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Measure Applications Partnership 2020 Considerations for Implementing Measures in Federal Programs: Clinicians

FINAL REPORT

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Guidance on Cross-Cutting Issues

Summary

- **Care coordination is critical to preventing avoidable hospital admissions and readmissions. Healthcare entities have a joint responsibility for care coordination. Accountability measures at the health plan, health system, and clinician group levels should balance appropriate attribution and shared responsibility for patient outcomes.**
- **MAP recognized that the opioid epidemic has serious implications for provider accountability, as providers have the capacity to manage pain appropriately and offset the risk of opioid use disorder.**

The Measure Applications Partnership (MAP) provides multistakeholder, prerulemaking input to the Centers for Medicare & Medicaid Services (CMS) on measures under consideration for payment and reporting programs. During the 2019-2020 cycle, 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) 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.
- **Medicare Part C and D Star Ratings** – The Part C and D Star Ratings provide beneficiaries with a reflection of Medicare Advantage (MA) and Medicare Drug Plan. The Star Ratings encompass multiple dimensions of high quality care with a focus on aspects of care within control of the plan. The Star Ratings also serve as the basis of Quality Bonus Payments (QBPs) available to high-performing MA plans.

MAP's prerulemaking 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 ideal measure sets according to NQF criteria. 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; avoid unintended consequences with benefits that outweigh burden and risk; and promote parsimony and alignment among public and private quality programs.

Overarching Themes

Care Coordination and Attribution

MAP emphasized the importance of shared accountability for performance measures of avoidable hospital admissions, readmissions, and emergency department use that are incorporated into public reporting and payment programs. Clinicians and health systems have the potential to implement care interventions that can offset disease progression and reduce high-cost, low-efficiency healthcare. Measures of patient outcomes require balancing the goals of shared accountability of clinicians and health systems, and appropriate attribution of outcomes that can be influenced by each entity.

MAP expressed concern that many care coordination measures are process measures that assess steps along a patient episode of care, but do not measure if all care is coordinated through a centralized and shared care plan for the patient. MAP also acknowledged that these measures may be appropriate in early stages of transition toward truly coordinated, holistic, and individualized care.

MAP recognized that addressing social determinants is a critical element to effective care coordination for patient transitions. However, MAP also noted the challenges with addressing these social determinants through measurement. Patient outcomes may be influenced by a patient's health status and sociodemographic factors in addition to healthcare services, treatments, and interventions. MAP acknowledged that data limitations and data collection burden may limit risk adjustment, but measures of accountability should monitor for any incorrect inferences about provider performance. Clinicians and health systems need information to understand differences in outcomes among patient cohorts to drive improvement, but MAP suggested caution on performance assessments involving social determinants.

Appropriate Opioid Measurement

MAP reviewed three health plan level measures of appropriate opioid utilization. MAP noted that the current phase of the opioid crisis is predominantly driven by an increased uptake of fentanyl-laced heroin leading to increases in overdose and death. MAP acknowledged an important shared responsibility for individual providers, health systems, and health plans to address issues of pain management and function as well as to identify and address issues associated with opioid use disorder (OUD).

MAP emphasized that the proper metrics need to be applied across the U.S. healthcare system such that opioid overdose deaths continue to decline in a manner that is verifiable. Furthermore, the metrics applied must minimize undesirable consequences such as needless suffering from pain, increases in other substance use disorders, or transitioning from prescription to illegal drugs as a result of being unable to obtain appropriate pain medication. This includes the need for increased, appropriate co-prescribing of Naloxone with opioids (for pain or for persons with OUD). Similarly, MAP called for better initial prescribing measures to balance appropriate use of opioids for pain management with associated risks. Additionally, MAP identified the need in federal quality and performance programs to include new measures assessing patient-centered analgesia treatment planning, including appropriate tapering

strategies to reasonably decrease or discontinue opioid treatment, measures of long-term recovery from OUD, and measures of physical and mental health comorbidities with OUD.

Meaningful Measures Initiative Considerations for Clinicians

MAP provided feedback to CMS' proposed changes on the Meaningful Measures Initiative as well as measurement approaches and innovations put forward by the Institute for Healthcare Improvement. MAP focused the discussion on the Meaningful Measures Initiative on advanced analytics, transparency, emerging data sources, and support for CMS' focus on maternal mortality and morbidity.

