  - Measure development efforts for clinician specialties that lack measures should focus on outcomes and composites
  - 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)
- Previously Identified Gaps available in reference materials

Finalize Pre-Rulemaking Recommendations for Clinician Group Reporting

Clinician Group Reporting Criteria for Satisfactory Reporting in PQRS for 2014

Reporting Mechanism	Group Practice Size	Criterion
GPRO Web Interface	25-99 EPs	• Report on all measures included in the web interface
	100+ EPs	• Report on all measures included in the web interface • Report all CG-CAHPS measures
Qualified Registry	2+ EPs	• Report at least 9 measures covering at least 3 of the NQS domains OR • 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
EHR	2+ EPs	• Report 9 measures covering at least 3 of the NQS domains • 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

Clinician Workgroup Recommendations for Clinician Group Reporting

- PQRS Group Practice Reporting Option web interface (GPRO) requires clinician groups to report on a set of 18 finalized measures, rather than selecting a subset of measures
- In spring 2013, the Clinician Workgroup provided input on measures applicable to clinician group reporting, recommending 16 measures for inclusion in Physician Compare and VBPM
- Having provided prior input on the measure set, workgroup considered how the measure set could be enhanced

Clinician Workgroup Recommendations for Clinician Group Reporting

- Future expansion of the measure set should focus on measures that highlight a group's ability to provide coordinated seamless care
- Workgroup supported NQF #0576 Follow-Up After Hospitalization for Mental Illness for inclusion in GPRO
- Workgroup also noted that existing measures address the medication management gap—NQF# 0022 Use of High Risk Medications in the Elderly and NQF# 0553 Care for Older Adults-Medication Review
- Workgroup identified gaps remaining for clinician group reporting, including patient-reported outcomes, optimal vascular care, and surgery-specific measures

Finalize Pre-Rulemaking Recommendations for Individual Clinician Reporting

Meeting Binder: Tab 2, Clinician Excel

Individual Clinician Reporting Criteria for Satisfactory Reporting in PQRS for 2014

Measure Type	Reporting Mechanism	Criterion
Individual Measures	Claims Qualified Registry EHR	• Report at least 9 measures covering 3 NQS domains • 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 • 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
Measures Groups	Qualified Registry	• Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients
Measures Selected by Qualified Clinical Data Registry	Qualified Clinical Data Registry	• 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. • Must select 1 outcome measure

Clinician Workgroup Recommendations for Individual Clinician Reporting

- A goal across all clinician programs is to encourage clinician participation, particularly as PQRS transitions from an incentive program to a penalty program in 2015
- The Clinician Workgroup sought to encourage clinician participation by identifying measures that are clinically relevant for all clinician specialties
- Workgroup supported incorporating measures used in Maintenance of Certification (MOC) programs into the federal programs
- Implementation of the Quality Clinical Data Registries reporting option will assist in ensuring that all clinicians will be able to participate in the federal programs

Core Measures for Individual Clinician Reporting

Core Measures for Individual Clinician Reporting

Purpose

- Would address critical improvement gaps
- Align payment incentives
- Reduce reporting burden
- Allow comparability across clinicians

Core Measures for Individual Clinician Reporting

Implementing a Core Measure Set

- Option #1
  - Identify a subset of measures that all clinicians would be required to report
- Option #2
  - Identify multiple core sets, for each specialty or groups of related specialties

Core Measures for Individual Clinician Reporting

- The Clinician Workgroup would prefer to identify a core set of measures that all clinicians could report but recognized this would be a challenging task given the wide variation in clinical practice
- Consideration for segmenting clinicians into groups that would report common core sets:
  - Clinicians who see patients regularly versus those who do not
  - Care setting
  - Types of encounters (e.g., episodic vs. longitudinal)
  - Population served (e.g., high volume of vulnerable populations

Core Measures for Individual Clinician Reporting

- Workgroup would ideally like to identify a few (e.g., 2-3) measures that all clinicians in a segment would report to support comparisons across larger cohorts of clinicians
- Core set should focus on measure topics that drive broad improvements in healthcare delivery:
  - Promote shared accountability
  - Address cost
  - Assess care longitudinally

Core Measures for Individual Clinician Reporting

- Core measure topics should include:
  - Patient-reported outcomes (e.g., health related quality of life, shared decision-making, experience with care)
  - Care coordination and communication across providers and settings
  - Medication management
  - Cultural competency
  - Population health
  - Health disparities

Finalize Pre-Rulemaking Recommendations for Hospital Measures Under Consideration for Clinician Programs

Application of Hospital Measures for Clinician Programs

- Measures in PQRS do not adequately cover hospital-based physicians
- During 2014 rulemaking, HHS identified two options for applying existing hospital measures to clinician performance measurement programs:
  - Re-specify existing hospital-level measures for application to clinicians
  - Apply a hospital's performance rates to clinicians practicing in that hospital
- Final rule deferred incorporating the IQR measures in PQRS until 2015 due to operational issues

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Clinician Workgroup Recommendations for Applying Hospital Measures to Clinician Programs

- Generally, workgroup supports both options for using hospital-level measures to assess clinician performance
  - **Re-specifying hospital measures**:
    - » Individual clinician performance is important to consumers; a subset of hospital-level measures should be re-specified for individual clinicians
    - » Hospital-level measures that are best suited for this option are in areas of care where consumers are able to select their providers, with significant variation in clinician performance, and where care is largely attributed to providers
    - » MAP cautioned that HHS would need to develop methods for aggregating clinicians' data from multiple hospitals and to ensure psychometric soundness
  - **Applying hospital performance rates:**
    - » May be best suited for hospitalists, other clinicians who are dedicated to one hospital system, areas of care where consumers are unable to select their clinicians (e.g., critical events, ED visits), and areas that focus on the systems of a hospital (e.g., throughput measures)

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Opportunity for Public Comment

Cross-Program Input from the MAP Dual Eligible Beneficiaries Workgroup

Who are Dual Eligible Beneficiaries?

Among 9.2 million dual eligible beneficiaries:

- 60 percent are older adults; 40 percent are individuals under 65 with a disability
- Half have less than a high school education
- 55% have a limitation in an activity of daily living
- 17% self-report poor health
- 29% have an inpatient hospital stay annually
- More than 60% have three or more chronic conditions: the most common being cardiovascular disease, diabetes, dementia, arthritis, and depression
- Combined Medicare and Medicaid spending reached $272 billion in 2009

Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. MedPAC and MACPAC. December 2013.

Liaison Approach for Pre-Rulemaking

- Modeling last year's successful approach, MAP identified liaisons from the Dual Eligible Beneficiaries Workgroup to participate in the setting-specific workgroups' pre-rulemaking deliberations.
- Liaisons represented the perspective of vulnerable beneficiaries during review of measures under consideration and strategic discussions:
  - Highlighted MUCs from the Dual Eligible Beneficiaries Family of Measures.
  - Raised cross-cutting issues of person-centeredness, disparities, and cultural competency.

Features of High-Quality Care for Dual Eligible Beneficiaries

- **Setting goals for care:** Person-centered plans of care should be developed in collaboration with an individual, his/her family, and his/her care team. Each plan should establish health-related goals and preferences that incorporate medical, behavioral, and social needs.
- **Understanding chronicity of care:** The majority of dual eligible beneficiaries have multiple chronic conditions. In addition, many people with disabilities require long-term supports, of varying intensity, throughout their lifetimes.
- **Accommodating cognitive limitations:** More than 60 percent of dual eligible beneficiaries are affected by a mental or cognitive impairment, such as those resulting from intellectual/developmental disability, mental illness, dementia, substance abuse, or stroke.
- **Care transitions and communication:** Communication and coordination across all providers is vital. Transactions between the medical system and the community-based services system are particularly important for beneficiaries who use long-term supports.

Dual Eligible Beneficiaries Family of Measures

The Family of Measures is used as a tool to promote alignment:

- The family of measures contains 57 total measures and a list of prioritized gap areas.
- The majority of the measures in the family are currently in use across HHS programs.
  - 39 of the measures are finalized in at least one HHS program.
  - 30 are finalized in more than one program.
- 9 measures under consideration across 10 programs are drawn from the family of measures.

Measures Under Consideration for PAC/LTC Programs from the Dual Eligible Beneficiaries Family of Measures

NQF # and Endorsement	Measure Title	Program for Which Measure Is Under Consideration	Workgroup Decisions
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	End-Stage Renal Disease Quality Incentive Program	Support
0418 Endorsed	Screening for Clinical Depression	End-Stage Renal Disease Quality Incentive Program	Support
0420 Endorsed	Pain Assessment and Follow-Up	End-Stage Renal Disease Quality Incentive Program	Support
0674 Endorsed	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Inpatient Rehabilitation Facilities Quality Reporting	Conditional Support

Dual Eligible Beneficiaries Workgroup's Reaction to PAC/LTC Workgroup Themes

- The PAC/LTC Workgroup encouraged better-aligned incentives across programs, care settings, and into community to achieve coordinated care.
  - Noted gap in coordination with ancillary entities (e.g., DME vendors)
- Considered fit-for-purpose of measures within specialized PAC/LTC settings that experience different quality issues (e.g., fall rates).
- Many PAC/LTC settings are very specialized, yet if an individual is receiving most care through PAC or LTC, attention must be paid to preventive services.
- Urged more widespread use of hospice and palliative care measures.
- Encouraged by measures in pipeline to fill gaps:
  - Functional outcome measures of mobility and self-care (in development).
  - Re-hospitalization or ED use during home health (being tested).

