MEASURE APPLICATIONS PARTNERSHIP

MAP 2019 Considerations for Implementing Measures in Federal Programs: Merit-Based Incentive Payment System (MIPS) and Medicare Shared Savings Program (SSP)

FINAL REPORT

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NATIONAL QUALITY FORUM

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CONTENTS

GUIDANCE ON CROSS-CUTTING ISSUES FOR MIPS AND SSP

Summary

- Appropriate attribution is critical for accurate performance assessment and provider engagement in accountability programs.
- Cost measures must be aligned with balancing measures (e.g., clinical quality measures, efficiency measures, access measures, and appropriate use measures) to ensure delivery of high-quality care.

The Measure Applications Partnership (MAP) provides multistakeholder, pre-rulemaking input to the Centers for Medicare & Medicaid Services (CMS) on measures under consideration for payment and reporting programs. This year, MAP reviewed measures under consideration for the following programs:

- **Merit-Based Incentive Payment System (MIPS)** – MIPS is one of two tracks in the Quality Payment Program (QPP) policy designed to reform Medicare Part B payments. Individual clinicians self-select quality measures to submit to CMS. A clinician who participates in an Advanced Alternate Payment Model (Advanced APM) is excluded from MIPS.
- **Medicare Shared Savings Program (SSP)** – SSP creates incentives for healthcare providers to work together voluntarily to coordinate care and improve quality for their patient population. Eligible providers, hospitals, and suppliers may participate in the SSP by creating or participating in an Accountable Care Organization (ACO). If ACOs meet program requirements and the ACO quality performance standards, they are eligible to share in savings.

MAP's pre-rulemaking recommendations for measures in these programs reflect the MAP Measure Selection Criteria (MSC) and how well the measures address the goals of the program. The MSC highlight characteristics of an ideal measure set. The MSC complement program-specific statutory and regulatory requirements. The MSC focus on selecting high-quality measures that address the aims of better care, healthy people/communities, and affordable care; fill critical measure gaps; and increase alignment among programs. The selection criteria seek measures that are NQF-endorsed whenever possible; address a performance gap; diversify the mix of measure types; relate to person- and family-centered care and services; relate to disparities and cultural competency; and promote parsimony and alignment among public and private quality programs.

OVERARCHING THEMES

Emphasizing Appropriate Attribution and Level of Analysis for Incorporated Measures

MAP emphasized the importance of attribution, or the assigning of patients and their outcomes to the appropriate accountable unit (e.g., a clinician, a group of clinicians, an ACO), for performance measures that are incorporated into payment programs. MAP members noted that the measures under consideration routinely represent important and relevant clinical topics. However, MAP discussed that the measures need both to assess high-priority topics and to demonstrate that they can evaluate performance at the appropriate level of analysis to ensure the information provided is meaningful and actionable. Included measures must be actionable as well as valid and reliable at the level of analysis of the program.

Appropriate attribution is essential to the success of value-based purchasing. Attribution can help to ensure patients have a clinician or team of clinician to take responsibility for their care and serve as their primary advocate who can help coordinate their care, navigate a fractured health care system, and promote high-quality outcomes. Accurate attribution is also essential to empowering patients to be informed healthcare consumers. Patients want to understand who is responsible for their care, and many want a say in determining who the individual or group of clinicians is responsible for their care. However, measures that are not appropriately attributed and applied at the correct level of analysis can diminish the value of measurement for both clinicians and patients. For example, MAP members noted that selecting the appropriate quality measures for accountability programs can have enormous impact on the acceptance of the program and engagement of clinicians. On the other hand, inappropriate attribution can assign incorrect results. This can cause high performers not to receive the scores they deserve, leading to demoralization, burnout, and a lack of confidence in measure results, and potentially undermining the relevance of the performance measurement enterprise by providing confusing and potentially contradicting information to consumers.

MAP emphasized these concerns when reviewing measures under consideration. Throughout the deliberations, MAP frequently did not recommend measures that lack established results at the proper level of analysis. Furthermore, MAP members repeatedly recommended that measures with promising testing results undergo the NQF endorsement process to ensure that they are valid, reliable, and are appropriately attributed to a payment program's level of analysis.

