NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership
All MAP Pre-Rulemaking Process Web Meeting

November 16, 2016 | 12:00 pm-2:00 pm ET

Streaming Playback Audio Online

- Direct your web browser to http://nqf.commpartners.com/se/Meetings/Playback.aspx?meeting.id=851411
- If you need technical assistance, you may send an email to nqf@commpartners.com

Meeting Objectives:

- Provide an overview of the pre-rulemaking approach the setting-specific workgroups will use to evaluate measures included on the measures under consideration list.

12:00 pm **Welcome and Review of Meeting Objectives**
Harold Pincus, MAP Coordinating Committee Co-Chair

12:10 pm **Creation of the Measures Under Consideration List**
Pierre Yong, Centers for Medicare and Medicaid Services

12:25 pm **Debrief from September Coordinating Committee Meeting**
Kim Ibarra, Senior Project Manager, NQF

12:30 pm **MAP's Pre-Rulemaking Approach**
Kim Ibarra, Senior Project Manager, NQF

12:35 pm **Review of the Preliminary Analysis Algorithm**
Erin O'Rourke, Senior Director, NQF

1:00 pm **Voting Process**
Yetunde Ogungbemi, Project Analyst, NQF

1:25 pm **Discussion Guide**
Jean-Luc Tilly, Project Manager, NQF

1:40 pm **Opportunity for Public Comment**

1:55 pm **Summary of Next Steps, and Adjourn**
Yetunde Ogungbemi, Project Analyst, NQF

2:00 pm **Adjourn**

NATIONAL QUALITY FORUM

Measure Applications Partnership

All MAP Pre-Rulemaking Process Web Meeting

November 16, 2016

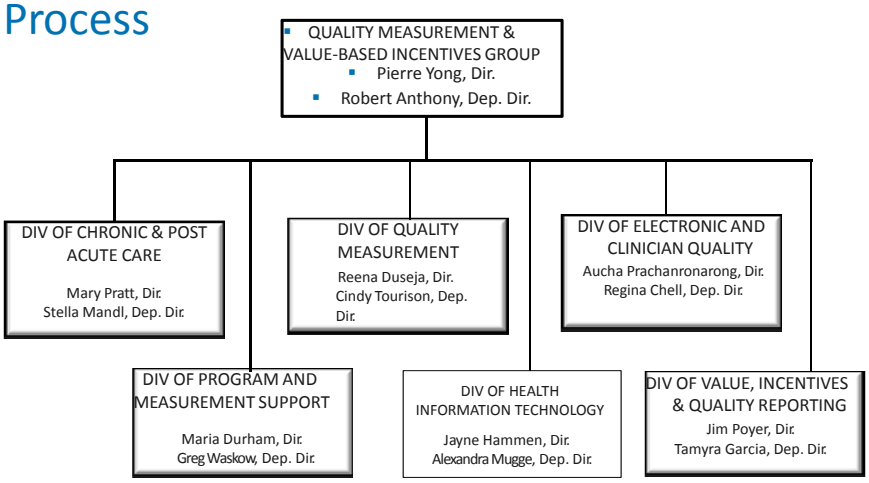
Welcome

Agenda

- Creation of the Measures Under Consideration (MUC) List
- Debrief of September Coordinating Committee Meeting
- Review of the MAP Pre-Rulemaking Approach
- Preliminary Analysis Algorithm
- Recommendations for Removal
- Voting Process
- Discussion Guide
- Public Comment
- Next Steps

Creation of the MUC List

CMS' Center for Clinical Standards & Quality: Home to the Pre-Rulemaking Process



Statutory Authority: Pre-Rulemaking Process

- ***Under section 1890A of the Act and ACA 3014, DHHS is required to establish a pre-rulemaking process under which a consensus-based entity (currently NQF) would convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures for use in certain federal programs. The list of quality and efficiency measures DHHS is considering for selection is to be publicly published no later than December 1 of each year. No later than February 1 of each year, NQF is to report the input of the multi-stakeholder groups, which will be considered by DHHS in the selection of quality and efficiency measures.***