Measures Under Consideration for Hospital Programs from the Dual Eligible Beneficiaries Family of Measures

NQF # and Status	Measure Title	Program for Which Measure Is Under Consideration	Workgroup Decision
0028 Endorsed	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Inpatient Psychiatric Hospital Quality Reporting	Do Not Support
1659 Endorsed	Influenza Immunization	Inpatient Psychiatric Hospital Quality Reporting; Meaningful Use	Conditional Support for both programs
1789 Endorsed	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Hospital Readmission Reduction Program	Split Decision

Dual Eligible Beneficiaries Workgroup's Reaction to Hospital Workgroup Themes

- The Dual Eligible Beneficiaries Workgroup agreed with the Hospital Workgroup's recommendation that HHS consider The Joint Commission's tobacco (TOB) and substance use (SUB) measures as alternatives to MUCs for inpatient psychiatric facilities.
- All-Cause Readmissions in the Hospital Readmission Reduction Program:
  - NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure is in the Dual Eligible Beneficiaries Family of Measures.
  - Strong support for potential programmatic changes to make comparisons among peer groups.
- Urged more widespread use of hospice and palliative care measures, beginning with PPS-Exempt Cancer Hospitals.

Dual Eligible Beneficiaries Workgroup's Reaction to Hospital Workgroup Themes

- The Hospital Workgroup did not support two measure concepts under consideration for the Hospital Outpatient Quality Reporting Program (OQR) intended for the partial hospitalization population:
  - No Individual Psychotherapy: number of episodes of care with no units of individual psychotherapy or psychiatric testing billed.
  - Group Therapy: number of episodes of care with only group therapy billed.
- Dual Eligible Beneficiaries Workgroup noted that some psychiatric services must be individualized, so the measure concepts have some face validity.
- However, the measures have more to do with historical billing abuses than with high-quality psychiatric care.
- The IOM is forming a panel on psychotherapy measures this year and its findings will be relevant to this issue.

Measures Under Consideration for Clinician Programs from the Dual Eligible Beneficiaries Family of Measures

NQF # and Status	Measure Title	Program(s) for Which Measure Is Under Consideration	Workgroup Decisions
0005 Endorsed	CAHPS Clinician/ Group Surveys	Medicare Shared Savings Program; Physician Compare; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program	Support
0576 Endorsed	Follow-Up After Hospitalization for Mental Illness	Medicare Shared Savings Program	Support

Dual Eligible Beneficiaries Workgroup's Reaction to Clinician Workgroup Themes

- Already high concordance between the Dual Eligible Beneficiaries Family of Measures and measures in use in clinician programs.
- Agreed with Clinician Workgroup's Guiding Principles, noting that considering only Medicare programs is limiting.
- Discussion centered on the need to generate an adequate volume of clinicians choosing to report cross-cutting measures relevant to dual eligible beneficiaries, such as through use of a core measure set.
- Suggested that MAP should also review measures for primary care medical homes for alignment purposes.

Next Steps for the Dual Eligible Beneficiaries Workgroup

- Topic areas for consideration in 2014:
  - Quality of life measurement
  - Person- and family-centered care, including review of progress of MAP Task Force
  - Integration of primary care and behavioral health
- Upcoming events:
  - March 2014 web meeting
  - April 2014 in-person meeting

Discussion

- Questions or comments?
- How can we best continue to integrate the Dual Eligible Beneficiaries Workgroup perspective into our pre-rulemaking decisions?

MAP Pre-rulemaking: Finalize Pre-rulemaking Recommendations for Hospital Programs

Measures Under Consideration for Hospital Programs

CMS Program	# of Measures
Ambulatory Surgical Center Quality Reporting	3
Hospital Acquired Condition Reduction Program	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
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	6
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	6

Pre-Rulemaking Input on Inpatient Quality Reporting (IQR) Program Measure Set

IQR Program Summary

- **Program Type**:
  - Pay for Reporting – Information is reported on the Hospital Compare website
- **Incentive Structure**:
  - Hospitals receive a 2.0% reduction in their annual payment update for non-participation
- **Statutory Requirements for Measures:**
  - Should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures
  - HHS can add or replace measures in appropriate cases
  - Measures should align with the National Quality Strategy
  - Measures should align with the Meaningful Use program when possible

Pre-Rulemaking Input on the IQR Program Measure Set

- Reviewed 11 measures under consideration:
  - Support=4
  - Conditionally Support=6
  - Split=1
  - No longer under consideration=1
- Overarching themes:
  - Strong preference for NQF-endorsed measures
  - Need to balance measurement innovations with EHR use challenges
  - Gaps addressed:
    - Supported measures addressing affordability
    - Supported adding pediatric and maternal/child health measures to expand the populations covered by IQR
    - Conditionally supported measures to address gaps in public reporting of HACs

Pre-Rulemaking Input on the IQR Program Measure Set

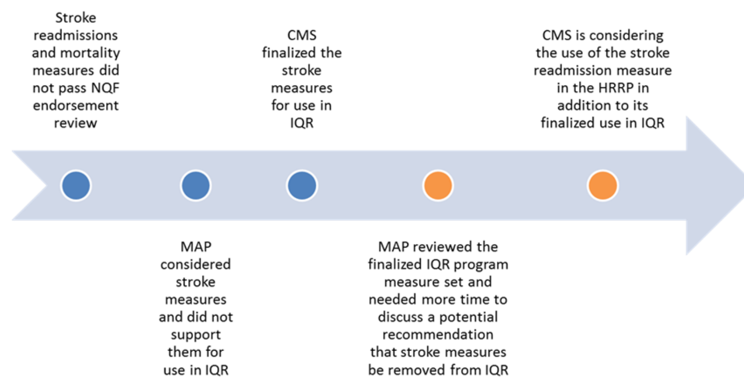
Key Issue: Stroke Outcome Measures

- MAP is asked to make recommendations on:
  - Retention of stroke readmission and mortality measures in IQR
  - Application of the readmission measure for the Hospital Readmissions Reduction Program (HRRP)

Pre-Rulemaking Input on the IQR Program Measure Set

Past and Present Actions on Stroke Outcome Measures:

- MAP did not support these measures previously due to lack of NQF-endorsement; endorsement concerns that the NIH Stroke Scale is not in the risk adjustment model



Meeting Binder: Tab 4, Hospital Excel

Pre-Rulemaking Input on the IQR Program Measure Set

Stakeholder Support and Additional Considerations for Stroke Outcome Measures

- Consumers, payers, and purchasers need information on stroke outcomes, and strongly supported these measures
- Providers raised concerns about the scientific acceptability of the measures and possible unintended consequences
  - Stroke centers may be unfairly penalized; patients misdirected
  - Some members cautioned results could reflect issues with clinical guidelines for treating stroke, definition of a stroke center, risk adjustment of the measures, or some combination of factors
- CMS believes the measures are sound and currently account for severity
  - CMS data shows performance is similar between stroke centers and other facilities, with high volume driving outlier results

Pre-Rulemaking Input on the IQR Program Measure Set

Workgroup Recommendations on Stroke Outcome Measures

- Retain the readmission measure for the Inpatient Quality Reporting Program (IQR)
- Did not support the readmission measure for the Hospital Readmissions Reduction Program (HRRP)
- Unable to come to consensus on retaining the stroke mortality measure for IQR

Pre-Rulemaking Input on the IQR Program Measure Set

Action Item: Decision on Retaining the Stroke Mortality Measure

- Should MAP recommend removal of the stroke mortality measure from the IQR program?

Meeting Binder: Tab 4. Please refer to the MAP Hospital Program Measure Tables, IQR tab for full measure specifications. Measure ID is 2027.

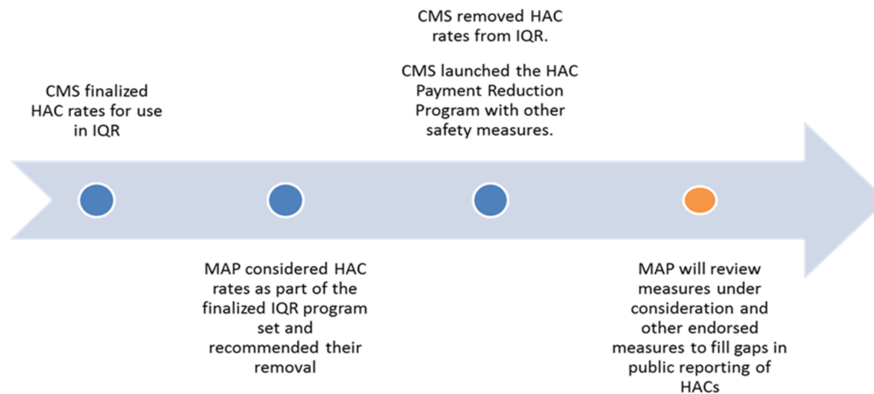
Pre-Rulemaking Input on the IQR Program Measure Set

Key Issue: Hospital Acquired Condition Measures

- MAP recommended removing the hospital-acquired condition (HAC) rates from IQR that populates Hospital Compare and replacing them with NQF-endorsed measures
- Not all conditions previously covered by an HAC rate have been replaced with an endorsed measure
- CMS will report measures from the HAC Reduction Program on Hospital Compare
- MAP is asked to:
  - Identify measures under consideration and other endorsed measures to fill the gaps in HACs on Hospital Compare

Pre-Rulemaking Input on the IQR Program Measure Set

Past and Present Actions:



Pre-Rulemaking Input on the IQR Program Measure Set

Workgroup Recommendations

- Current gaps in publicly reported information:
  - Air embolism
  - Blood incompatibility
  - Foreign body left during procedure
  - Manifestations of poor glycemic control
- Supported or conditionally supported measures across multiple programs to fill gaps
- Air embolism, a very low frequency event, remains a gap area

Pre-Rulemaking Input on Outpatient Quality Reporting (OQR) Program Measure Set

OQR Program Summary

- **Program Type:** Pay for Reporting – Information available on Hospital Compare
- **Incentive Structure:** 2% reduction in annual OPPS payment update for non-participation
- **Statutory Requirements for Measures:**
  - Program should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures
  - The Secretary can add or replace any measures in appropriate cases