Aligning Cost Measurements with Quality Improvement Efforts

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires that cost measures implemented in MIPS include consideration of clinically coherent groups, specifically patient condition groups or care episode groups. MAP acknowledged that implementing cost measurement is a critical aspect of recognizing high-value care. NQF has established a framework for the use of cost and resource measures in the context of quality. NQF's work on endorsing cost and resource use measures emphasizes that measures of cost and quality must be aligned in order to truly understand the efficiency and value of care. Moreover, NQF has defined efficiency broadly as the resource use (or cost) associated with a specific level of performance with respect to the other five Institute of Medicine (IOM) aims of quality: safety, timeliness, effectiveness, equity, and patient-centeredness.

Through its pre-rulemaking work, MAP emphasized the importance of aligning cost and quality measures to truly understand efficiency while protecting against potential negative unintended consequences of cost measures such as the stinting of care or the provision of lower quality care. MAP provided several recommendations to safeguard quality of care while measuring the cost of the care provided. First, MAP recommended that balancing measures be incorporated into the program when feasible. These balancing measures could include clinical quality measures, efficiency measures, access measures, and appropriate use measures.

In addition to focusing on the quality of the care provided, MAP stated that CMS should continually monitor for signs of inequities of care. MAP specifically noted a concern for stinting on care, which would disproportionately impact higher risk patients. Relatedly, MAP recommended clinical and social risk adjustment models to incentivize providers who demonstrate expertise when dealing with increased risk.

Lastly, MAP commented on the need to link clinician behaviors to cost. MAP members appreciated that CMS used technical expert panels to determine which components of cost an assessed clinician or group can control. MAP reinforced the need for this process to be transparent and understandable to clinicians who are being evaluated. MAP members stated that the measure testing results must be available and demonstrate appropriate attribution. MAP heard several public comments that the testing process for the cost measures was rapid and only limited information was made available. MAP recommended that CMS continue to disseminate testing information and educate clinicians. Additionally, MAP stated that continuous feedback should be collected to gauge how measures are performing after implementation.

CONSIDERATIONS FOR SPECIFIC PROGRAMS

Merit-Based Incentive Payment System (MIPS)

The Merit-Based Incentive Payment System (MIPS) was established by MACRA. MIPS consolidated Medicare's existing incentive and quality reporting programs for clinicians into a single program. MIPS makes positive and negative payment adjustments for Eligible Clinicians (ECs) based on performance in four categories:

- Quality
- Cost
- Advancing care information
- Improvement activities

To meet the quality component of the program, individual ECs or groups of ECs choose six measures to report to CMS. One of these measures must be an outcome measure or other high-priority measure. Clinicians can also choose to report a specialty measure set. In the 2018-2019 pre-rulemaking deliberations, MAP reviewed 21 measures for the MIPS program.

MAP Decision: Conditional Support for Rulemaking

MAP conditionally supported 17 measures for MIPS. Of these, eleven measures were under consideration for the cost domain of the program. MAP conditionally supported ten episode-based cost measures pending NQF endorsement. MAP recognized the need to reduce healthcare costs but cautioned that measures must be accurate and actionable. MAP noted that CMS and the Cost and Efficiency Standing Committee should continue to evaluate the risk adjustment model of these measures and consider the potential need to account for social risk factors in the model. MAP also noted that review of the measures should ensure an appropriate attribution methodology and that the measure adequately addresses the issue of small numbers. MAP emphasized the need to ensure that cost measures truly address factors within a clinician's reasonable control and recommended the Standing Committee consider if there is a demonstrated link between clinician behavior and the costs captured by the measure.

In addition to the episode-based cost measures, MAP conditionally supported MUC18-148 *Medicare Spending per Beneficiary (MSPB) Clinician Measure* pending NQF endorsement. MAP noted that this measure would be an update to the existing MSPB measure in MIPS but noted that neither the updated nor the original measure has been reviewed by NQF Cost and Efficiency Standing Committee, limiting the ability of the group to determine the validity of the changes to the measure. MAP noted a number of specific considerations for this measure. Specifically, MAP urged CMS to continue testing the changes to this measure, which are removing costs that are unlikely related to the clinician and a new attribution model, to ensure that they produce the intended results. In particular, MAP noted the need to ensure the measure demonstrates validity and reliability at the National Provider Identifier (NPI) level. MAP also noted the desire to avoid double counting clinician costs in the total cost measures and the episode-based cost measures and for CMS to consider consolidating the MSPB and Total Per Capita Cost measure also used in MIPS to avoid overlap. MAP raised concern about the challenges of getting access to field test data. CMS should monitor for unintended consequences to patients such as under treatment, impact on technology innovation, and access to treatment for high-risk, high-resource use patients. MAP urged CMS to continuously test and refine the risk adjustment model and incorporate social risk factors, when appropriate. Lastly, MAP also recommended that QIOs could assist in providing education on this measure to clinicians.

