MEASURE APPLICATIONS PARTNERSHIP

MAP 2018 Considerations for Implementing Measures in Federal Programs:

Merit-Based Incentive Payment System (MIPS) and Medicare Shared Savings Program (MSSP)

FINAL REPORT

MARCH 15, 2018

NATIONAL QUALITY FORUM

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GUIDANCE ON CROSS-CUTTING ISSUES FOR MIPS AND MSSP

Summary

- Cost measures are essential to advance the goals of the Merit-Based Incentive Payment System. However, MAP recognized that cost measures must be actionable and accurate.
- Composite measures are well suited to capture the care provided for a condition and serve as a comprehensive view of performance.
- MAP supported the measure removal criteria that CMS proposed. MAP put forward considerations for CMS' criteria, specifically, unintended consequences, provider burden and operational issues, appropriate risk adjustment, and consumer value.

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 (MSSP) – MSSP 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 MSSP 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

Balance the need to assess costs while ensuring accurate measurement.

MAP recognized the importance of incorporating cost measures into value-based payment programs such as MIPS. Cost measures are essential tools for understanding healthcare utilization and identifying areas for improvement. 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.[1] To meet this requirement, CMS developed a series of episode-based cost measures and submitted them for MAP's consideration.

CMS presented the development process for the episode-based cost measures under consideration to MAP. MAP members had the opportunity to review all aspects of the process, including the overall methodology, the technical details, and the methodology, which incorporated stakeholder input. However, MAP members and members of the public cautioned that these are new measures, and testing information must be available to all stakeholders.

MAP emphasized the need to ensure that the information generated by these measures is actionable and allows clinicians to understand how they can improve their performance. MAP members encouraged CMS to provide detailed data to clinicians, as detailed data are more actionable for clinicians than an aggregated measure score alone.

MAP acknowledged that cost measurement presents unique challenges that differ from clinical quality measurement. While supporting the development of cost measures, MAP stressed the need to accurately capture resource use. MAP noted that cost measures should be appropriately risk-adjusted for clinical and social risk factors when appropriate. MAP also emphasized the importance of providing equitable care and that appropriate risk adjustment can help ensure that clinicians who care for more complex and vulnerable patients are not unfairly penalized with lower measure scores for factors that these clinicians cannot control.

MAP noted that cost measures use claims data to mitigate the need for additional data collection. However, CMS should consider the burden associated with interpreting the measure score results from these complex measures. MAP recommended that these measures be routinely evaluated and tested, especially during the early stages of implementation. To address these concerns about the usability and scientific acceptability of these measures, MAP emphasized that CMS should seek NQF endorsement for these cost measures.

Finally, MAP recommended several considerations for CMS when implementing these cost measures. MAP cautioned that some of these cost measures (e.g., intracranial hemorrhage or cerebral infarction) capture heterogeneous populations requiring varying plans of care and thus varied cost expectations. MAP encouraged CMS to ensure that these measures can be assessed across providers given the patient populations. Additionally, MAP advised that CMS ensure that tertiary medical centers or other facilities that accept transfers of higher acuity patients are not unfairly penalized due to differences in the presenting condition severity. MAP also noted that factors such as cost of living and real estate prices can affect healthcare costs and suggested that CMS consider regional comparisons rather than comparison to a national average when publically reporting this measure.

Implement composite measures to drive improvements across multiple quality domains and provide more understandable information to patients.

MAP members were encouraged to see additional composite measures under consideration for use in the programs and noted that composite measures present a more comprehensive view of care provided for a condition; however, they also acknowledged that these measures may pose additional technical challenges during the measure development process. For example, MAP noted that a composite measure for vaccinations, such as adult vaccinations, would be preferred over individual measures that address a particular vaccine administration. However, MAP also recognized that a vaccine composite measure may be more difficult to develop and maintain due to changing evidence and clinical guidelines that could vary by condition.

While MAP was also encouraged to see several condition-specific composites (i.e., diabetes care and vascular care) under consideration, MAP noted challenges to implementing these measures. MAP recognized the importance of composite measures to address the multiple aspects of care that must be managed in order to improve the underlying condition. However, MAP acknowledged that composite measures specified at the individual clinician level can pose challenges if a particular clinician or specialist does not have sufficient control over the care for that particular condition.