MAP encouraged CMS to continue its efforts to optimize predictive analytics and artificial intelligence to understand opportunities for quality improvement. These efforts should prioritize increased feedback to providers through actionable quality measurement and clinical decision support. MAP supported CMS' commitment to transparency and enabling consumers and patients to have the information that enables them to select providers. MAP noted that this effort should be part of a larger approach to engage and include beneficiaries in their care, including understanding the measures that are reported publicly.

Ensuring appropriate interpretation of publicly reported measures is critical to driving toward goals of health system improvement. MAP offered the example that beneficiaries could misinterpret when providers are doing well in publicly reported measures of lowered resource use or cost for beneficiaries. Providers often interpret lower resource use as patients experiencing fewer complications and other unnecessary expenditures. Patients may interpret lower resource use as fewer appropriate services being provided to manage their health. Further, MAP encouraged CMS to focus on patient safety in public reporting, allowing beneficiaries to choose healthcare providers who perform especially well. It was noted that consumers find these types of measures more intuitive and useful than many other types.

MAP supported efforts by local communities, health systems, specialty societies, and others to develop new types of performance measures using emerging data sources. There are measures already housed in qualified clinical data registries that can be taken through the NQF process and deployed into federal programs with more confidence than new measures. MAP supported efforts to move to greater electronic measurement. MAP emphasized the need for electronic clinical quality measures (eCQMs), but expressed the concern that interoperability continues to impose challenges for the implementation and meaningful use of these types of measures. This concern is particularly highlighted when patients transition between providers and the information from prior care does not travel with them, but the accountability for performance on quality measures related to the beneficiaries does. MAP also put forward that measures that draw on other electronic sources beyond the electronic health record (EHR) should be considered, including the use of all-payor data.

MAP also supported CMS' priority in addressing maternal mortality and morbidity. MAP was encouraged by CMS bringing MUC2019-114 *Maternal Morbidity* (reviewed by the MAP Hospital Workgroup) to MAP for consideration, and MAP encouraged CMS to address the U.S. maternal morbidity and mortality crisis through appropriate transition to outcomes measurement. Finally, MAP acknowledged that wellness measures represent an opportunity to align payment and quality initiatives across healthcare settings.

Considerations for Specific Programs

Merit-Based Incentive Payment System

MIPS was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MIPS consolidated preexisting Medicare 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
- Promoting interoperability
- 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 2019-2020 prerulemaking deliberations, MAP reviewed four measures for the MIPS program:

- MUC2019-28 *Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-Based Incentive Payment System (MIPS) Eligible Clinicians and Eligible Clinician Groups*
- MUC2019-27 *Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups*
- MUC2019-66 *Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate*
- MUC2019-37 *MIPS Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions*

MAP Decision: Support for Rulemaking

MAP considered for inclusion in the MIPS program MUC2019-28 *Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) Eligible Clinicians and Eligible Clinician Groups*. This respecified measure attributes outcomes to MIPS-participating clinicians and clinician groups and assesses each provider's complication rate, defined as any one of the specified complications occurring from the date of index admission to up to 90 days after the date of the index procedure.

MAP supported MUC2019-28 for rulemaking. MAP noted that this measure can improve the quality of surgical care delivery and follow-up care for a common and costly surgical procedure performed for Medicare beneficiaries. MAP agreed that patient-reported outcomes performance measures related to TKA and THA would also be desirable but would be complementary to this measure. MUC2019-28 is endorsed as NQF 3493 and is a respecified version of *Hospital-level Risk-standardized Complication rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)*

(NQF 1550), which was developed for patients aged 65 years and older using Medicare claims. MAP noted that NQF 1550 is currently being used in the CMS Hospital Inpatient Quality Reporting Program, though it underwent substantial respecification to allow for clinician and clinician group attribution. In adapting the hospital-level measure for MIPS-eligible clinicians, the same cohort of patients will be measured, but the outcomes will be attributed to a larger number of healthcare entities with a shared responsibility for delivery of high quality postsurgical care. The MAP Rural Health Workgroup noted that this measure will be limited to clinicians/clinician groups with at least 25 patients, limiting concern of low case volume for rural providers. However, access to supportive services prior to surgery will be even more critical when these procedures are performed in the outpatient setting, and access to such services may be more limited in rural areas.