MAP reviewed and conditionally supported two patient-reported outcome measures for MIPS. MAP also conditionally supported MUC18-063 *Functional Status Change for Patients with Neck Impairments* and MUC18-038 *International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) Change 6-12 Months after Diagnosis of Benign Prostatic Hyperplasia* with the condition of NQF endorsement. MAP was encouraged by the inclusion of these patient-reported outcome performance measures (PRO-PM) in the program. Historically, MAP has underscored the importance of including additional PRO-PMs in both MIPS and SSP. With respect to MUC18-063, MAP emphasized the importance of ensuring that the proprietary survey tool remain freely available to providers. In reference to MUC18-038, MAP members expressed concerns about the measure's ability to feasibly obtain response rates electronically or in a clinic setting. Developers noted that patients may be prompted to complete this survey upon check-in, via tablet, or post check-in. Developers clarified that the measure has been tested using multiple EHRs. MAP members encouraged the developer to demonstrate feasibility of collecting the measure through multiple EHRs.

MAP reviewed three measures under consideration addressing appropriate care. MAP conditionally supported MUC18-031 *Time to Surgery for Elderly Hip Fracture Patients* pending NQF endorsement. MAP recognized the strong clinical evidence base for this measure but noted the developer and the NQF Standing Committee evaluating it for endorsement should review the exclusion criteria and consider other clinical situations where this surgery may be inappropriate such as for palliative care patients or patients with cardiovascular contraindications for surgery. MAP also noted the need to clarify the timeframe of the episode such that time zero is the time of admission and consider the impact of transfers. MAP also conditionally supported MUC18-032 *Discouraging the Routine Use of Occupational and/or Physical Therapy after Carpal Tunnel Release* with the condition of NQF endorsement. MAP highlighted concerns about the measure's lack of exclusions when receiving clinically appropriate physical or occupational therapy for another condition that occurs concurrently with a carpal tunnel release and recommended the Standing Committee consider the exclusions when reviewing the measure for endorsement. Finally, MAP conditionally supported MUC18-047 *Multimodal Pain Management* with the condition of NQF endorsement. MAP members voiced support for this measure as an important clinical topic in light of the current opioid epidemic.

MAP also conditionally supported MUC18-057 *Annual Wellness Assessment: Preventive Care* with the condition of NQF endorsement and harmonization of subcomponents within the MIPS program. MAP conditionally supported this measure pending NQF endorsement and harmonization of the subcomponents of this measure with existing measures in the program. MAP was encouraged that the measure is electronically specified, but raised concerns about the misalignment between MUC18-057 and the subcomponent measures currently included in MIPS. MAP recommended that developers incorporate exclusions for cognitive impairment and limited life expectancy (hospice, palliative care, advanced cancer, and others), and that exclusions be consistent among measures. Finally, MAP also highlighted the potential for underreporting this measure and cautioned that this measure includes services for which the clinical research and guidance is mixed (e.g., annual mammograms). MAP encouraged the Standing Committee reviewing this measure for endorsement to consider this variation among guidelines and to assess if the measure includes appropriate exclusion criteria.

MAP Decision: Do Not Support With the Potential for Mitigation

MAP did not support three measures for rulemaking with the potential for mitigation. MAP recognized the clinical importance of MUC18-062

Adult Immunization Status (also considered for the SSP); however, MAP did not support this measure for rulemaking with the potential for mitigation, which would include specifying and testing the measure at the clinician level of analysis. Additionally, MAP noted the revised measure and testing should be submitted for NQF endorsement review. MAP cautioned there is a need for a review with more detailed specifications while considering variability of benefits (i.e., reimbursement for vaccinations), vaccine shortages, data availability/feasibility, and more clarity into the timeframe of reporting. Finally, MAP noted that the composite measure required internal harmonization of its component parts.