Pre-Rulemaking Input on the OQR Program Measure Set

- Reviewed 6 measures under consideration:
  - Do Not Support=3
  - Split=1
  - No Longer under Consideration=2
- Overarching themes:
  - Additional mental/behavioral health measures are needed but the measures under consideration did not address quality of care or patient outcomes
  - Measuring complications may be challenging as outpatient facilities do not track patients over time

Pre-Rulemaking Input on the OQR Program Measure Set

Action Item: High-Acuity Care Visits after Outpatient Colonoscopy Procedure Measure

- Unable to reach consensus
- Measure is not NQF-endorsed; currently being specified
  - Measure description: Combined rate of unplanned admissions, emergency department visits, and observation stays among Medicare FFS beneficiaries after receiving a colonoscopy at an ambulatory surgery center or other outpatient facility
- Important quality and safety issue but incidence may be low
- Implementation may be difficult because patients are not tracked after procedures
- Exclusion criteria need further development

Meeting Binder: Tab 4 Please refer to the MAP Hospital Program Measure Tables, OQR tab for full measure specifications. MUC ID is XDEMA

Pre-Rulemaking Input on Ambulatory Surgical Center Quality Reporting (ASCQR) Program Measure Set

ASCQR Program Summary

- **Program Type:** Pay for Reporting – Program takes effect CY 2014
- **Incentive Structure:** 2% reduction in annual ASC payment system update for non-participation
- **Statutory Requirements for Measures:**
  - Measures may be similar or the same as those reported in IQR or OQR
  - Program should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures
  - To extent feasible, outcome and patient experience measures should be risk-adjusted
  - The Secretary can add or replace any measures in appropriate cases

Pre-Rulemaking Input on the ASC Program Measure Set

- Reviewed 3 measures under consideration:
  - Split=1
  - No Longer under Consideration=2
- Overarching themes:
  - Measuring complications may be challenging as facilities due not track patients over time
  - Concerns about implementing clinician-level measures for a facility-level program

Pre-Rulemaking Input on the ASCQR Program Measure Set

Action Item: High-Acuity Care Visits after Outpatient Colonoscopy Procedure Measure

- Unable to reach consensus
- Measure is not NQF-endorsed; currently being specified
  - Measure description: Combined rate of unplanned admissions, emergency department visits, and observation stays among Medicare FFS beneficiaries after receiving a colonoscopy at an ambulatory surgery center or other outpatient facility
- Important quality and safety issue but incidence may be low
- Implementation may be difficult because patients are not tracked after procedures
- Exclusion criteria need further development

Meeting Binder: Tab 4 Please refer to the MAP Hospital Program Measure Tables, ASCQR tab for full measure specifications. MUC ID is XDEMA

Pre-Rulemaking Input on the HAC Reduction Program

Hospital-Acquired Condition (HAC) Reduction Program Summary

- **Program Type:**
  - Pay for Performance – Information will be reported on the Hospital Compare website beginning FY 2015
- **Incentive Structure:**
  - Hospitals scoring in the highest quartile for rates of HACs will have their Medicare payments reduced by 1% for all DRGs
  - FY 2014 IPPS rule created two domains which will be used to create a total HAC score that will be used to determine payment adjustments
- **Statutory Requirements for Measures:** Measures should address the same conditions as the HAC "no-pay" policy and any other conditions HHS deems appropriate.

Pre-Rulemaking Input on the HAC Reduction Program Measure Set

- Reviewed 4 measures under consideration:
  - Support=2
  - Do Not Support=1
  - Split=1
- Overarching themes:
  - Supported measures of conditions that are harmful to patients and very costly to treat
  - Gaps addressed:
    - Blood Incompatibility

Meeting Binder: Tab 4

Pre-Rulemaking Input on the HAC Reduction Program Measure Set

Action Item: PSI-9: Perioperative Hemorrhage or Hematoma Rate

- Addresses perioperative hemorrhage or hematoma cases with control of perioperative hemorrhage, drainage of hematoma, or a miscellaneous hemorrhage- or hematoma-related procedure following surgery.
- Important area of patient safety but concerns about the scientific properties of the measure:
  - Not NQF-endorsed.
  - Removed from the PSI-90 during the endorsement process; however, some data shows reliability of PSI-90 may be better with PSI-9 included.

Meeting Binder: Tab 4. Please refer to the MAP Hospital Program Measure Tables, HAC tab for full measure specifications. MUC ID is XAFLG

Pre-Rulemaking Input on Hospital Readmission Reduction Program (HRRP) Measure Set

HRRP Program Summary

- **Program Type**: Pay for Performance
- **Incentive Structure**: Hospitals determined to have excess readmissions will receive a reduction in DRG payment rates. The maximum payment reduction is 2% in FY 2014 and 3% for FY 2015 and beyond.
- **Statutory Requirements for Measures:**
  - Measures should be NQF-endorsed.
  - Readmissions unrelated to prior discharge should be excluded from the measures.
  - In FY 2015, the Secretary can expand the program to include other applicable conditions.

Pre-Rulemaking Input on the HRRP Measure Set

- Reviewed 3 measures under consideration:
  - Support=1
  - Do Not Support=1
  - Split=1
- Overarching themes:
  - Need to address additional conditions
  - Balance between implementing measures to drive improvement and needing experience before measures are used for payment
  - Need a methodology to avoid duplication of all-cause and condition-specific measures

Pre-Rulemaking Input on the HRRP Measure Set

MAP Guidance for the Selection of Avoidable Admission and Readmission Measures

- Readmission measures should be part of a suite of measures to promote a system of patient-centered care coordination.
- All-cause and condition-specific measures of avoidable admissions and readmissions are both important.
- Monitoring by program implementers is necessary to understand and mitigate potential unintended consequences of measurement.
- Risk adjustment is necessary for fair comparisons of readmission rates.
- Readmission measures should exclude planned readmissions.

Pre-Rulemaking Input on the HRRP Measure Set

Key Issue: Implementation of Hospital-Wide All-Cause Unplanned Readmission Measure

- MAP is asked to provide input on the potential implementation of NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure in the HRRP.
- Measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmissions for any eligible condition within 30 days of discharge for patients 18 and older.

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Meeting Binder: Refer to All-Cause Readmissions Section of the draft pre-rulemaking report

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Pre-Rulemaking Input on the HRRP Measure Set

Measure Background

	#1789 (CMS/Yale)
Readmission Type	All-Cause
Measure Type	Unplanned
Level of Analysis	Hospital

Tested Population	Medicare FFS/Commercial
	• Condition categories (CCs)
	• 5 clinical cohorts
	  • Medicine
	  • Surgery/Gynecology
	  • Cardiorespiratory
	  • Cardiovascular
	  • Neurology

Risk Adjustment Method	Hierarchical logistic regression

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Meeting Binder: Refer to All-Cause Readmissions Section of the draft pre-rulemaking report

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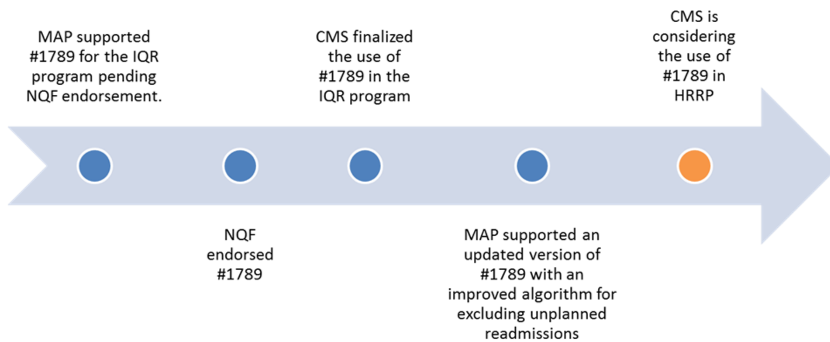
Pre-Rulemaking Input on the HRRP Measure Set

Past and Present Actions



Meeting Binder: Refer to All-Cause Readmissions Section of the draft pre-rulemaking report

Pre-Rulemaking Input on the HRRP Measure Set

Action Item: NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure

- Hospital Workgroup did not reach consensus; vote 13-10 in favor of conditional support.
  - All-cause data is needed; measure recently implemented in IQR and need additional experience before using for payment.
  - Wary of payment implications for safety net and rural providers. MedPAC recommends HRRP compare hospitals within peer groups.
  - Including both all-cause and condition-specific readmission measures could result in a double penalty for the same event unless program structure is designed to accommodate this.
- Dual Eligible Beneficiaries Workgroup Guidance:
  - Crucial issue for vulnerable populations; measure included in the Dual Eligible Beneficiaries Family of Measures.
  - Strongly supported MedPAC's programmatic recommendation to protect safety net providers from negative unintended consequences.
- Should MAP support implementation of NQF #1789 in HRRP?

Meeting Binder: Tab 4. Please refer to the MAP Hospital Program Measure Tables, HRRP tab for full measure specifications. Measure ID is 1789.