MAP discussed the potential for composite measures to address appropriate use. For example, MAP noted that a composite measure that pairs the appropriate use of a test (i.e., only being used when it should) with the effective screening (i.e., ensuring that all of the eligible population receives the screening test) would be a stronger measure than ones focusing on each component individually.

Finally, MAP acknowledged that there may be technical challenges in composite measure development. For example, the individual measures that make up the composite may have different subpopulations represented. This could cause difficulties with attribution of the care provided. Additionally, the collection of data for such composite measures might not be feasible in all electronic health records (EHRs).

Overall, while MAP supported the direction and priority placed on composite measures to address important quality challenges, MAP noted that this type of measure poses challenges, including measure development complexities and attribution issues. These challenges are more prominent at the individual clinician level of analysis. MAP recommended continued measure development in this area with actionable subcomponents.

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 2017-2018 pre-rulemaking deliberations, MAP reviewed 22 measures for the MIPS program.

MAP Decision: Support for Rulemaking

MAP supported three measures. MAP supported MUC 17-194 *Optimal Vascular Care*, a composite measure that addresses multiple components of high-quality vascular care. MAP noted the importance of this measure due to the prevalence of ischemic vascular disease. While MAP supported implementation of the composite measure, MAP also acknowledged the utility of the individual subcomponents of the measure to drive quality improvement. MAP received one public comment on this measure disagreeing with its recommendations. The commenter noted that this measure would require an update to align with new guidelines for high blood pressure and should be risk-adjusted or stratified to enable fair and valid comparisons across physicians.

MAP also supported two NQF-endorsed patient-reported outcome-based performance measures: MUC 17-168 *Average Change in Functional Status Following Lumbar Spine Fusion Surgery* and MUC 17-169 *Average Change in Functional Status Following Total Knee Replacement Surgery*. MAP stressed the need for more patient-reported outcome-based performance measures and the importance to patients of improving functional status. MAP received four public comments on these measures. Overall, commenters supported MAP's decision and reiterated the value of PROs and improving functional status. One commenter suggested MUC17-168 could be modified to allow the use of other validated instruments.

MAP Decision: Conditional Support for Rulemaking

MAP conditionally supported 17 measures. Of these, eight episode-based cost measures received conditional support pending NQF endorsement. MAP recognized the need to reduce healthcare costs but cautioned that measures must be accurate and actionable. MAP recommended that the NQF Cost and Efficiency Standing Committee review the measures to ensure appropriate clinical and social risk adjustment, exclusions, and attribution methodology. MAP noted the importance of cost measurement to improving value across the healthcare system but cautioned that measures should be appropriately specified to avoid potential unintended consequences. MAP members noted the importance of the clinical logic used to define the cohorts in the cost measures. Further, MAP specifically emphasized the need to ensure that MUC 17-262 *ST-Elevation Myocardial Infarction (STEMI) with Percutaneous*

Coronary Intervention (PCI) is appropriately specified to capture new procedures emerging in STEMI care.

MAP received 22 comments on these measures. Commenters split in their support of these measures. Several noted the importance of addressing healthcare costs and the potential of these measures to provide important information about healthcare utilization. However, commenters expressed several concerns about these measures, noting the lack of available information on testing, and cautioned that these measures assess cost without consideration of quality. Commenters emphasized that these measures should be appropriately specified including the time period of the measure and the risk adjustment methodology. Commenters noted the potential impact of social risk on these measures and agreed with MAP that they should be examined for social risk factors to ensure fair comparisons across clinicians.

MAP conditionally supported one measure of appropriate use, MUC17-173 *Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture*. This measure addresses the inappropriate use of DXA scans for patients, women age 50 to 64 without risk factors for osteoporosis. MAP recognized the need for early detection of osteoporosis but agreed that DXA scans should only be performed on the appropriate population under the age of 65. Performing DXA scans in accordance with current guidelines could prevent unnecessary healthcare spending. MAP noted that this measure could complement the existing osteoporosis screening measure, QPP#039: *Screening for Osteoporosis for Women Aged 65-85 Years of Age*. MAP recognized the possible need for a balancing measure to prevent the underuse of DXA scans. While MAP acknowledged that one measure ideally would address both the appropriate and inappropriate use of DXA scans, MAP recognized the potential challenges to developing such a measure. MAP recommended that NQF endorsement be a condition for supporting this measure. MAP also recommended that the relevant NQF Standing Committee specifically examine the issue of feasibility across EHRs.