MAP similarly did not support MUC18-048 *Potential Opioid Overuse* for rulemaking with the potential for mitigation. MAP identified distinctions in the morphine milligram equivalents dose between this measure and the related measures that MAP conditionally supported for inclusion in the SSP (MUC18-077 *Use of Opioids from Multiple Providers in Persons without Cancer* and MUC18-078 *Use of Opioids at High Dosage in Persons without Cancer*). MAP highlighted the potential reporting burden for physicians reporting under both SSP and MIPS and therefore recommended mitigation through harmonization with MUC18-077 and MUC18-078. Mitigation would include coordination of the appropriate morphine milligram equivalents (MME) dose. MAP members recognized the importance of measures that could address inappropriate use of opioids but expressed concern that a lack of coordination across measures around issues such as MME dose could undermine the value of measurement as a mechanism to address the current epidemic. In particular, MAP expressed concerns about the varying MME dose in this measure with other measures under consideration, specifically MUC18-077 and MUC18-078. MAP was encouraged by comments from measure developers about efforts to align measures around the current CDC guidelines and emphasized the importance of harmonization across related opioid measures and alignment across programs (e.g., Medicare and Medicaid). MAP encouraged developers to remain coordinated in their efforts to develop measures addressing opioid use.

MUC18-149 is discussed in more detail in the subsequent section. MUC18-149 *Total Per Capita Cost* with the condition of NQF endorsement. Finally, MAP did not support MUC18-149 *Total Per Capita Cost* for rulemaking with the potential for mitigation. Mitigating factors include greater transparency around the attribution model and testing results. MAP noted that this measure is an updated version of the total per capita cost measure currently used in MIPS and the potential updates include changes in the attribution methodology. MAP raised concerns about the lack of available information on the measure's validity testing. MAP also noted a need to better understand how this measure handles the issue of small numbers and evaluate if there is a need to include social risk factors in the measure's risk adjustment model. Finally, MAP also noted the desire to avoid double counting clinician costs in the total cost measures and the episode-based cost measures and for CMS to consider consolidating the MSPB and TPCC measures to avoid overlap.

MAP Decision: Do Not Support

MAP did not support MUC18-119 *Psychoses/ Related Conditions* for rulemaking. MUC18-119 was one of the eleven episode-based cost measures submitted for consideration. MAP expressed concerns about the measure's validity with respect to the attribution model, noting that the measure may ineffectively assess quality of care in the target population due to several factors which fall outside the clinician's locus of control. MAP noted that patients with psychosis or related conditions require community supports but the availability of such supports can vary significantly depending on where a patient resides. MAP also noted that these conditions are often accompanied by a number of physical comorbidities that are not treated

by the clinician managing the patient's mental health but which could influence the results of this measure. Finally, MAP noted that many outpatient behavioral health clinicians do not accept Medicare or Medicaid and cautioned that this measure could exacerbate access issues.

Medicare Shared Savings Program (SSP)

SSP was established by Section 3022 of the Affordable Care Act (ACA). Eligible providers, hospitals, and suppliers may participate in SSP by creating or participating in an Accountable Care Organization (ACO). ACOs that meet the program requirements and quality standards are eligible for shared savings. There are four shared savings options: (1) one-sided risk model (providers do not assume shared losses); (1+) two-sided risk model (providers assume limited losses [less than higher tracks]); (3) two-sided risk model (sharing of savings and losses and possibly sharing in a greater portion of savings than track 1 ACOs); and (4) two-sided risk model (sharing of savings and losses with greater risk than track 2, but possibly sharing in the greatest portion of savings if successful). SSP aims to promote accountability for a patient population, care coordination, and the use of high-quality and efficient services.1

MAP considered five measures for the Medicare Shared Savings Program (SSP). MAP conditionally supported three measures, two of which address opioid overuse: MUC18-077 *Use of Opioids from Multiple Providers in Persons without Cancer* and MUC18-078 Use of *Opioids at High Dosage in Persons without Cancer*. MAP recognized the importance of these measures given the current public health opioid crisis and supported the measures with the condition that duplication is considered between these measures and MUC18-079. MAP members recognized the importance of measures that could address inappropriate use of opioids but expressed concern that a lack of coordination across measures around issues such as MME dose could undermine the value of measurement as a mechanism to address the current epidemic. In particular, MAP expressed concerns about the varying MME dose in this measure with other measures under consideration, specifically MUC18-048. MAP was encouraged by comments from measure developers about efforts to align measures around the current CDC guidelines and emphasized the importance of harmonization across related opioid measures and alignment across programs (e.g., Medicare and Medicaid). MAP encouraged developers to remain coordinated in their efforts to develop measures addressing opioid use. Additionally, MAP cautioned that CMS would need to ensure that the required Medicare Part D data is readily available to ACOs. MAP also highlighted the importance of exclusions for palliative care in the measure's specifications.