Pre-Rulemaking Input on Hospital Value-based Purchasing (VBP) Program Measure Set

VBP Program Summary

- **Program Type**:
  - Pay for Performance – Payments are based on information publicly reported on the Hospital Compare website
- **Incentive Structure**:
  - A portion of Medicare reimbursements are withheld to fund a pool of VBP incentive payments.
  - Hospitals are scored relative to other hospitals, as well as on how their performance has improved over time. The higher of these scores on each measure is used in determining incentive payments.
- **Statutory Requirements for Measures:**
  - Must be included in IQR and reported on Hospital Compare 1 year prior to use in VBP
  - Should include efficiency measures including measures of “Medicare Spending per Beneficiary”
  - HHS can add or replace measures in appropriate cases
  - Measures of readmissions are statutorily excluded

Pre-Rulemaking Input on the VBP Program Measure Set

- Reviewed 14 measures under consideration:
  - Support=4
  - Do Not Support=10
- Overarching themes:
  - Need to keep the set parsimonious to avoid diluting incentives
  - Emphasize areas of critical importance for high performance and quality improvement; performance on some MUCs was too high to justify VBP inclusion

Pre-Rulemaking Input on PPS-Exempt Cancer Hospital Quality Reporting Program Measure Set

PCHQR Program Summary

- **Program Type:** Required Reporting – Program began FY 2014
- **Incentive Structure:** Program does not currently include incentive/penalty for failing to report. CMS plans to address incentives in future rulemaking.
- **Statutory Requirements for Measures:**
  - Program should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures.
  - Measures should reflect the level and most important aspects of care furnished by PCHs as well as gaps in quality of cancer care.
  - The Secretary can add or replace any measures in appropriate cases.

Pre-Rulemaking Input on the PCHQR Program Measure Set

- Reviewed 6 measures under consideration:
  - Support=2
  - Conditional Support=4
- Overarching themes:
  - Measures should be NQF-endorsed to ensure they reflect current evidence
  - Patient-reported outcomes are important but data collection can be burdensome
  - Safety and overuse are key issues
  - Importance of patient-centered care and shared decision-making
  - Gaps addressed:
    - NQF #1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits addresses the previously identified gap of patient-reported symptoms
    - Supported 4 measures from the Hospice and Palliative Care Family identified by the PAC/LTC Workgroup that could address the identified gap of palliative care

Pre-Rulemaking Input on the PCHQR Program Measure Set

- The PAC/LTC and Hospital Workgroups recommended the following measures to address the gap in palliative care.
- The measures are not on the CMS list of measures under consideration but would be appropriate to use in the PCHQR program.

NQF #	Title
#1641	Treatment Preferences
#1634	Hospice and Palliative Care – Pain Screening (paired with 1637)
#1637	Hospice and Palliative Care – Pain Assessment (paired with 1634)
#0326	Advance Care Plan

Pre-Rulemaking Input on Inpatient Psychiatric Facility Quality Reporting Program Measure Set

IPFQR Program Summary

- **Program Type:** Pay for Reporting – Program began FY 2014
- **Incentive Structure:** 2% reduction in annual IPPS payment update for non-participation
- **Statutory Requirements for Measures:**
  - Program should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures
  - The Secretary can add or replace any measures in appropriate cases

Pre-Rulemaking Input on the IPFQR Program Measure Set

- Reviewed 10 measures under consideration:
  - Support=1
  - Conditional Support=2
  - Do Not Support=7
- Overarching themes:
  - Hospital and Dual Eligible Beneficiaries Workgroups preferred The Joint Commission's tobacco, substance abuse, and hospital-based inpatient psychiatric services suites.
    - Currently used and in the final stages of endorsement.
  - Influenza vaccination is important but specifications should be clear before implementation to avoid conflict with IQR.
  - Need for additional outcome measures.
  - Gaps addressed:
    - Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care addresses the gap pf person-centered care.

Pre-Rulemaking Input on Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs (Meaningful Use) Measures

Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)

- **Program Type:** Pay for Reporting – Stage 1 began in 2011
- **Incentive Structure:**
  - Incentive payments provided to eligible hospitals and CAHs as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.
- **Statutory Requirements for Measures:**
  - Measures of 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 should be included.
  - Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.
  - Preference should be given to quality measures endorsed by NQF.

Pre-Rulemaking Input on Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs Measures

- Reviewed 6 measures under consideration, all were conditionally supported
- Overarching themes:
  - Supportive of alignment with IQR and attempts to minimize burden; however, different measures may be needed across the two programs as some hospitals have challenges implementing MU requirements.

Opportunity for Public Comment

Finalize Pre-Rulemaking Recommendations for Post-Acute Care and Long-Term Programs

Measures Under Consideration for PAC/LTC Programs

CMS Program	Number of Measures Under consideration
Inpatient Rehabilitation Facility (IRF) Quality Reporting Program	8
Long-Term Care Hospital (LTCH) Quality Reporting Program	3
End Stage Renal Disease Quality Incentive Program (ESRD-QIP)	21
Home Health (HH) Quality Reporting Program	4
Hospice Quality Reporting (HQR) Program	0
Nursing Home (NH) Quality Initiative and NH Compare programs	0

Key Issues from PAC/LTC Workgroup Discussions

PAC/LTC High-Leverage Opportunities and Core Measure Concepts

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental health
Goal Attainment	• Establishment of patient/family/caregiver goals • Advanced care planning and treatment
Patient Engagement	• Experience of care • Shared decision-making
Care Coordination	• Transition planning
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions

Key Issues: PAC/LTC Workgroup

- The Post-Acute Care and Long-Term Care Workgroup reviewed 36 measures under consideration
  - Support=13
  - Conditionally support=18
  - Do not support= 5
- Need to align performance measurement across PAC/LTC settings as well as with other settings
  - Harmonizing measures to promote patient-centered care across the healthcare continuum
  - Measures should be applicable to specific populations
- Recommend care transition measures
  - Setting-specific admission and readmission measures to address the unique needs of the heterogeneous PAC/LTC population
  - Consider attribution issues and unintended consequences when further refining measures

Key Issues: PAC/LTC Workgroup

- Encourage care coordination and communication, and shared accountability among acute care providers and PAC/LTC facilities in providing preventive care
  - Unclear which provider is responsible for monitoring patients' complex care needs
  - Ensure the timely receipt of appropriate services
- Emphasize the importance of filling the critical measure gaps (i.e., the core concepts not addressed in the programs) across PAC/LTC programs. The PAC/LTC core concepts that would enhance the current measure sets include:
  - Goal attainment
  - Medication management and reconciliation, and adverse drug events
  - Functional and cognitive status
  - Patient and family experience of care and engagement in care
  - Transitions in care

Pre-Rulemaking Input on the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program Measure Set

IRF Quality Reporting Program Summary

- **Program Type**: Pay for Reporting, Public Reporting
- **Incentive Structure**: Must submit data on quality measures to receive annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year. Incentive structure begins in FY 2014.
- **Statutory Requirements for Measures:** Measures for FY 2014 and subsequent years should:
  - Improve patient safety, reduce adverse events, and encourage better coordination of care and person- and family-centered care.
  - Address the primary role of IRFs–the rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community post-discharge.

Pre-Rulemaking Input on the IRF Quality Reporting Program Measure Set

- The PAC/LTC Workgroup reviewed 8 measures under consideration:
  - Support=1
  - Conditionally Support=7
- Overarching themes:
  - The program measure set could be enhanced by addressing core measure concepts not currently addressed in the set.
  - Recommended measures that address conditions such as *C. difficile*, MRSA, and pain, which would affect patients' ability to fully participate in rehabilitation programs.

Pre-Rulemaking Input on the Long-Term Care Hospital (LTCH) Quality Reporting Program Measure Set

LTCH Quality Reporting Program

- **Program Type**: Pay for Reporting, Public Reporting
- **Incentive Structure**: Must submit data on quality measures in order to receive annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual payment update. Incentive structure begins in FY 2014.
- **Statutory Requirements for Measures:** Measures for FY 2014 and subsequent years should:
  - Promote patient safety, better coordination of care, and person- and family-centered care.
  - Address the primary role of LTCHs–to provide extended medical care to individuals with clinically complex problems.

Pre-Rulemaking Input on the LTCH Quality Reporting Program Measure Set

- The PAC/LTC Workgroup reviewed 3 measures under consideration:
  - Support=1
  - Conditionally Support=2
- Overarching themes:
  - Functional status assessment should cover a broad range of mobility issues applicable to all patients.
  - Supported a measure addressing Ventilator-Associated Events for healthcare facilities to help them monitor ventilator use and identify improvements for preventing complications.

Pre-Rulemaking Input on the End Stage Renal Disease Quality Incentive Program (ESRD-QIP)Measure Set

ESRD-QIP Summary

- **Program Type**: Pay for Performance, Public Reporting Website
- **Incentive Structure**: Starting in PY 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions will be on a sliding scale, which could amount to a maximum of 2 percent per year.
- **Statutory Requirements for Measures:** Measures specified for the ESRD QIP include measures that:
  - Assess anemia management that reflect the labeling approved by the FDA for such management;
  - Assess dialysis adequacy;
  - Assess patient satisfaction; and
  - Additional measures, such as, iron management, bone mineral metabolism, and vascular access, including maximizing the placement of arterial venous fistula.

Pre-Rulemaking Input on the ESRD-QIP Measure Set

- The PAC/LTC Workgroup reviewed 21 measures under consideration:
  - Support=7
  - Conditionally Support=9
  - Do Not Support=5
- Overarching themes:
  - Supported measures that address several cross-cutting areas previously noted as gaps (e.g., depression, pain) and other important measurement topics for the ESRD population.
  - Emphasized the importance of providing preventive care to ESRD patients who spend more time in dialysis facilities and visit their primary care clinicians less frequently.

Pre-Rulemaking Input on the Home Health (HH) Quality Reporting Program Measure Set

HH Quality Reporting Program Summary

- **Program Type:** Pay for Reporting, Public Reporting
- **Incentive Structure:** Home health agencies (HHA) that do not submit data will receive a 2 percentage point reduction in their annual HHA market basket percentage increase.
- **Statutory Requirements for Measures:** None

Pre-Rulemaking Input on the HH Quality Reporting Program Measure Set

- The PAC/LTC Workgroup reviewed 4 measures under consideration:
  - Support=4
- Overarching themes:
  - Admissions/readmissions measures need to adjust for all factors that could influence a patient's likelihood of readmission to the hospital or emergency department.
  - Preferred a measure, Depression Screening Conducted and Follow-Up Plan Documented, which includes an element of follow up to the existing depression measure in the set.