MAP conditionally supported two measures assessing quality of care for diabetes: MUC17-181 *Optimal Diabetes Care* and MUC17-215 *Diabetes A1c Control (<8.0)*. MUC17-181 is a composite that includes MUC17-215 as a component. MAP agreed that the composite measure would address multiple components of high-quality care and recognized the importance of this measure given the prevalence of diabetes. Although MAP supported the composite measure, the group also acknowledged the utility of the individual subcomponents to drive quality improvement. MAP acknowledged that the availability of the *Diabetes A1c Control* measure may discourage use of the *Optimal Diabetes Care* composite measure. MAP supports composite measures to address several aspects of quality; however, the group cautioned that these measures can be more burdensome for clinicians to report. Given the structure of the quality domain of MIPS, MAP recognized having MUC17-215 as a reporting option could help ensure that more clinicians choose to report on diabetes care.

MAP received three public comments on these measures. Commenters did not agree with MAP's recommendations, noting that these measures should be appropriately risk-adjusted to allow for fair comparisons and be respecified to align with current blood pressure guidelines prior to use in rulemaking.

MAP also conditionally supported MUC17-234 *Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication*, a component of MUC 17-194 *Optimal Vascular Care*. MAP acknowledged the importance of use of aspirin or anti-platelet medication as a critical element of high-quality vascular care. MAP acknowledged both that clinicians may still report aspirin or anti-platelet medication measures separately from the

composite to drive quality improvement but also acknowledged that this measure may crowd out the use of the *Optimal Vascular Care* composite measure. MAP also acknowledged a competing measure in the program, QPP #204 *IVD Use of Aspirin or Another Antiplatelet*. MAP conditionally supported MUC17-234 based on the condition that there are no competing measures in the program. MAP did not receive any public comments on this measure for MIPS.

MAP conditionally supported MUC17-310 *Zoster (Shingles) Vaccination*. MAP recognized the new guidelines currently under development for the Zoster vaccination that could affect the amount of doses, the age of administration, and the specific vaccine that is used. MAP noted that the developer should monitor the development of those guidelines and modify the measure as necessary. MAP further emphasized the need for a composite measure looking at all appropriate adult vaccinations, but acknowledged the challenges in developing such a measure since it may be time-consuming, expensive, and a difficult concept to operationalize. MAP also noted the impact that insurance status could have on the ability of people to afford this vaccine and recommended that coverage is considered when implementing this measure. MAP recommended conditional support for this measure pending NQF endorsement, noting that the endorsement process will address evidence concerns stemming from the new guidelines. MAP received one public comment disagreeing with its recommendations. The commenter raised concerns about the effectiveness of the original vaccine and noted a need to monitor evidence for the new vaccine.

MAP also conditionally supported MUC17-367 *HIV Screening* pending NQF review and endorsement. MAP acknowledged the importance of HIV screening from a population health perspective and reiterated that many patients may not recognize their risk for HIV or do not report behavior that may put them at risk. While MAP noted the importance of this screening measure, MAP also recognized that this measure targets patients who may not self-identify as being at high risk for HIV and should be screened. Furthermore, MAP highlighted the potential stigma associated with HIV screening that may prohibit increased screening rates and contribute to underdiagnosed HIV. Ultimately, MAP members expressed that stigma should not be a concern for this measure; however, MAP members raised questions about whether encouraging screening through the MIPS program is the most effective strategy to increase screening rates generally. MAP also expressed concern that the measure under consideration might not be able to identify individuals who may have been screened for HIV in the community and questioned how that data would be captured. When this measure is reviewed for NQF endorsement, MAP recommended that the relevant Standing Committee review the patient cohort definition (i.e., patients with a previous HIV diagnosis and patients who refuse screening) and how screening performed in the community is captured in the endorsement review of this measure. MAP received one public comment disagreeing with MAP's recommendation, noting that this measure could be subject to gaming.

MAP conditionally supported three measures addressing improvement in function or symptom management pending NQF review and endorsement: MUC17-170 *Average Change in Functional Status Following Lumbar Discectomy Laminotomy Surgery*, MUC17-177 *Average Change in Leg Pain Following Lumbar Spine Fusion Surgery*, and MUC17-239 *International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia*. MAP reiterated the value of PROs and was encouraged to see additional patient-reported outcome measures. MAP received four public comments on these measures. Comments generally supported MAP's recommendations, but one commenter suggested that these measures could be modified to use other validated instruments.