MAP also conditionally supported MUC18-062 *Adult Immunization Status* (also considered for MIPS) pending NQF endorsement. MAP highlighted the need for a review with more detailed specifications while considering variability of benefits (i.e., reimbursement for vaccinations), vaccine shortages, data availability/feasibility, and more clarity into the timeframe of reporting, and MAP noted that the composite measure required internal harmonization of its component parts. Finally, the MAP recommended that developers test the measure at the ACO level of analysis.

MAP did not support MUC18-106 *Initial Opioid Prescription Compliant with CDC Recommendations* for rulemaking with the potential for mitigation, which would include testing the measure at the ACO level. Although MAP recognized the clinical importance of addressing opioid overuse in the SSP, MAP identified the need for substantive updates to the measure. Most notably, MAP recommended that the developer specify and test the measure at the ACO level of analysis.

Finally, MAP did not support MUC18-079 *Use of Opioids from Multiple Providers and at High Dosage in Persons without Cancer* for rulemaking.

MAP noted redundancies between this measure and MUC18-077 and MUC18-078. In an effort to remain parsimonious, the MAP favored the former two measures for inclusion in the SSP.

Overall, MAP received 38 comments on the proposed measures for the SSP program. Several commenters expressed support for MUC18-062, and one commenter recommended harmonization prior to program implementation. Several commenters expressed the need for palliative care exclusions for MUC18-077, MUC18-078, and MUC18-079 while others highlighted unintended consequences. Finally, commenters called for refinements to the exclusions for MUC18-106 and expressed concerns about the measure's suitability for ACOs, noting unintended consequences.

ENDNOTE

1 CMS. About the program website. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html. Last accessed December 2018.

APPENDIX A:
Program Summaries

The material in this appendix was drawn from the CMS Program Specific Measure Priorities and Needs document, which was released in May 2018.

Merit-Based Incentive Payment System

Program History and Structure

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS by law to implement an incentive program for clinicians. This program, referred to as the Quality Payment Program, provides two participation pathways for clinicians:

- The Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)

MIPS combines three Medicare "legacy" programs—the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals—into a single program. Under MIPS, there are four connected performance categories that will affect a clinician's future Medicare payments. Each performance category is scored independently and has a specific weight, indicating its contribution towards the MIPS final score. The MIPS performance categories and their 2018 weights towards the final score are: Quality (50 percent); Advancing Care information (25 percent); Improvement Activities (15 percent); and Cost (10 percent). The final score (100 percent) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.

High-Priority Measures for Future Consideration

CMS will not propose the implementation of measures that do not meet the MIPS measure set gaps or criteria of performance. The gap areas include, but are not limited to, orthopedic surgery, pathology, radiology, mental health and substance use conditions, oncology, palliative care, and emergency medicine. MIPS has a priority focus on outcome measures, measures that fill a topped out specialty area, and measures that are relevant for specialty providers. CMS identified outcome measures as high-priority for future measure consideration. Outcome measures show how a healthcare service or intervention influences the health status of patients; for example, the percentage of patients undergoing isolated CABG surgery who require postoperative intubation greater than 24 hours, the rate of surgical complications, or the rate of hospital-acquired infections. CMS identifies the following as high-priority for future measure consideration:

1. **Person and Family Engagement (Care is Personalized and Aligned with Patient's Goals, End of Life Care According to Preferences, Patient's Experience and Functional Outcomes**). This means that the measure should address the experience of each person and their family—and the extent to which they are engaged as partners in their care.
    a. CMS wants to specifically focus on patient-reported outcome measures (PROMs). Person- or family-reported experiences of being engaged as active members of the healthcare team and in collaborative partnerships with providers and provider organizations.
2. **Communication and Coordination of Care (Medication Management, Admissions and Readmissions to Hospitals, Seamless Transfer**

of Health Information). This means that the measure must address the promotion of effective communication and coordination of care—and coordination of care and treatment with other providers.