Pre-Rulemaking Input on Hospice Quality Reporting (HQR) Program

HQR Program Summary

- **Program Type**: Pay for Reporting, Public Reporting
- **Incentive Structure**: Failure to submit required quality data shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year. Incentive structure begins in FY2014.
- **Statutory Requirements for Measures:** None.

Pre-Rulemaking Input on the Hospice and Palliative Measures

- There were no measures under consideration for the HQR Program.
- To promote alignment across settings, the PAC/LTC Workgroup provided input on finalized hospice measures that could be incorporated into hospital programs.
- The workgroup expressed concern that NQF #0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment had been finalized for removal from the HRQ program due to implementation issues; recommended further measure development of a pain outcome measure.

Opportunity for Public Comment

Follow-up on MAP Off-Cycle Measure Review Process

MAP Off-Cycle Measure Review

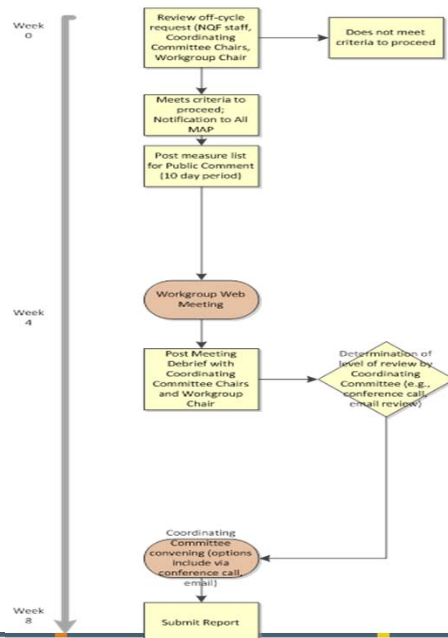
Background

- HHS has asked MAP to perform "off-cycle" (previously called "ad hoc") reviews of measures outside of the usual pre-rulemaking process in exceptional circumstances.
- As required under NQF's contract with HHS, off-cycle reviews are on expedited timelines (eight-week period).
- MAP Coordinating Committee discussed at the October 3, in-person meeting the importance of:
  - Maintaining the integrity of the process.
  - Delivering high quality recommendations to HHS.
  - Preserving the opportunity for MAP member and public comment.

Draft Principles of Off-Cycle Measure Review

- Off-cycle reviews are not intended to replace MAP's annual pre-rulemaking process, and will only be conducted in exceptional circumstances. Criteria for accepting an off-cycle review include:
  - The measures address a previously identified gap area of high impact.
  - A year delay would prevent HHS from meeting a statutory or regulatory requirement.
  - The measure would promote alignment and reduce measurement burden.
- A decision to conduct an off-cycle review will carefully balance the opportunity to provide multi-stakeholder input with maintaining the integrity of MAP's processes.
- Clear and transparent notification that MAP will be undertaking an off-cycle review will be provided to MAP Coordinating Committee and workgroup members and the public.

Draft Process for Off-Cycle Measure Review



Coordinating Committee Discussion

- Does the approach sufficiently maintain the integrity of MAP processes while offering flexibility to deliver timely recommendations to HHS?

MAP Input on the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces

Health Insurance Exchange (HIX) Quality Rating System (QRS) Task Force Membership

Workgroup Chair: Elizabeth Mitchell

Organizational Members

Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
The Advanced Medical Technology Association	Steve Brotman, MD, JD
Aetna	Andrew Baskin, MD
America's Essential Hospitals	David Engler, PhD
America's Health Insurance Plans	Aparna Higgins, MA
American Association of Retired Persons	Joyce Dubow, MUP
American Board of Medical Specialties	Lois Nora, MD, JD, MBA
American Medical Group Association	Samuel Lin, MD, PhD, MBA, MPA, MS
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	David Ferriss, MD, MPH
Consumers' CHECKBOOK	Robert Krughoff, JD
Humana, Inc.	George Andrews, MD, MBA, CPE
Iowa Healthcare Collaborative	Lance Roberts, PhD
March of Dimes	Cynthia Pellegrini
Memphis Business Group on Health	Christie Upshaw Travis, MHSA
National Business Coalition on Health	Colleen Bruce, JD
National Partnership for Women and Families	Emma Kopleff, MPH
SNP Alliance	Chandra Torgerson, MS, RN, BSN
The Brookings Institute	Mark McClellan, MD, PhD

HIX QRS Task Force Membership

Subject Matter Experts

Child Health	Richard Antonelli, MD, MS
Health IT	Thomas von Sternberg, MD
Measure Methodologist	Debra Saliba, MD, MPH
Medicaid ACO	Ruth Perry, MD
Nursing	Gail Stuart, PhD, RN

Federal Government Members

Centers for Medicare & Medicaid Services (CMS)	Deborah Green
Health Resources and Services Administration (HRSA)	Terry Adirim, MD, MPH

MAP HIX QRS Task Force Charge

- Advise the MAP Coordinating Committee on recommendations for the hierarchical structure, organization, and measures for the child and family core sets of the QRS
  - MAP is not providing recommendations on the marketplace websites, materials, displays, or minimum benefits
  - The QRS' primary purpose is to inform consumer choice of Qualified Health Plans (QHPs) in the marketplaces
- The task force is time-limited and consists of current MAP members from the MAP Coordinating Committee and all MAP workgroups with relevant interests and expertise

Timeline for HIX QRS Task Force Activities

Date	Activities
September 26: Task Force Web Meeting	• Review task force charge, background of the QRS, and relevant populations • Consider health plan information available to consumers and define scope of MAP's input
October 18: Task Force Web Meeting	• Define the highest leverage measurement opportunities for the marketplace populations • Review the MAP Measure Selection Criteria (MSC) and consider how it will be used in marketplace QRS decision-making framework • Consider the ideal hierarchy and measurement domains for consumer decision-making
November 20-21: Task Force In-Person Meeting	• Develop recommendations and rationale regarding measures for inclusion in QRS • Develop recommendations and rationale regarding structure of QRS • Identify gaps in measure to enable consumer decision-making
December: Task Force Teleconference	• Finalize recommendations and rationale regarding the QRS structure and measure • Identify measures to fill high-priority gaps to enable consumer decision-making
December: Public Comment Draft Report	• Task force review of draft report via email • Report posted to NQF website for a two-week public comment period
January 7-8: MAP Coordinating Committee In-Person Meeting	• MAP Coordinating Committee review of public comment draft and public comments received • HIX QRS Task Force will be asked to join by phone • Finalize recommendations and rationale on measures for inclusion and structure of QRS
January: Final Report	• Submit final report to DHHS

MAP Input on the Marketplaces Quality Rating System

- Vision for Enabling Consumer Choice in the Health Insurance Marketplaces
  - Making Information Accessible to Consumers
  - Making Information Meaningful for Consumers
  - Phased Approach to Implementation
- Input on Proposed Marketplaces QRS
  - Hierarchical Structure for the Quality Rating System
  - Measures for the Quality Rating System
- Path Forward

Vision for Enabling Consumer Choice in the Health Insurance Marketplaces

Key Inputs to the Decision-Making Framework

- MAP Measure Selection Criteria
  - MAP MSC Sub-Criterion 3.2: Measure sets for public reporting programs should be meaningful for consumers and purchasers
  - MAP Clinician and Hospital Workgroup Guiding Principles defined the types of measures that are most meaningful to consumers
- Previous findings on consumer choice
  - Scans of the literature
  - Review of applicable frameworks
- Health plan functions that impact quality and are meaningful to consumers
- Types of information available on health plan quality
  - Accreditation and recognition programs
  - Rating and Ranking Systems
  - Web sites with consumer comments and ratings
- State marketplaces under development

Vision for Enabling Consumer Choice in the Health Insurance Marketplaces

- Making Information Accessible to Consumers
  - Interactive and customizable
  - Consumer-friendly (and tested) language
  - Summary and detailed information
- Making Information Meaningful to Consumers
  - Prioritized high-leverage opportunities: Cost, Experience, and Quality
  - Plan and network provider-level quality information
- Phased Approach to Implementation
  - Initial implementation may be limited to existing quality measures
  - Avoid unnecessary burden and align health plan reporting requirements

Task Force's Recommended QRS Structure

Experience: Plan Experience and Provider Experience

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity
Experience	Plan Experience	Experience with Health Plan	• Patient and Family Experience/ Satisfaction • Shared Decision-Making • Quality of Providers • Member Complaints and Grievances
		Access to Plan Resources	• Member Access to Information • Member Education • Cultural Competency • Access to Health Plan Resources, Medical Records
		Access to Care	• Access to Care, Specialists, and Network Adequacy • Covered Services/Benefits • Utilization Management
	Provider Experience	Provider	• Patient and Family Experience/ Satisfaction • Shared Decision-Making • Access to Medical Records

Task Force's Recommended QRS Structure

Cost

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity
Cost	Cost	Cost	Cost Task force members further defined the cost to include: • Out of pocket costs • Premiums • Efficient Resource Use

Task Force's Recommended QRS Structure

Quality: Health Plan Quality, Provider Quality

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity
Quality	Health Plan Quality/Provider Quality	Staying Healthy	• Maternal Health • Well-Infant, Child, Adolescent Care • Behavioral/Mental Health • Screening, Immunization, and Treatment of Infectious Disease • Tobacco, Alcohol and Substance Use • Weight Management and Wellness Counseling • Dental and Vision Care
		Living with Chronic Illness	• Cardiovascular Care • Diabetes Care • Asthma and Respiratory Care • Cancer Screening and Treatment
		Coordination	• Care Coordination and Case Management • Medication Management • Advanced Illness Care • Care for Older Adults • Readmissions