MAP Decision: Conditional Support for Rulemaking

MAP conditionally supported two measures for MIPS, pending review and endorsement by the appropriate NQF Standing Committee.

MAP reviewed MUC2019-27 *Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups*. This respecified measure attributes outcomes to MIPS participating clinician groups and assesses each group's readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the measure's specialty cohorts based on discharge condition categories or procedure categories: medicine, surgery/gynecology, cardiorespiratory, cardiovascular, and neurology.

MAP conditionally supported MUC2019-27 for rulemaking. Support for this measure is pending removal and replacement of NQF 1789 in the MIPS program measure set with this measure, and NQF Standing Committee review at the physician group level in the fall 2019 cycle. MAP noted that this measure is a respecified version of the measure *Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any conditions* (NQF 1789), which was developed for patients 65 years of age and older using Medicare claims.

MAP encouraged CMS to ensure the validity of the measure and the attribution approach, particularly for smaller case volumes. MAP encouraged CMS to carefully consider the attribution method for groups of specialists. MAP urged CMS to investigate the reliability of the attribution method and adjust the model should it inappropriately attribute patients to specialists.

MAP emphasized the importance of addressing unplanned readmissions, and noted that physician groups can influence this outcome by supporting appropriate medication reconciliation at discharge, reducing infection risk, and ensuring proper outpatient follow-up. MAP suggested that this measure promotes a systems-level approach by clinicians, and suggested a future focus on readmissions for especially high-risk conditions such as COPD and heart failure. MAP noted that the NQF Standing Committee had requested additional information from the developer on reliability performance of this measure at various case sizes for the physician group level of analysis in the course of the consensus development process (CDP).

MAP also noted that the NQF Standing Committee expressed support for the attribution of physician groups within MUC2019-27 in coordination with hospitals and other members of the care team in the spring 2019 cycle. At the time of review, the NQF Standing Committee had encouraged

the developer to expand testing of socio-demographic status (SDS) risk factors for this measure. The NQF Standing Committee did not support this measure at the individual clinician level. The endorsement consideration of this measure was deferred to the fall 2019 cycle. The MAP Rural Health Workgroup did generally support this measure but expressed concern that it may disadvantage rural providers and may result in unfair penalties.

MUC2019-66 Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate was also reviewed by MAP. This measure identifies the percentage of adult hemodialysis patient-months using a catheter continuously for three months or longer for vascular access, attributable to an individual clinician practitioner or group practice.

MAP conditionally supported MUC2019-66 for rulemaking. As the measure has not been reviewed by an NQF Standing Committee to determine the strength of the measure's reliability and validity, MAP's support is conditional upon NQF endorsement. MAP noted that the use of a long-term catheter has a higher observed mortality rate than the use of arteriovenous fistula; thus, this measure has the potential to provide greater quality of care for patients by reducing the associated mortality and morbidity from long-term catheter use.

MAP noted that a modified version of this measure is currently being used in a CMS quality program—the End-Stage Renal Disease Quality Improvement Program (ESRD QIP). The measure is being modified to allow for individual clinician and clinician groups specifications. While MAP questioned the ability of providers to move patients from catheters to fistulas, the measure developer noted that clinicians can influence this, as evidenced by rate improvements after implementation of this measure in ESRD QIP. MAP expressed concern on the reliability of the measure and encouraged CMS to rigorously test the measure. The Rural Health Workgroup noted that kidney diseases are prevalent conditions in rural populations. They emphasized that rural patients on dialysis are older and have more comorbidities, and voiced concern that these patients might be pressed to use a fistula, even when there is less benefit.

MAP Decision: Do Not Support with the Potential for Mitigation

MAP also reviewed *MUC2019-37 MIPS Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions* for the MIPS program. This measure was also considered by MAP for inclusion in the SSP; MAP deliberations on this measure in the SSP quality measure set are included under the SSP section. This measure captures the annual risk-standardized rate of acute, unplanned hospital admissions among Medicare fee-for-service (FFS) patients aged 65 years and older with multiple chronic conditions (MCC).