MAP Decision: Refine and Resubmit Prior to Rulemaking

MAP recommended that two measures under consideration be refined and resubmitted. First, MAP encouraged CMS to refine and resubmit MUC17-345 *Patient Reported and Clinical Outcomes Following Ilio-Femoral Venous Stenting*. MAP noted the importance of this composite measure, as it evaluates patient-reported and clinical outcomes following ilio-femoral venous stenting. However, MAP noted that although the individual component measures have been tested, the composite measure is early in development and has not been fully tested at the clinician level. Therefore, MAP recommended that the measure be refined and resubmitted pending the completion of testing of the composite measure. MAP encouraged the measure developer to demonstrate that the composite measure adequately accounts for patients who are lost to follow-up during their testing of this composite measure. MAP did not receive public comments on this measure.

MAP also recommended that MUC17-139 *Continuity of Pharmacotherapy for Opioid Use Disorder* be refined and resubmitted. MAP acknowledged the role of public health in addressing opioid use disorder and noted the gap of measures in this area; however, MUC17-139 is specified and tested at the health plan and state levels. MAP recommended that the measure be tested and endorsed at the clinician and clinician group levels before implementation in MIPS. MAP encouraged the relevant NQF Standing Committee to evaluate the attribution method, reliability, and validity of this measure at the individual clinician and practice levels. MAP received one public comment on this measure noting the concerns about attribution and the performance of the measure at the clinician level of analysis.

Medicare Shared Savings Program (MSSP)

MSSP was established by Section 3022 of the Affordable Care Act (ACA). Eligible providers, hospitals, and suppliers may participate in MSSP 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 three shared savings options: (1) one-sided risk model (providers do not assume shared losses), (2) two-sided risk model (sharing of savings and losses and possibly sharing in a greater portion of savings than track 1 ACOs), and (3) 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). MSSP aims to promote accountability for a patient population, promote care coordination, and promote the use of high-quality and efficient services.[2]

MAP considered three measures for the Medicare Shared Savings Program (MSSP). MAP conditionally supported two measures addressing diabetes care: MUC17-181 *Optimal Diabetes Care* and MUC17-215 *Diabetes A1c Control (<8.0)*. MAP recognized the importance of these measures given the prevalence of diabetes. MAP conditionally supported MUC17-181 based on the condition that there are no competing measures in the program and that the measure is updated to the most current clinical guidelines. In addition, MAP recommended risk stratification be appropriately applied to the measure.

MAP has emphasized the value of composite measures to address multiple facets of care and provide information that consumers readily understand; however, MAP also acknowledged the importance of MUC17-215 *Diabetes A1c Control (<8.0)* as a critical element of high-quality diabetes care. While this measure is included in

the *Optimal Diabetes Care* composite measure, MAP recognized that the A1c control measures may drive specific quality improvement efforts. MAP also acknowledged the competing measure, ACO #7 *Hemoglobin A1c Poor Control*. MAP conditionally supported MUC17-215 with the condition that there are no competing measures in the program and the measure is appropriately risk-adjusted or stratified to enable fair and valid comparisons across clinicians.

MAP also conditionally supported MUC17-234 *Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication*. MAP acknowledged the importance of use of aspirin or anti-platelet medication as a critical element of high-quality vascular care. While this measure is included in the *Optimal Vascular Care* composite measure, MAP recognized that the aspirin or anti-platelet medication measures may drive specific quality improvement efforts. MAP also acknowledged that there is a competing measure in the program, ACO #30 *IVD Use of Aspirin or Another Antiplatelet*. MAP conditionally supported this measure with the condition that there are no competing measures in the program.

Overall, MAP received 11 comments on the proposed measures for the MSSP program. Several commenters supported the diabetes measures (MUC17-181 and MUC17-215) with one recommendation that the composite diabetes measure (MUC17-181) be adjusted to not be an all-or-nothing measure. Some commenters did not support the diabetes measures (MUC17-181 and MUC17-215) and recommended that the measures be risk-adjusted or stratified to enable fair and valid comparisons across physicians. One commenter did not support the diabetes and vascular measures (MUC17-181, MUC17-215, and MUC17-234) unless competing measures from the MSSP program are removed.