Task Force's Input on Proposed Marketplaces QRS

Hierarchical Structure: Comparing the Recommended to the Proposed

- Support use of overall summary scores and consumer-friendly hierarchical structure
  - Support high-level summaries of health plan quality and functions to drill down to more detailed performance results in the QRS
  - System must be tested with consumers to ensure information is consumer-friendly
- Recommend reporting health plan and network provider performance in experience and quality tiers
  - Initial years will include health plan performance, but include performance by all levels of providers over time
- Expanding beyond plan efficiency to affordability
  - Consumers find out-of-pocket costs, premiums, etc., most valuable

Task Force's Input on Proposed Marketplaces QRS

Hierarchical Structure: Recommended Enhancements to Proposed Structure

- The proposed structure included member experience with health plan as a component of plan efficiency and affordability
  - Recommend placing this information in the experience tier
- The proposed structure subcomponents within clinical quality management are care coordination, clinical effectiveness, patient safety, and prevention
  - Recommend slightly altering these components by incorporating safety into care coordination and renaming clinical effectiveness "living with chronic illness"
- The proposed structure combines several measures into composites, whereas MAP's recommendation includes subdomains
  - Agree with the use of composite measures within the QRS; however, those composites should be tested and endorsed as composites

Task Force's Input on Proposed Marketplaces QRS

Proposed Measures

MAP Recommendations and Rationale	Family Core Set	Child Core Set
Total Proposed Measures	**42**	**25**
Support	27	19
Conditional Support	9	4
Do Not Support	6	2

Task Force's Input on Proposed Marketplaces QRS

Proposed Measures

- Proposed set limited to currently available measures
  - Recommend expanding over time and adding provider performance reporting
- Identified Gap-Filling Measures
  - NQF #0541 Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category
  - Additional measures for phasing into the program over time: NQF #1560 Relative Resource Use for People with Asthma and NQF #1561 Relative Resource Use for People with COPD

Path Forward

- *Begin addressing measure gaps in the QRS immediately*
  - Highest priority gaps include measures of shared decision-making and cost (i.e., total out of pocket costs)
- *Test the QRS with consumers prior to initial implementation*
  - Test the structure and hierarchy
  - Refine consumer-friendly language, explanations, and displays
- *Include provider level quality information in the QRS within three years of initial implementation*
  - Provide information about provider performance
  - Enable customers to identify a provider of their choice while selecting plans
- *Provide functionality for customized information in the QRS within five years of initial implementation.*
  - Include functionality for consumers to access the information most important to them

Public Comments on the Draft HIX QRS Report

- Draft report available for public comment December 23-January 6
- Comments received from 7 organizations were generally supportive of MAP's recommendations

Public Comments on the Draft HIX QRS Report

General Support for Task Force's Recommended QRS Structure

- Be customizable, interactive, and meaningful to consumers
  - Emphasis on need for consumer-friendly terms
- Include experience, quality, and cost
  - Should be displayed so that a consumer can consider all three aspects when selecting a health plan
- Build on existing, successful strategies to collect and report quality information
  - Explore using additional data sources, including registries
  - Align with other settings/program, including measures used by CMS for hospitals, physician, pharmaceutical, home health
- Phase implementation over time as strategies become feasible

Public Comments on the Draft HIX QRS Report

Concerns Expressed with Task Force's Recommended QRS Structure

- Health plan quality rating should be based on statistically significant differences in plan quality
- Quality should be displayed at level meaningful to consumer (e.g., regional or market levels)
- Be conscious of data collection and reporting burden on health plans and providers
- Comments were split on MAP's proposed phasing strategy
  - Too slow- Additional testing and development is needed now to implement additional functionalities in the QRS
  - Too fast- Recommendations put forth are complex and burdensome

Public Comments on the Draft HIX QRS Report

Concerns Expressed with Task Force's Recommended QRS Structure

- Comments noted that provider-level information is highly valuable to consumers, and health plans are responsible for including high quality providers in their networks
  - "Health plans are selling a package of services that includes both health plan services and provider services. Health plans should be held accountable for the quality of the providers they select for their networks. For many people, these in-network provides will be the only providers they can afford to visit."
- Other comments noted that provider-level measurement would increase burden and creates small number issues
  - "While we are supportive of performance measurement at the provider level, we do not believe that the QRS is the most suitable tool for this level of reporting as other avenues for provider performance reporting that are based on data from all payers would result in more reliable, and thus more meaningful, information on provider performance."

Public Comments on the Draft HIX QRS Report

Task Force's Input on HHS' Proposed Measures

- Input on MAP recommendations:
  - NQF #0541 Proportion of Days Covered: Support
  - Adolescent Well-Care: Do not Support
- Additional Gaps:
  - Vision Care (particularly measures related to pediatric eye care)
  - Total Cost of Care

Public Comments on the Draft HIX QRS Report

Disagreement with Task Force's Input on HHS' Proposed Measures

- Relative Resource Use Measures: Task force supported
  - Commenters noted that these measures are not meaningful to consumers and do not directly address affordability
- Global Rating of Health Plan: Task force conditionally supported
  - Commenters noted that this measure has been used in other programs and that the information is valuable to consumers

Opportunity for Public Comment

Revisit Workgroup Recommendations- Follow-Up from Day 1

Revisit PAC/LTC Workgroup Recommendations

End Stage Renal Disease Quality Incentive Program

- PAC/LTC WG did not support 2 measures because they are already collected for certification purposes
  - NQF #0260 Assessment of Health-related Quality of Life (Physical & Mental Functioning)
    - Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year
  - Comorbidity Report
    - Annual reporting in CROWNWeb of patients who have one or more of any of the 24 qualifying comorbidities, or “none of the above”
- Workgroup noted that incorporating these measures in the ESRD-QIP would duplicate existing requirements and increase data collection burden
- Coordinating Committee noted that existing information could be leveraged for use in the payment program
- Does the Coordinating Committee want to change the MAP recommendation to ‘Support’ or ‘Conditional Support’, or keep the workgroup’s recommendation of ‘Do Not Support’?

Meeting Binder: Tab 5
PAC/LTC Excel

Revisit Clinician Workgroup Recommendations

Medicare Shared Savings Program

- Clinician Workgroup conditionally supported 4 CG-CAHPS Supplemental Items
  - Care Coordination
  - Between Visit Communication
  - Educating Patient about Medication Adherence
  - Stewardship of Patient Resources
- Workgroup's condition was that the measures should be submitted for and receive NQF-endorsement
- Does the Coordinating Committee want to change the MAP recommendation to 'Support' or keep the workgroup's recommendation of 'Conditional Support'?

Meeting Binder: Tab 2
MSSP and GPRO Excel

MAP Families of Measures

Families of Measures and Core Measure Sets

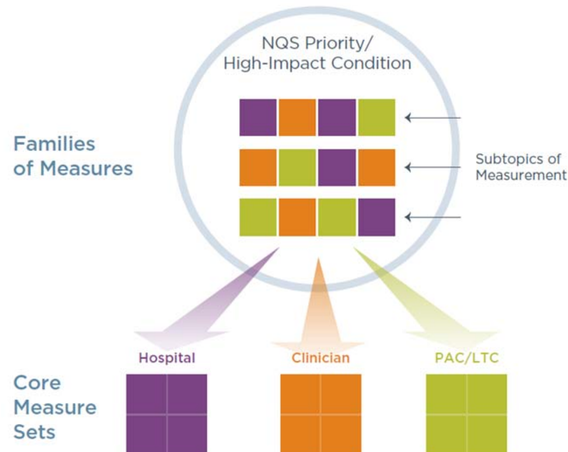
Families of Measures

"Related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS " (e.g., care coordination family of measures, diabetes care family of measures)

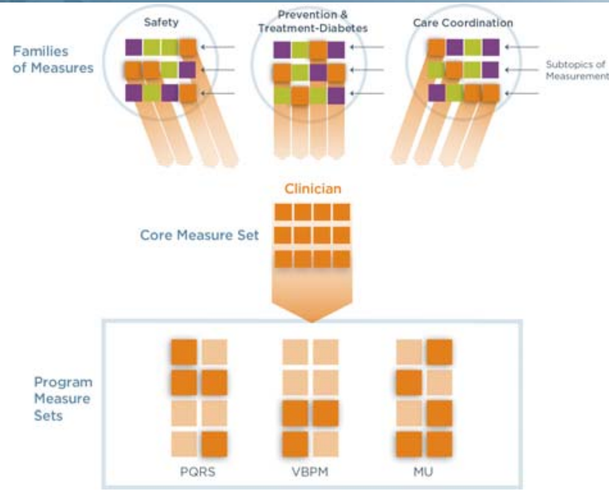
Core Measure Sets

"Available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., ambulatory clinician measure set, hospital core measure set, dual eligible beneficiaries core measure set)

