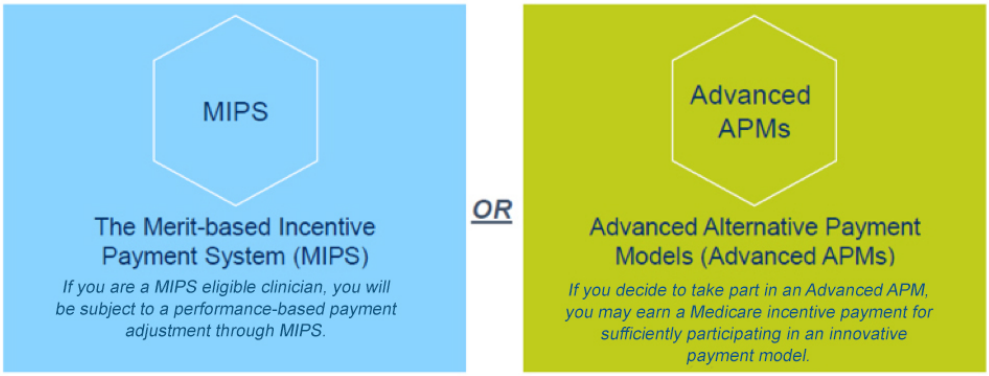
Quality Payment
PROGRAM

2018 Annual Call for Quality Measures Fact Sheet

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have made major cuts to payment rates for clinicians participating in Medicare. The law requires us to implement the Quality Payment Program and gives you 2 ways to participate:



Under MIPS, there are 4 performance categories that affect your future Medicare payments. Each performance category is scored by itself and has a specific weight that's part of the MIPS Final Score. The MIPS payment adjustment assessed for MIPS eligible clinicians is based on the Final Score. These are the performance category weights for the 2018 performance period:

What is the MIPS Annual Call for Measures?

The “Annual Call for Measures” process asks these stakeholders and others for their feedback:

- Clinicians
- Professional associations and medical societies that represent eligible clinicians
- Researchers
- Consumer groups
- Other stakeholders

Specifically, we are asking them to send us Quality measures for consideration in the Quality performance category.

Stakeholder recommendations are part of our rigorous quality measure selection process. It’s unlikely that stakeholders will send us measures or activities that they don’t think apply to clinicians or can be reliably and validly measured at the individual clinician level. As part of our quality measure selection process, we ask stakeholders to recommend quality measures by submitting specifications, as well as related research and background to us to review and consider. This information helps us to know if suggested quality measures apply to clinicians and are:

- Feasible
- Reliable
- Valid at the individual clinician level
- Evidence-based
- Scientifically acceptable

Right now, we won’t accept Government Performance and Results Act (GPRA) measures that Tribes and Urban Indian health organizations are already required to report as quality measures. There are many GPRA measures that are similar to measures that are already in the program. Also, some GPRA measures are similar to measures that are part of a Core Quality Measure Collaborative (CQMC) core measure set.

As much as possible, we want to reduce the duplication of measures and to align with measures used by private payers. If there are measures reportable within GPRA that don’t duplicate MIPS measures, we urge our stakeholders to work with measure owners to submit them during our annual Call for Measures.

When Do We Pick Measures?

We use stakeholder feedback to pick measures and activities that are:

- Applicable
- Feasible
- Scientifically acceptable
- Reliable
- Valid at the individual clinician level

- Not the same as existing measures and activities for notice and comment rulemaking

The recommended list of new measures is made publicly available for comment for a set period of time. We evaluate the comments we get from the rulemaking process before we make a final choices. A final annual list of measures for MIPS eligible clinicians will be published in the Federal Register no later than November 1 of the year before the first day of a performance period.

This means that for the 2019 program year, the final clinical quality measures for the Quality performance category published in the "Federal Register" will be available November 1, 2018. We'll also post all final measures on https://qpp.cms.gov.

Quality Performance Category

What are quality measures?
Quality measures are tools that help us measure or quantify health care processes, outcomes, patient and perceptions that go with being able to give high quality health care. Quality measures also help us link outcomes that relate to 1 or more of these quality goals for health care that's:

- Effective
- Safe
- Efficient
- Patient-centered
- Equitable
- Timely

How do we pick quality measures?
The National Quality Forum (NQF) formed the Measure Application Partnership (MAP) to give stakeholders the chance to say whether the measures being considered are applicable to clinicians, feasible, scientifically acceptable, reliable, and valid at the clinician level.