3. **Making Care Affordable (Appropriate Use of Healthcare, Patient-focused Episode of Care, Risk Adjusted Total Cost of Care)**. This means that the measure must address the affordability of healthcare including unnecessary health services, inefficiencies in healthcare delivery, high prices, or fraud. Measures should cause change in efficiency and reward value over volume.
4. **Making Care Safer (Healthcare-Associated Infections, Preventable Healthcare Harm)**. This means that the measure must address either an explicit structure or process intended to make care safer, or the outcome of the presence or absence of such a structure or process, and harm caused in the delivery of care. This means that the structure, process, or outcome described in "a" must occur as a part of or as a result of the delivery of care.
5. **Appropriate Use**. CMS wants to specifically focus on appropriate use measures. This means that the measure must address appropriate use of services, including measures of overuse.

The identification of topped out measures may lead to potential measure gaps. A measure may be considered topped out if measure performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. Topped out process measures are those with a median performance rate of 95 percent or higher, while nonprocess measures are considered topped out if the truncated coefficient of variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors. CMS continues to identify topped out measures through the benchmark file. The column labeled topped out in the benchmark file will indicate whether the measure is topped out with a designation of "yes". Through the use of the topped out measure criteria and additional criteria that are only intended to phase in the topped out scoring policy, CMS has identified six quality measures that will activate the special topped out scoring policy, beginning with the 2018 performance period.

The six quality measures are:

- Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin
- Melanoma: Overutilization of Imaging Studies in Melanoma
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
- Image Confirmation of Successful Excision of Image-Localized Breast Lesion
- Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description
- Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description

As topped out measures are removed from the program, CMS will monitor the impact of these removals on the quality measure specialty sets that are available for clinician reporting. CMS strongly encourages measure developers to review the benchmark file that identifies topped out measures, and develop measures that may replace those topped out measures for future program years. In addition, CMS also welcomes stakeholder suggestions to address these potential gaps within the measure sets.

Measure Requirements

CMS applies criteria for measures that may be considered for potential inclusion in the MIPS. At a

minimum, the following criteria and requirements must be met for selection in the MIPS.

CMS is statutorily required to select measures that reflect consensus among affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities. To the extent practicable, quality measures selected for inclusion on the final list will address at least one of the following quality domains: Effective Prevention and Treatment, Making Care Safer, Communication and Coordination of Care, Best Practices of Healthy Living, Making Care Affordable, or Person and Family Engagement. In addition, before including a new measure in MIPS, CMS is required to submit for publication in an applicable specialty-appropriate, peer-reviewed journal the measure and the method for developing the measure, including clinical and other data supporting the measure.

- Measures implemented in MIPS may be available for public reporting on Physician Compare.
- Measures must be fully developed, with completed testing results at the clinician level and ready for implementation at the time of submission (CMS' internal evaluation).
- Preference will be given to measures that are endorsed by the National Quality Forum (NQF).
- Measures should not duplicate other measures currently in the MIPS. Duplicative measures are assessed to see which would be the better measure for the MIPS measure set.
- Measure performance and evidence should identify opportunities for improvement. CMS does not intend to implement measures in which evidence identifies high levels of performance with little variation or opportunity for improvement, e.g., measures that are "topped out."
- Claims measures must also be reportable via another data submission mechanism (e.g., registry, eCQM). MIPS is not accepting claims only measures.
- Section 101(c)(1) of the MACRA requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals prior to implementing in MIPS. The Peer-Review Journal template provided by CMS must accompany each measures submission. Please see the template for additional information.
- eCQMs must meet EHR system infrastructure requirements, as defined by MIPS regulation. Beginning with calendar year 2019, eCQMs will use clinical quality language (CQL) as the expression logic used in the Health Quality Measure Format (HQMF). CQL replaces the logic expressions currently defined in the Quality Data Model (QDM).
  - The data collection mechanisms must be able to transmit and receive requirements as identified in MIPS regulation. For example, eCQMs being submitted as Quality Reporting Data Architecture (QRDA) III must meet QRDA – III standards as defined in the CMS QRDA III Implementation Guide.
  - eCQMs must have HQMF output from the Measure Authoring Tool (MAT), using MAT v5.4, or more recent, with implementation of the clinical quality language logic. Additional information on the MAT can be found at https://ecqi.healthit.gov/ecqm-tools/tool-library/measure-authoring-tool
  - Bonnie test cases must accompany each measure submission. Additional information on eCQM Tools and resources can be found at https://ecqi.healthit.gov/ecqm-tools-key-resources.
  - Reliability and validity testing must be conducted for measures.