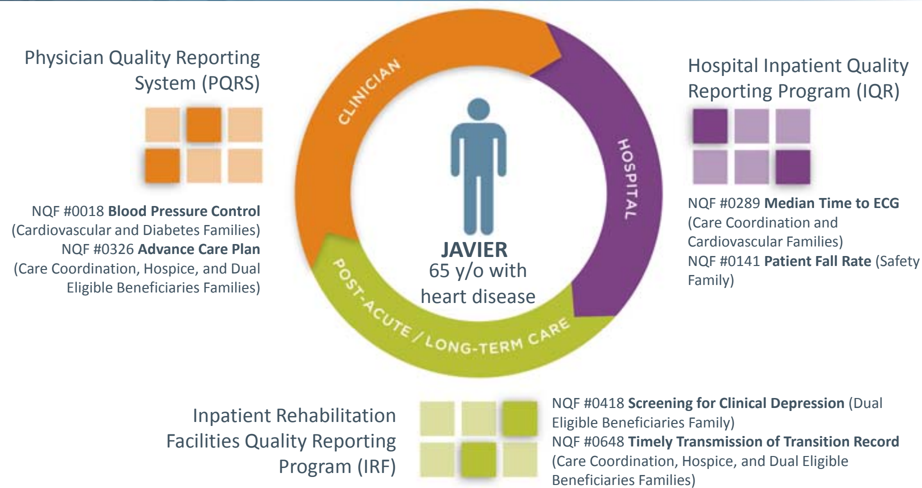
Families of Measures



Families of Measures Populating Core Sets and Program Sets



A Patient-Centered Approach to Core Measure Sets



MAP Families of Measures: Defining Affordability

Approach to Developing an Affordability Family of Measures

1. Develop consensus-based definitions of affordability

- Define the parameters of affordability taking into account multiple stakeholders' perspectives
- Conduct stakeholder outreach to understand the range of definitions and perspectives

Approach to Developing an Affordability Family of Measures

2. Identify and Prioritize High-Leverage Opportunities for Measurement

- Identification of high-leverage opportunities
  - Major cost drivers across settings and populations(e.g., vulnerable populations, commercially insured, Medicaid, Medicare)
  - National Quality Strategy
  - IOM's Healthcare Imperative: Lowering Costs and Improving Outcomes report
  - Public-sector efforts
  - Private-sector efforts
- Prioritization of high-leverage opportunities
  - Impact, improvability, inclusiveness
  - Areas of waste, inefficiency, overuse
- Consider how high-leverage opportunities span the patient-focused episode of care
  - Do the high-leverage opportunities span settings, levels of analysis?
  - How should measures addressing the high-leverage opportunities vary across settings?

Approach to Developing an Affordability Family of Measures

3. Scan of Available and Pipeline Measures that Address the High-Leverage Opportunities

- NQF-endorsed portfolio of measures
- Measures in federal and state programs
- Measures in private sector programs

Approach to Developing an Affordability Family of Measures

4. Define the Affordability Family of Measures and Measure Gaps

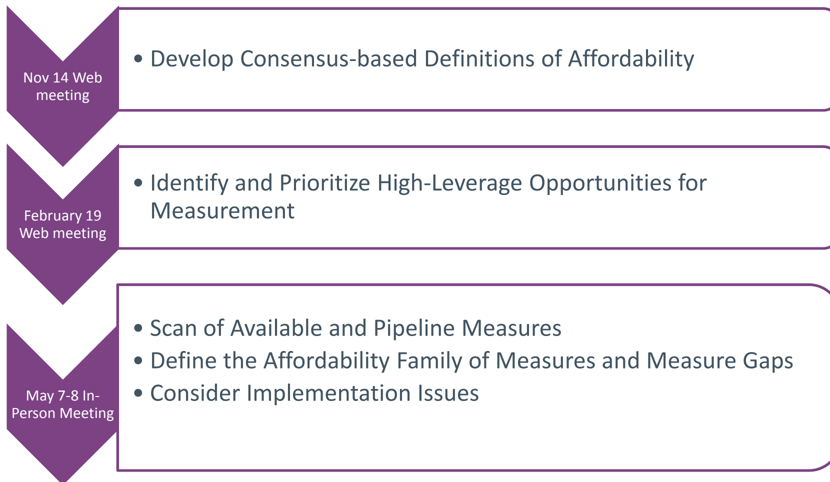
- Considerations for defining the family
  - Do available measures address relevant care settings, populations, level of analysis?
  - When appropriate are measures harmonized across settings, populations, levels of analysis?
  - What are the types of measures available for each setting, population, level of analysis?
- Consider implementation barriers

Approach to Developing an Affordability Family of Measures

5. Consider the application of principles developed through related NQF work in the context of public and private programs

- MAP will provide input on the principles developed by an expert panel convened under a complimentary RWJF-funded project
- These principles will explore:
  - Linking cost and quality
  - Attribution
  - Risk adjustment
  - Exclusions
  - Reliability/small numbers
  - Patient perspectives on affordability

MAP Affordability Task Force Timeline



Develop Consensus-based Definitions of Affordability

Overview and Approach

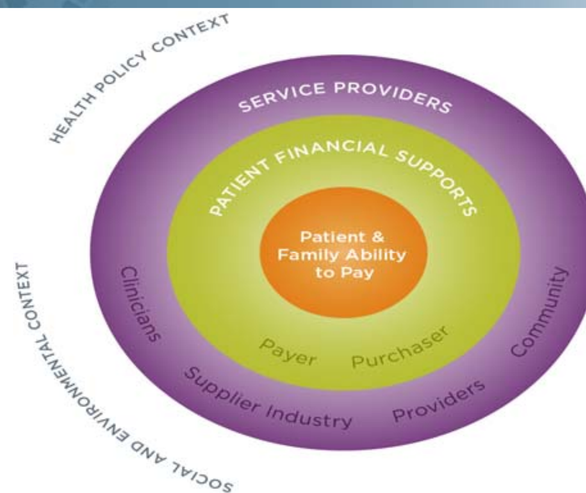
- Affordability is subjective and often used interchangeably with other terms such as value, efficiency, and cost.
- Built on prior work and solicited direct input through a public comment period asking stakeholders:
  - How does your organization define affordability? Please provide a brief description.
  - Please provide a brief definition for each term in your definition of affordability.
  - Based on your definition of affordability above, what information or data is needed to assess affordability?
  - Does your organization currently collect information on affordability? If yes, what types of data do you collect and how?
  - Please provide any additional feedback here you wish to offer that MAP should consider in defining affordability through multiple stakeholder perspectives.

Develop Consensus-based Definitions of Affordability

Conceptual Model & Definitions

- Developed a patient-centered definition of affordability
  - Affordability is **the patient and family's ability to pay for needed health care without undue burden**
    - Influenced by value, efficiency, and the actions of all stakeholders
    - Important to recognize these interdependencies and the need to hold costs down in order to sustain or increase affordability
- Created a conceptual model to illustrate the factors influencing affordability

Develop Consensus-based Definitions of Affordability



Develop Consensus-based Definitions of Affordability

Measuring Affordability

- Affordability is determined by the actions of all stakeholders
- Measurement should reflect the ability and responsibility of all stakeholders to improve quality while minimizing costs
- Defined measurement opportunities from each stakeholder perspective

Develop Consensus-based Definitions of Affordability

Community Perspectives

- Goals:
  - Improve healthcare affordability and increase access to services
  - Lower costs while eliminating disparities and addressing disease management, health promotion and disease prevention, and patient safety
- Measurement Opportunities:
  - Total cost of care and associated clinical quality outcomes at the population level
- Accountable for:
  - Promoting public health
  - Providing patient supports

Develop Consensus-Based Definitions of Affordability

Provider Perspectives

- Goals:
  - Deliver high quality care while reducing costs
  - Improve care processes and show the value of services
- Measurement Opportunities:
  - Efficiency
  - Overuse
- Accountable for:
  - Demonstrating the efficiency of services provided

Develop Consensus-based Definitions of Affordability

Clinician Perspectives

- Goals:
  - Ensure meaningful outcomes such as return to health, improved functional status, and efficiency of service delivery
  - Decrease administrative burden
  - Decrease inefficiencies and fragmentation
- Measurement Opportunities:
  - Quality and efficiency of services
- Accountable for:
  - High quality care at the lowest possible cost
  - Promoting safety, care coordination, and population health

Develop Consensus-based Definitions of Affordability

Public and Private Payer Perspectives

- Goals:
  - Identify and assess resource use
  - Purchase services based on value
  - Understand variation across markets
  - Cover costs of services while maintaining take-home wages and competiveness (private payers) or ability to fund other programs (public payers)
- Measurement Opportunities:
  - Pairing cost and quality measures
- Accountable for:
  - Providing high quality care that addresses the needs of beneficiaries while limiting costs

Develop Consensus-based Definitions of Affordability

Purchaser Perspectives

- Goals:
  - Offer efficient and high-value healthcare services that are affordable to employees and sustainable to the purchaser
  - Cover salaries and insurance premiums while maintaining competiveness
  - Offer services that improve health and productivity, reduce absenteeism, and lost work time
- Measurement Opportunities:
  - Total cost of care
  - Employer contribution
  - Information pairing cost and clinical quality

Develop Consensus-based Definitions of Affordability

Supplier/Industry Perspectives

- Goals:
  - Reduce costs
  - Maintain incentives for innovation and research and development
  - Decrease costs by increasing safety
- Measurement Opportunities:
  - Efficiency
  - Safety
  - Overuse

Goals for the Affordability Family of Measures

- Promote alignment across settings and sectors
- Create a comprehensive picture of affordability considering all perspectives
- Include measures related to cost drivers and other key components of cost
  - Use to identify high-leverage opportunities and available measures
- Build on existing measures of quality, cost, and efficiency
- Lay out a path forward to build on these initial measures and consider barriers to measurement

Approach to Developing an Affordability Family of Measures

Key Questions

- Does the Coordinating Committee agree with the definition developed by the Task Force?
- Are there additional measurement opportunities that should be considered?
- Are the goals for the family of measures on target?

Affordability Task Force Next Steps

Upcoming Meetings

- Web meeting: February 19, 1-3 PM ET
- In-person meeting: May 7-8, time TBD

MAP Families of Measures: Preview of Person- and Family-Centered Care and Population Health Families of Measures

MAP Families of Measures

- **MAP Families of Measures:**
  - Provide a pathway to align measures of quality and cost across public and private programs
  - Indicate the highest priorities for measurement, best available measures that should be used in public reporting and payment programs, and critical measure gaps that must be filled to enable a more complete picture of quality.