MAP did not support MUC2019-37 for rulemaking in MIPS with potential for mitigation. The measure is a modified version of an existing NQF-endorsed measure (NQF 2888), last reviewed for endorsement in 2016. MAP noted that the newly developed measure differs from its predecessor in a few ways:

- Cohort: CMS added diabetes as a cohort-qualifying condition.
- Outcome: CMS narrowed the outcome to focus on admissions where risk can be reduced by providing high-quality ambulatory care, so that the measure can be used to assess ambulatory (rather than ACO-wide) care quality.

- Risk-adjustment: CMS added social risk factors to the risk-adjustment model.

MAP noted several potential areas of mitigation for the measure: 1) The measure should apply to clinician groups, not to individual clinicians; 2) The measure should use a higher reliability threshold, e.g., 0.7; 3) The measure developer should consider the NQF guidance on attribution and consider patient preference and selection as a method of [attribution](#); and 4) The measure should undergo the NQF endorsement process. MAP suggested that rather than moving directly to this outcome measure, process measures that would get to the desired outcome might be an appropriate stepwise approach to increasing accountability. The MAP Rural Health Workgroup noted that chronic conditions included in this measure are prevalent in rural residents. However, the Rural Health Workgroup does not believe this measure should be linked to payment for rural clinicians or clinician groups.

Within the MIPS measure set, MAP identified several gaps, specifically in the areas of primary care, access, continuity, comprehension, and care coordination. MAP also suggested that CMS consider adding measures that determine whether a course of therapy is indeed the best for the patient to optimize reductions in cost and harm. MAP also emphasized measures of diagnostic accuracy and primary care patient-reported outcomes measures.

Medicare Shared Savings Program

The Medicare SSP was established by Section 3022 of the Affordable Care Act (ACA). Eligible providers, hospitals, and suppliers may participate in the SSP by creating or participating in an 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); 2) 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.

MAP considered a single measure for the Medicare SSP during the 2019-2020 cycle.

MAP conditionally supported MUC2019-37 *MIPS Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions* pending NQF endorsement. MAP noted that with over 80 percent of adults over the age of 65 having MCCs, this measure has the potential to significantly improve the quality of care for the Medicare beneficiary population. MAP also noted that this measure carries a higher reliability score than the measure considered for MIPS, but it is also appropriate for the SSP program. MAP noted that ACOs in SSP focus on processes and interventions that reduce disease progression and undesirable sequelae that lead to hospital admission for Medicare patients with MCCs. Moreover, the accountability structure of an ACO allows for stronger oversight and care coordination to influence measure performance within the ACO system.

MAP also noted that this measure is similar to ACO 38: All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions. CMS clarified that the measure under consideration is intended to replace that measure within the SSP measure set through the rulemaking process.

MAP identified several measure gaps within SSP: diagnostic efficiency, measures of cultural change, and additional measures of care coordination and handoffs using eQMs.

Medicare Part C and D Star Ratings

During this review cycle, MAP also reviewed five measures for inclusion in the Medicare Part C and D Star Ratings Program. This is the first year that MAP reviewed measures for this program. CMS publishes the Medicare Part C and D Star Ratings each year to measure the quality of health and drug services received by beneficiaries enrolled in MA and Prescription Drug Plans (PDPs or Part D plans). The Star Ratings also reflect the experiences of beneficiaries and assist beneficiaries in finding the best plan for them. The Star Ratings support CMS' efforts to put the patient first. As part of this effort, patients should be empowered to work with their healthcare providers to make healthcare decisions that are best for them. An important component of this effort is to provide Medicare beneficiaries and their family members with meaningful information about quality and cost to assist them in being informed and active healthcare consumers. In 2019, approximately 66 million Americans were enrolled in Medicare, with 34 percent of beneficiaries in a Part C plan.

The Part C and D Star Rating Program involves three types of health plans:

- Medicare Advantage-Prescription Drug Plans (MA-PD plans) – offering both health (Part C) and drug (Part D) benefits;
- Medicare Advantage Only Health Plans (MA-only plans) – offering only health benefits; and
- Stand-alone Prescription Drug Plans (PDPs) – offering only drug benefits to supplement benefits received through Original Medicare.