The MAP meets every year (usually in December and January) to give input on measures for different Medicare quality programs. To make the annual list of quality measures, we give stakeholders the chance to give input on proposed measures through notice and comment rulemaking. The law also requires us to submit new measures to an applicable, specialty-appropriate peer reviewed journal.

The quality measures performance category focuses on measures in the following domains for future measure consideration and selection:

- Effective clinical care
- Patient safety
- Communication and care coordination
- Person and caregiver-centered experience and outcomes

- Community and population health
- Efficiency and reducing costs

Appendix 1 has more details on MIPS 2018 measure priorities and needs.

What is the quality measures submission process?

Here's the general measure submission process:

- In JIRA, an online software we use throughout the measure submission process, we post:
  - Instructions about the pre-rulemaking process
  - The JIRA Measures under Consideration (MUC) template
  - Other information we think you'll need for the measure submission process
- We'll announce when JIRA's open to accept proposed quality measure submissions. This is tentatively scheduled to start in late February and close on June 1, 2018.
- We'll give our different audiences a calendar of meetings they attend between January-June to learn about the MUC cycle.

When stakeholders submit measures that don't make the final (MUC) list, they or their point of contact will be contacted in JIRA to let them know. We'll give the submitters the reason we're not recommending the measure for MAP review. If we recommend that the measure should be revised and resubmitted, the stakeholder can resubmit the measure in the next annual Call for Measures cycle.

Where can I learn more?

- Quality Payment Program
- Quality Measures Specifications
- CMS Call for Measures Webpage
- JIRA for Quality Measures

Appendix I

Merit-based Incentive Payment System (MIPS)
2018 Quality Measure Priorities and Needs
Centers for Medicare & Medicaid Services
Center for Clinical Standards and Quality
February 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 3 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%); Promoting Interoperability (formerly Advancing Care Information) (25%); Improvement Activities (15%); and Cost (10%). The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.

Quality Performance Category

Current Program Measure Information:
To implement the quality performance category of MIPS, CMS anticipates using **the Annual Call for Measures** that lets clinicians and organizations, including but not limited to those representing MIPS eligible clinicians (professional associations and medical societies) and other stakeholders (researchers and consumer groups) submit quality measures for consideration. The recommended list of new quality measures will be publicly available for comment through the rulemaking process before making a final selection of new quality measures. This list does not include Qualified Clinical Data Registry (QCDR) measures as those measures are proposed and selected through a separate process.

The quality performance category focuses on measures in the following six domains for future measure thought and selection. The following is a table detailing the number of quality measures prioritized under each domain that are currently implemented in the MIPS program:

MIPS Measure Domain	Number of Quality Measures in MIPS	
	Implemented/Finalized* (2018 Measure Set)	Proposed ** (2017 MUC list)
Effective Clinical Care	129	TBD***
Patient Safety	46	TBD***
Communication/Care Coordination	424	TBD***
Community/Population Health	16	TBD***
Efficiency and Cost Reduction	23	TBD***
Person and Caregiver-Centered Experience and Outcomes	19	TBD***
TOTAL	275	TBD***

**Implemented/Finalized: Quality measures implemented/finalized for data collection.*
***Proposed: The Notice of Proposed Rulemaking (NPRM) has not yet been released that would include proposed measures from the 2017 Measures Under Consideration (MUC) list.*
****To Be Determined as of January 2018.*

High Priority Quality 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. 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 health care service or intervention influences the health status of patients. For example, the percentage of patients who died because of surgery (surgical mortality rates) or the rate of surgical complications or hospital-acquired infections. 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.

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 non-process 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". The identification of topped out measures may lead to potential measure gaps. Through the use of the topped out measure criteria and additional criteria that is 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
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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.

* For reference purposes, the 2018 Benchmark file is posted online here: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Quality-Benchmarks.zip.

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 MIPS 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.
  - 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.
    - 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% active codes
Test eCQM logic using a set of test cases that cover all branches of logic with 100% pass rate	Bonnie	Excel file of test patients showing testing results (Bonnie export)

References

- Value Set Authority Center
- Bonnie
- eCQI Resource Center
- CMS Measures Management System Blueprint
- Overview of Rulemaking Process for Measure Selection
- Quality Payment Program