INPUT ON MEASURE REMOVAL CRITERIA

As part of the pre-rulemaking process, CMS reviewed the current criteria and considerations for the removal of existing measures in federal programs. The criteria presented are meant to apply broadly across programs and settings, and are not intended to enumerate specific measures for removal.

MAP recommended additional criteria for CMS to consider for removal of measures in program measure sets including:

- **Burden.** While MAP supported the reduction of measurement burden, members also expressed the need to balance the value of a measure with its burden. MAP noted that some of the most meaningful measures may have a high measurement burden. There may be negative unintended consequences if low burden measures are prioritized over meaningful measures with a higher burden.
- **Preference for outcome measures.** MAP discussed the need to balance measure types in programs. While outcomes are often preferred, process measures that are proximal to important outcomes and have a solid evidence base should be considered. MAP also supported the use of composite measures that provide a comprehensive view of performance. Finally, MAP highlighted the need for a broad range of measures applicable to providers, their relevant specialties, and their patients.
- **Variation in performance.** MAP discussed the complexity of using variation in performance as a measure removal criteria. Some members noted that there are several measures essential to quality maintenance and safety that lack performance variation or may have less than optimal performance across providers. The removal of these measures could lead to negative unintended consequences. MAP also noted that understanding why performance on a measure has not improved is an important input to determining whether a measure should be removed.

MAP also noted the need to ensure that measures in the CMS program sets are high-value; however, MAP cautioned that CMS should balance removing measures with maintaining a focus on important quality and public health issues and ensuring progress among low performers. MAP members also pointed out the value of consistency in the program measure sets and cited the costs associated with adapting to changing measures and shifting the focus of quality improvement efforts.

Finally, MAP stressed the importance of defining value from the patient perspective, emphasizing the need to ensure that measures address the issues that patients and consumers find most important. MAP also noted the necessity of engaging patients and their families in the measure development and selection process.

ENDNOTES

1 Centers for Medicare & Medicaid Services (CMS). Merit-based Incentive Payment System (MIPS): Episode-Based Cost Measure Field Test Reports Fact Sheet. Baltimore, MD: CMS; 2017. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Cost-Measures-Field-Test-Fact-Sheet.pdf. Last accessed February 2018.

2 CMS. About the program website. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html. Last accessed February 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 April 2017.

Merit-Based Incentive Payment System

Program History and Structure

The Merit-Based Incentive Payment System (MIPS) is established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repeals the Medicare sustainable growth rate (SGR) and improves Medicare payment for physician services. The MACRA consolidates the current programs of the Physician Quality Reporting System (PQRS), The Value-Based Modifier (VM), and the Electronic Health Records (EHR) Incentive Program into one program (MIPS) that streamlines and improves on 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 the 2019 payment year. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in the 2021 payment year, 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.

High Priority Measures for Future Consideration

CMS will not propose the implementation of measures that do not meet the MIPS criteria of performance and measure set gaps. MIPS has a priority focus on outcome measures and measures that are relevant for specialty providers. CMS identifies the following as high-priority for future measure consideration:

1. *Person and caregiver-centered experience and 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 health care team and in collaborative partnerships with providers and provider organizations.
2. *Communication and care coordination*: 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. *Efficiency/cost reduction*: This means that the measure must address the affordability of health care including unnecessary health services, inefficiencies in health care delivery, high prices, or fraud. Measures should cause change in efficiency and reward value over volume.
4. *Patient Safety*: 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 over use.

In addition, CMS identified outcome measures as high-priority for future measure consideration.

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: Communication and Care Coordination, Community/Population Health, Effective Clinical Care, Efficiency and Cost Reduction, Patient Safety, Person and Caregiver-Centered Experience and Outcomes. 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.
- Preference will be given to electronically specified measures (eCQMs)
- eCQMs must meet EHR system infrastructure requirements, as defined by MIPS regulation.
  - 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 Implementation Guide.
- Measures must be fully developed and tested.
  - Reliability and validity testing must be conducted for measures.
  - Feasibility testing must be conducted for eCQMs.
  - eCQMs must have MAT output.
  - 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.
- 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."
- Measures must be fully developed and ready for implementation at the time of submission.
- 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.

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 health care 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 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

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 that align with recommendations from the Core Quality Measures Collaborative

APPENDIX B:
MAP Clinician Workgroup Roster and NQF Staff

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