  - In addition to the above, feasibility testing must be conducted for eCQMs. Testing data must accompany submission. For example, if a measure is being reported as registry and eCQM, testing data for both versions must be submitted.

- eCQM Readiness: How do I know if an eCQM is ready for implementation in MIPS

STEP 1: ASSESS AND DOCUMENT ECQM CHARACTERISTICS

Characteristic	Testing	Documentation for CMS*
Is the eCQM feasible?	Feasibility test results	NQF's feasibility score card
Is the eCQM a valid measure of quality and/or are the data elements in the eCQM valid?	Correlation of data element or measure score with "gold-standard," or face validity results	Kappa agreement between EHR extracted data element and chart abstract and/or correlation between measure score and a related external measure of quality
Is the eCQM reliable?	Provider level reliability testing for measure score in the setting which the measure is intended to be reported	Reliability coefficient using signal-to-noise or split half inter-rater reliability

*Testing results must come from at least two different EHR installations

STEP 2: ASSESS AND DOCUMENT ECQM SPECIFICATION READINESS

Requirement	Tool	Documentation for CMS
Specify eCQM according to CMS and ONC standards	Measure Authoring Tool (MAT)	MAT output to include, at minimum, HQMF and human readable files
Create value sets that use current, standardized terminologies	The National Library of Medicine's Value Set Authority Center (VSAC)	Published value sets in the VSAC that have been validated against the most recent terminology expansion with 100 percent active codes
Test eCQM logic using a set of test cases that cover all branches of logic with 100 percent pass rate	Bonnie	Excel file of test patients showing testing results (Bonnie export)

Medicare Shared Saving Program

Program History and Structure

Section 3022 of the Affordable Care Act (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Shared Savings Program that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery. The Medicare Shared Savings Program (Shared Savings Program) was designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in healthcare costs. Eligible providers, hospitals, and suppliers may voluntarily participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). If ACOs meet program requirements and the ACO quality performance standard, they are eligible to share in savings, if earned. There are four shared savings options:

Measure Requirements

Specific measure requirements include:

1. Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients.
2. Measures that are targeted to the needs and gaps in care of Medicare fee-for-service patients and their caregivers.
3. Measures that align with CMS quality reporting initiatives, such as the Quality Payment Program.
4. Measures that support improved individual and population health.
5. Measures addressing high-priority healthcare issues, such as opioid use.
6. Measures that align with recommendations from the Core Quality Measures Collaborative.

Track	Financial Risk Arrangement	Description
1	One-sided	Track 1 ACOs do not assume downside risk (shared losses) if they do not lower growth in Medicare expenditures.
Medicare ACO Track 1+ Model*	Two-sided	Medicare ACO Track 1+ Model (Track 1+ Model) ACOs assume limited downside risk (less than Track 2 or Track 3).
2	Two-sided	Track 2 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs.
3	Two-sided	Track 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 3 ACOs take on the greatest amount of risk, but may share in the greatest portion of savings if successful.

*The Track 1+ Model is a time-limited CMS Innovation Center model. An ACO must concurrently participate in Track 1 of the Shared Savings Program in order to be eligible to participate in the Track 1+ Model.

APPENDIX B:
MAP Clinician Workgroup Roster and NQF Staff

WORKGROUP CO-CHAIRS (VOTING)

Bruce Bagley, MD

Amy Moyer

ORGANIZATIONAL MEMBERS (VOTING)

American Academy of Pediatrics (inactive 2018-2019)

American Association of Nurse Practitioners
Diane Padden, PhD, CRNP, FAANP

American College of Cardiology
J. Chad Teeters, MD, MS, RPVI, FACC

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Trudy Mallinson MS, PhD

America's Physician Groups
Amy Nguyen Howell, MD, MBA, FAAFP

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Atrium Health
Scott Furney, MD, FACP

Consumers' CHECKBOOK
Robert Krughoff, JD

Council of Medical Specialty Societies
Helen Burstin, MD, MPH, FACP

Genentech
Dae Choi MBA, MPH

HealthPartners, Inc.
Kim Ritten

National Association of Accountable Care Organizations
Robert Fields, MD, MHA

Pacific Business Group on Health
Stephanie Glier

Patient-Centered Primary Care Collaborative
Ann Greiner, MS

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