MAP Families of Measures

Application of Families

- Measures Under Consideration that are included in MAP families are noted as such in pre-rulemaking materials, and can help guide recommendations on measure selection
  - Inclusion in multiple families may be a particularly important indicator of measures with strong potential to promote alignment and fill important gaps
- More than half of the measures in MAP families are finalized for use in one or more HHS programs, with a majority of these also used in one or more private programs

Approach to Developing Families of Measures

1. Identify and prioritize high-leverage opportunities for measurement
2. Perform a scan for currently available and pipeline measures that address the high-leverage opportunities
   - Ongoing NQF projects on related topics will serve as primary inputs for the MAP families, with potential additional measures obtained through other pathways such as NQF's new measure inventory pipeline
3. Establish consensus on which measures are included in the family
4. Identify measure gaps and limitations, such as implementation barriers

Key Elements for a Person- and Family-Centered Care Family of Measures

- Focused on the NQS priority: *"Ensuring that each person and family are engaged as partners in their care."*
- Performance measurement assessing person and family centered care should consider:
  - Patients' ability to understand clinical instructions and their confidence in managing chronic conditions
  - Patient and family involvement in decisions about healthcare, including joint development of treatment goals and longitudinal plans of care incorporating patients' expressed values and preferences
  - Patient experience with care and patient reported outcomes

Person- and Family- Centered Care Family of Measures

Key Questions:

1. What public or private initiatives are using measures that assess person- and family-centered care could be readily implemented in accountability programs?
2. What are the key implementation barriers to developing and using measures of person- and family-centered care?
3. Where are the greatest opportunities to promote person- and family-centered care by creating this family of measures?

Key Elements for a Population Health Family of Measures

- Focused on the NQS priority: "Working with communities to promote wide use of best practices to enable healthy living."
- Performance measurement assessing population health should promote health and well-being by:
  - Supporting community interventions that result in improved social, economic, and environmental conditions
  - Encouraging adoption of healthy lifestyle behaviors across the lifespan
  - Improving receipt of effective clinical preventive services in both clinical and community settings

Population Health Family of Measures

Key Questions

1. How much emphasis should be placed on including measures of social and environmental determinants of health, recognizing that relatively few endorsed measures on these topic are available at this time?
2. What role might this family of measures play in helping to inform non-traditional quality measurement/improvement programs, such as community health needs assessments?
3. More broadly, how might the population health family of measures be best used to help bridge the divisions between measuring quality of clinical care and public health?

MAP Families of Measures Task Forces Timelines

- **March** : MAP task forces web meetings to identify high-leverage opportunities
- **April-May**: MAP task forces In-person meetings to identify measures for inclusion in the families and prioritize gaps
- **June**: MAP Coordinating Committee in-person meeting to review and finalize recommendations
- **June**: 3-week public comment period on draft Report
- **July 1**: MAP Families of Measures Report due to HHS

Round-Robin Discussion: Determining Potential Measure Impact and Improving MAP's Processes

MAP Approach to Assessment of Potential Measure Impact

Assessing Potential Measure Impact

Background

- The Affordable Care Act requires HHS to assess the impact of quality and efficiency measures used in federal healthcare programs.
- HHS requested that MAP provide input on the potential impact of quality measures under consideration that MAP recommends for future use in federal programs.

Assessing Potential Measure Impact

How to Assess Potential Measure Impact

1. Clearly define "impact."
   - Use NQS as a guiding framework.
   - Use the RE-AIM Framework.

Reach	To what extent do the quality measures address the CMS populations of interest?
Effectiveness	Have the outcomes of measures improved in relations to the three aims?
Adoption	What changes have occurred in provider behavior and in health system behavior in response to the measurement programs?
Implementation	To what extent did CMS implement the program as initially intended?
Maintenance	Has performance changed over time? What factors are associated with those changes? Which measures are lagging and among which providers?

Assessing Potential Measure Impact

How to Assess Potential Measure Impact

2. Examine the extent to which measures under consideration can help program measure sets meet the MAP Measure Selection Criteria (MSC), particularly through **increasing measure alignment** and **closing priority performance gaps.**

Assessing Potential Measure Impact

How to Assess Potential Measure Impact

3. Closely integrate with parallel efforts that have related objectives for assessing measure impact.
   - Work with CMS to incorporate the outputs of its Technical Expert Panel and contractors related to impact assessment.
   - Strengthen feedback loops:
     - Continue using QPS portfolios.
     - Gather input from open commenting on measures.
     - Reach out to measure developers and other stakeholders.
     - Continue to update the MSC based on results of ongoing retrospective analyses and evaluations.

Complementary Roles of CMS Technical Expert Panel and MAP Assessment of Measure Impact

	CMS TEP	MAP
Perspective	Retrospective evaluation	Prospective evaluation
Composition	Primarily academic and technical experts	Broad multi-stakeholder group with diverse backgrounds
Primary Anticipated Output	Detailed analyses of impact, which may be at the individual measure level	Broad assessment of the potential impact of adding new measures under consideration to measure sets
Cross-Effort Representation	George Isham – TEP co-chair; Karen Adams and Allen Leavens – TEP members; CMS staff	George Isham – Coordinating Committee co-chair; Karen Adams and Allen Leavens – NQF staff; CMS staff
Funding	CMS contract with HSAG	No separate funding at this time beyond CMS funding of MAP pre-rulemaking activities

Coordinating Committee Recommendations on Impact

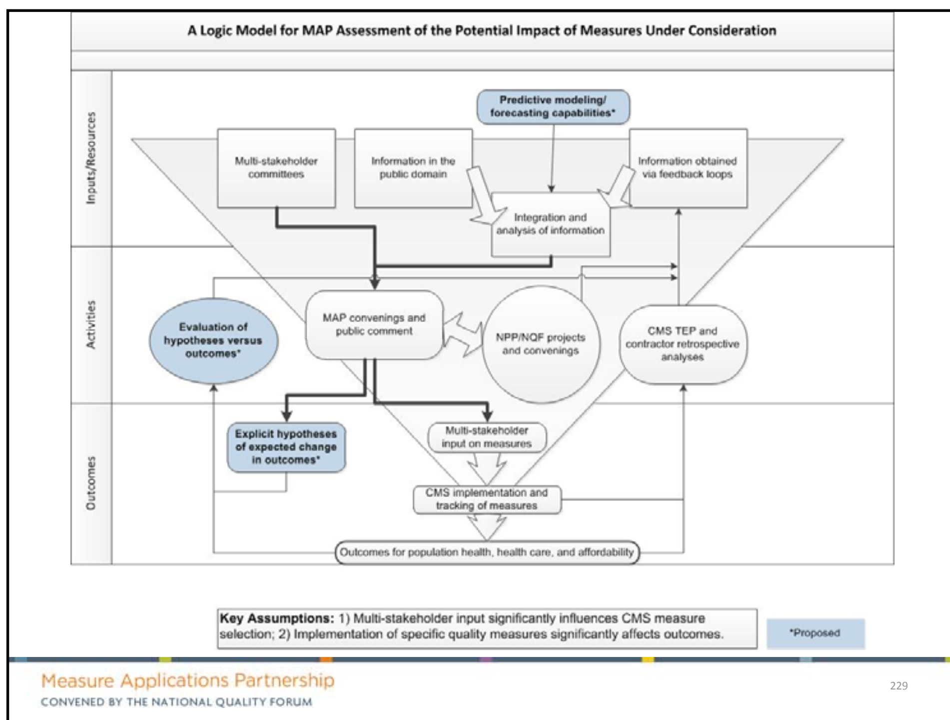
At the October 3, 2013 MAP Coordinating Committee meeting, the group's recommendations for further enhancements included:

- Seek and utilize additional quantitative and qualitative information on measures.
- Ensure that both potential positive and negative impacts are evaluated.
- Consider a stronger focus on measures that address upstream health determinants of large populations.
- Look beyond general impact to variations in impact for different populations that may signal disparities.
- For selected measures, develop explicit hypotheses and/or estimates on the range of impact that can be evaluated against outcomes at a later time.

Next Steps for Assessing Potential Impact of Measures

After the October 3, 2013 Coordinating Committee meeting, a small group of MAP members met to discuss potential next steps. Their recommendations include:

1. Develop a draft logic model capturing existing steps, and potential additions, in MAP's processes that are important in assessment of measure impact
2. Take a consumer-oriented approach to assessment of potential impact of measures
3. Do a stratified assessment of impact for purposes of feasibility and clarity



Questions for Coordinating Committee Discussion

- Does the draft logic model capture the essential elements and processes related to MAP assessment of potential measure impact? What might need to be changed or added?
- How can MAP take a consumer-oriented approach to assessment of potential measure impact?
- Which components of the impact assessment should be stratified?
- Should MAP now begin to formulate hypotheses about the potential impact of measures that are being recommended, with the expectation that these will be assessed against outcomes at a later time? If so, what is an appropriate level of detail?

Opportunity for Public Comment

Upcoming Activities

Public comment on Draft Pre-Rulemaking Report
January 13-27, 2014

Pre-Rulemaking Final Report Due to HHS
February 1, 2014

HIX QRS Report Due to HHS
January 24, 2014

MAP Dual Eligible Beneficiaries Workgroup Meeting
Web Meeting - Mid-March
In-person Meeting – April 10-11, 2014

Upcoming Activities

MAP Affordability Families of Measure Task Force
Web Meeting – February 19, 2014, 1-3pm ET
In-person Meeting – May 7-8, 2014

MAP Population Health Families of Measure Task Force
Web Meeting – March 11, 2014, 1-3pm ET
In-person Meeting – April 9, 2014

MAP Person- and Family-Centered Care Families of Measure Task Force
Web Meeting – March 26, 2014, 1-3pm ET
In-person Meeting – May 12, 2014

Thank You for Participating in MAP Activities