The Part C and D Star Rating Program consists of 48 quality and performance measures; MA-only contracts (without prescription drug coverage) are rated on up to 34 measures; and stand-alone PDP contracts are rated on up to 14 measures. Each year, CMS conducts a comprehensive review of the measures that make up the Star Ratings by assessing the reliability of the data, clinical recommendations, and feedback received from stakeholders. Star Ratings are designed for public reporting on Medicare Plan Finder, health plan quality improvement, marketing and enrollment, as well as for financial incentives. Per the Affordable Care Act, CMS makes QBPs to MA organizations that meet quality standards measured using a five-star quality rating. MA rebate levels for plans are tied to the contract's Star Rating. Plans that achieve four or more stars are given a 5 percent QBP. QBPs are not connected to the PDP program, only Medicare Advantage.

The five measures considered by MAP for the Part C and D Star Ratings were:

- MUC2019-14 *Follow-up after Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions*
- MUC2019-21 *Transitions of Care between the Inpatient and Outpatient Settings including Notifications of Admissions and Discharges, Patient Engagement and Medication Reconciliation Post-Discharge*
- MUC2019-57 *Use of Opioids at High Dosage in Persons without Cancer (OHD)*
- MUC2019-60 *Use of Opioids from Multiple Providers in Persons without Cancer (OMP)*
- MUC2019-61 *Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer (OHDMP)*

MAP Decision: Support for Rulemaking

In total, MAP considered three opioid measures for potential inclusion in the Part C and D Star Ratings. CMS has indicated in rulemaking that all three of these opioid measures will be publicly available in the Part C and D Star Ratings Display Measures beginning in 2020, but will not be used for calculation of a given plan's Star Rating. CMS also indicated that one measure will be used in the Star Ratings. The same measures were considered by MAP for inclusion in SSP during the last review cycle.

MAP reviewed the measure MUC2019-57 *Use of Opioids at High Dosage in Persons without Cancer (OHD)*. This measure represents the percent of beneficiaries receiving opioid prescriptions with an average daily morphine milligram equivalent (MME) greater than or equal to 90 mg over a period of 90 days or longer. MAP supported for rulemaking MUC2019-57 *Use of Opioids at High Dosage in Persons without Cancer (OHD)*. The measure has been endorsed by NQF at the health plan level as NQF 2940. MAP noted that this measure leads to health plans carefully considering the needs of patients at high doses, encouraging appropriate nonopioid pain management, providing appropriate personalized pain care plans, directly addressing OUD, and potentially tapering patients off of high-dose opioid regimens. While overall supportive of the measure, MAP noted that concerns have been raised that pressure from health plans to diminish prescribing could be associated with the unintended consequence of patients seeking illicitly obtained opioids or heroin. This may lead to changes in prescribing practices for clinicians to adhere to CDC prescribing guidelines that were intended to serve as guidance and not as a strict mandate. Moreover, MAP also expressed concerns that the U.S. doesn't have widespread adoption of good tapering strategies for persons on high opioid doses. The MAP Rural Health Workgroup agreed that opioid use is a relevant issue for rural residents, but expressed concern that without a balancing measure, there is a potential for patient harm due to forced tapering and the potential for seeking illicit drugs to treat pain. Rural residents have relatively less access to alternative pain treatment and other resources.

MAP supported for rulemaking MUC2019-60 *Use of Opioids from Multiple Providers in Persons without Cancer (OMP)*. MAP observed that the measure will encourage health plans to address pain management and OUD within their beneficiary population while avoiding unintended consequences associated with rapid decline of opioid dosages. This measure appropriately identifies either mismanaged pain or potential opioid-seeking behavior. MAP noted that this measure is endorsed at the health plan level as NQF 2950. MAP noted that all three opioid measures are currently in use in the SSP Opioid Utilization Reports as well as in the Part D Overutilization Monitoring System. The MAP Rural Health Workgroup suggested that although this measure could promote use of drug monitoring programs in rural areas, on the whole, it may not be particularly applicable due to the relatively few pharmacies in rural areas.

MAP expressed concern noting the comparable NCQA opioid measures in use within Healthcare Effectiveness Data and Information Set (HEDIS) and encouraged the harmonization with PQA's opioid measures used in Part C & D.

MAP Decision: Conditional Support for Rulemaking

MAP conditionally supported for rulemaking two of the five measures reviewed under the Part C and D Star Ratings Program. Measures in this category were given this designation primarily due to MAP's

preference that all measures considered by CMS for inclusion in federal programs undergo review by an NQF CDP Standing Committee to ensure scientific validity and reliability prior to implementation.

MAP reviewed MUC2019-14 *Follow-up after Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions*. This measure captures the percent of ED visits for Medicare beneficiaries aged 18 and older with multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit. Per the measure developer, multiple high-risk chronic conditions include two or more of the following health conditions: Alzheimer's disease, atrial fibrillation, chronic kidney disease, COPD, depression, heart failure, cardiovascular disease evidenced by acute myocardial infarction, and stroke or transient ischemic attack. Appropriate follow-up services include, but are not limited to, an outpatient visit; telephone visit; transitional or complex care management services, outpatient or telehealth behavioral health visit, or observation visit.

MAP conditionally supported MUC2019-14 for rulemaking, pending NQF endorsement. MAP noted the importance of the care coordination domain as a CMS priority. MAP observed that care coordination is the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of healthcare services. This measure is an additional process measure to the Medicare Part C and D Star Ratings that lends itself to better care efficiencies and coordination for health plans and their beneficiaries. MAP also discussed the increased utilization and costs associated with use of EDs for Medicare beneficiaries, particularly for patient groups with increased clinical needs such as dual-eligible beneficiaries and patients with behavioral health needs. Coordinating the care of beneficiaries who use emergency services is an important component to ensuring that they also are receiving outpatient care and preventive services with the potential to mitigate disease progression that results in further unnecessary use of emergency facilities. MAP expressed some concerns related to the measure, particularly they pertain to special needs plans being able to approach the timing, modality, and content of the follow-up, noting the need to ensure that health plans are aware that an ED visit has occurred and can respond appropriately.

The Rural Health Workgroup noted that the chronic conditions included in this measure are prevalent in rural residents, and that lack of access to care in rural areas may make performance on this measure more difficult for plans that cover rural residents. MAP was encouraged that telephone follow-up was included in this measure, but encouraged CMS to ensure that the telephone follow-ups are meaningful to patients.

MUC2019-21 *Transitions of Care between the Inpatient and Outpatient Settings including Notifications of Admissions and Discharges, Patient Engagement and Medication Reconciliation Post-Discharge* was also discussed by MAP. The measure assesses the percentage of discharges for members 18 years of age and older who had each of the following four indicators: notification of inpatient admission; receipt of discharge information; patient engagement after inpatient discharge; and medication reconciliation post-discharge. Plans report separate rates for individuals aged 18-64 and those aged 65 and older, as well as a total rate for each indicator in the measure.

MAP conditionally supported MUC2019-21 for rulemaking, pending NQF endorsement. MAP noted that this measure was also designated as a first-year measure for HEDIS 2018. MAP observed that Medicare beneficiaries are at particular risk during transitions of care because of higher comorbidities, declining cognitive function, and increased medication use. MAP noted important performance variation as well

as opportunity for improvement among health plans on all four components of the measure. Further, evidence indicates that good care transitions and care coordination reduce healthcare costs and improve outcomes. MAP also noted that the medication reconciliation post-discharge component of this measure is already included in the Star Ratings as an independent measure and has been since 2017. The measure developer (NCQA) indicated its intention to work with CMS to develop a plan to avoid the need for health plans to report on both measures. MAP expressed concern that this measure is not entirely electronic, but it was noted that alternative data sources are not available. The Rural Health Workgroup noted the importance of measures to assess transitions of care for rural residents, but the measure requires chart abstraction, which can be burdensome for small rural providers. It also noted that a yes/no checkbox measure of medication reconciliation may not drive improvements in care quality. There was some concern with the medication reconciliation component, particularly given the lack of pharmacists in rural areas.

Related to this measure, MAP noted that there is currently no measure that addresses care transitions in the measure set. MAP expressed concern that a patient-reported outcome measure in the same quality domain was not proffered. MAP strongly supported NQCA's intention to move the measure to an eCQM as the data become available to do so.

MAP Decision: Do Not Support for Rulemaking

MAP reviewed measure MUC2019-61 *Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer (OHDMP)*. MUC2019-61 combines the criteria of the other two opioid measures discussed, representing the percent of beneficiaries receiving opioid prescriptions with an average daily MME greater than or equal to 90 mg over a period of 90 days or longer, and opioid prescriptions from four or more prescribers and four or more pharmacies within 180 days or less.

MAP did not support for rulemaking MUC2019-61 *Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer (OHDMP)*. MAP observed that this measure was endorsed in 2017 as NQF 2951. This measure was also seen as duplicative of the other two measures, with little added benefit to the program from the combined measure. MAP emphasized the need for parsimony in the measure set.

MAP discussed measure gaps associated with the Medicare Part C and D Star Ratings and suggested that CMS add measures of access to provider networks, patient-reported outcomes measures related to functional status, and care coordination within care transitions. MAP expressed concern that the medication adherence measures do not capture rational nonadherence and patient preference, and also suggested the removal of older process measures such as diabetes screening in favor of measures that beneficiaries might find more useful when selecting a plan, such as out-of-pocket cost. MAP also suggested the inclusion of telehealth into existing measures.

Appendix A: Program Summaries

The material in this appendix was extracted from the [CMS Program Specific Measure Priorities and Needs document](#), which was released in April 2019, as well as the CMS website.

Medicare Parts C and D Star Ratings Program

Program History and Structure:

The Part C & Part D Star Ratings Program is based on sections 1851(d), 1852(e), 1853(o) and 1854(b)(3)(iii), (v), and (vi) of the Act and the general authority under section 1856(b) of the Act requiring the establishment of standards consistent with and to carry out Part C and Part D. We acted upon our authority to disseminate information to beneficiaries as the basis for developing and publicly posting the 5-star ratings system (sections 1851(d) and 1852(e) of the Act).

The Part C statute explicitly requires that information about plan quality and performance indicators be provided to beneficiaries to help them make informed plan choices. These data are to include disenrollment rates, enrollee satisfaction, health outcomes, and plan compliance with requirements. For Part C, the 5-star rating system is used in determining QBP status and in determining rebate retention allowances. The Part D statute (at section 1860D–1(c)) imposes a parallel information dissemination requirement with respect to Part D plans, and refers specifically to comparative information on consumer satisfaction survey results as well as quality and plan performance indicators. Part D plans are also required by regulation (§ 423.156) to make Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data available to CMS, and are required to submit pricing and prescription drug event data under statutes and regulations specific to those data. As of today, no QBPs are associated with the ratings of Part D sponsors.

Initially, the Star Ratings Program measures were aligned with CMS' Quality Strategy objectives of optimizing health outcomes by improving quality and transforming the healthcare system. These objectives are consistent with the Meaningful Measures Framework's six quality categories of: 1) promoting effective communication and coordination of care; 2) strengthening person and family engagement in care; 2) promoting effective prevention and treatment of chronic disease; 4) working with communities to promote best practices of healthy living; 5) making care affordable; and 6) making care safer by reducing harm caused in the delivery of care.

Medicare Shared Savings Program

Program History and Structure

Section 3022 of the ACA requires CMS to establish an SSP 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 SSP was designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce the rate of growth in health care costs. Eligible providers, hospitals, and suppliers may participate in the SSP by creating or participating in an ACO. If ACOs meet program requirements and the ACO quality performance standard, they are eligible to share in savings, if earned. There are three shared savings options: 1) one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year); 2) two-sided risk model

(sharing of savings and losses for all three years); and 3) two-sided risk model (sharing of savings and losses for all three years) with prospective assignment.

Merit-Based Incentive Payment System Program

Program History and Structure

MIPS was established by MACRA, which repeals the Medicare sustainable growth rate and improves Medicare payment for physician services. MACRA consolidates the current programs of the Physician Quality Reporting System, the Value-Based Modifier, and the Electronic Health Records Incentive Program into one program (MIPS) that streamlines and improves the three distinct incentive programs. MIPS will apply to doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in 2019. Other professionals paid under the physician fee schedule may be included in MIPS beginning in 2021, provided there are viable performance metrics available. Positive and negative adjustments will be applied to items and services furnished beginning January 1, 2019 based on providers meeting a performance threshold for four performance categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology. Adjustments will be capped at 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and future years.

Appendix B: MAP PAC/LTC Workgroup Roster and NQF Staff

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