Pre-rulemaking Process: Measure Selection

- Pre-rulemaking Process – provides for more formalized and thoughtful process for considering measure adoption:
  - Early public preview of potential measures
  - Multi-stakeholder groups feedback sought and considered prior to rulemaking (MAP feedback considered for rulemaking)
  - Review of measures for alignment and to fill measurement gaps prior to rulemaking
  - Endorsement status considered favorable; lack of endorsement must be justified for adoption.
  - Potential impact of new measures and actual impact of implemented measures considered in selection determination

CMS Quality Strategy Aims and Goals

CMS Quality Strategy Goals and Foundational Principles

Measure Inclusion Requirements

- Respond to specific program goals and statutory requirements.
- Address an important topic with a performance gap and is evidence based.
- Focus on one or more of the National Quality Strategy priorities.
- Identify opportunities for improvement.
- Avoid duplication with other measures currently implemented in programs.
- Include a title, numerator, denominator, exclusions, measure steward, data collection mechanism.
- Alignment of measures across public and private programs.

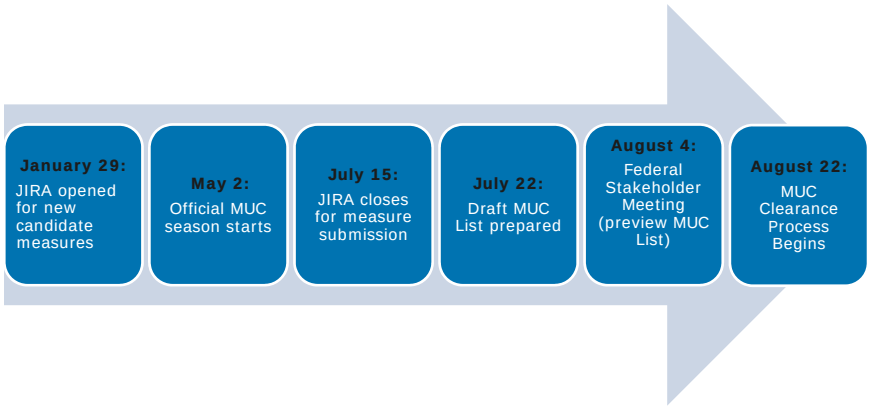
Caveats

- Measures in current use do not need to go on the Measures under Consideration List again
  - *The exception is if you are proposing to expand the measure into other CMS programs, proceed with the measure submission but only for the newly proposed program*
- Submissions will be accepted if the measure was previously proposed to be on a prior year's published MUC List, but was not accepted by any CMS program(s).
- Measure specifications may change over time, if a measure has significantly changed, proceed with the measure submission for each applicable program

Medicare Programs

Ambulatory Surgical Center Quality Reporting Program
End-Stage Renal Disease Quality Incentive Program
Home Health Quality Reporting Program
Hospice Quality Reporting Program
Hospital-Acquired Condition Reduction Program
Hospital Inpatient Quality Reporting Program
Hospital Outpatient Quality Reporting Program
Hospital Readmissions Reduction Program
Hospital Value-Based Purchasing Program
Inpatient Psychiatric Facility Quality Reporting Program
Inpatient Rehabilitation Facility Quality Reporting Program
Long-Term Care Hospital Quality Reporting Program
Medicaid and Medicare EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals
Medicare Shared Savings Program
Merit-based Incentive Payment System
Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
Skilled Nursing Facility Quality Reporting Program
Skilled Nursing Facility Value-Based Purchasing Program

Measures Under Consideration List Publishing



Q&A

Debrief of September 27 Coordinating Committee Meeting

Overview of September 27 Coordinating Committee Meeting

- Meeting objective:
  - *Review and revise the process the MAP Workgroups will use to make initial recommendations on measures under consideration*
- Refinements to the process:
  - *Measure sets will be reviewed holistically*
    - » MAP will have the opportunity to make recommendations on current measure set including recommendations for removal and identifying gaps
  - *All measures under consideration will be reviewed under one pathway*
    - » No longer a separate path for measures under development
  - *Preliminary analysis algorithm was updated*

Themes from discussion:

- Not evaluating measures under consideration for endorsement, but for readiness for rulemaking
- Need for better connections with end users
- Need for better integration with the CDP process
- Members have the ability to agree with staff preliminary analysis decision category, but disagree with rationale and open discussion
- Desire for meaningful measures that matter to patients and clinicians
- Removal of "topped out" measures

Q&A

Review of MAP Pre-Rulemaking Approach

Approach

The approach to the analysis and selection of measures is a four-step process:

1. Develop program measure set framework
2. Evaluate MUCs for what they would add to the program measure set
3. Identify and prioritize gaps for programs and settings
4. Develop recommendations for removal

MAP Measure Selection Criteria (MSC)

- Identify characteristics that are associated with ideal measure sets for public reporting and payment programs.
- Not absolute rules; provide general guidance and complement program-specific statutory and regulatory requirements
- Focus should be on the selection of high-quality measures that address the NQS's three aims, fill measurement gaps, and increase alignment.
- Reference for:
  - *evaluating the relative strengths and weaknesses of a program measure set*
  - *how the addition of an individual measure would contribute to the set*

MAP Measure Selection Criterion #1: NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

- Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
- Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
- Sub-criterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

MAP Measure Selection Criterion #2: Program measure set adequately addresses each of the National Quality Strategy's three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

- Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment
- Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being
- Sub-criterion 2.3 Affordable care

MAP Measure Selection Criterion #3: Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is "fit for purpose" for the particular program.

- Sub-criterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)
- Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers
- Sub-criterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)
- Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program
- Sub-criterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

MAP Measure Selection Criterion #4: Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program

- Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs
- Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes
- Sub-criterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

MAP Measure Selection Criterion #5: Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

- Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination
- Sub-criterion 5.2 Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives
- Sub-criterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

MAP Measure Selection Criterion #6: Program measure set includes considerations for healthcare disparities and cultural competency

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

- Sub-criterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)
- Sub-criterion 6.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

MAP Measure Selection Criterion #7: Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

- Sub-criterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)
- Sub-criterion 7.2 Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

MAP Decision Categories

- MAP Workgroups must reach a decision about every measure under consideration
  - *Decision categories are standardized for consistency*
  - *Each decision should be accompanied by one or more statements of rationale that explains why each decision was reached*
- The decision categories have been updated for the 2016-2017 pre-rulemaking process
  - *MAP will no longer evaluate measures under development using different decision categories*

MAP Decision Categories

Decision Category	Evaluation Criteria
Support for Rulemaking	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	The measure is fully developed and tested and meets assessments 1-6. However, the measure should meet a condition (e.g., NQF endorsement) specified by MAP before it can be supported for implementation. MAP will provide a rationale that outlines the condition that must be met. Measures that are conditionally supported are not expected to be resubmitted to MAP.
Refine and Resubmit Prior to Rulemaking	The measure addresses a critical program objective but needs modifications before implementation. The measure meets assessments 1-3; however, it is not fully developed and tested OR there are opportunities for improvement under evaluation. MAP will provide a rationale to explain the suggested modifications.
Do Not Support for Rulemaking	The measure under consideration does not meet one or more of the assessments.

Preliminary Analysis Algorithm

Preliminary Analysis of Measures Under Consideration

To facilitate MAP's consent calendar voting process, NQF staff will conduct a preliminary analysis of each measure under consideration.

The preliminary analysis is an algorithm that asks a series of questions about each measure under consideration. This algorithm was:

- Developed from the MAP Measure Selection Criteria, and approved by the MAP Coordinating Committee, to evaluate each measure
- Intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions

MAP Preliminary Analysis Algorithm

1. The measure addresses a critical quality objective not currently, adequately addressed by the measures in the program set.
2. The measure is an outcome measure or is evidence-based.
3. The measure addresses a quality challenge.
4. The measure contributes to efficient use of resources and/or supports alignment of measurement across programs.
5. The measure can be feasibly reported.
6. The measure is NQF-endorsed or has been submitted for NQF-endorsement for the program's setting and level of analysis.
7. If a measure is in current use, no implementation issues have been identified.

MAP Preliminary Analysis Algorithm

- Assessment 1: The measure addresses a critical quality objective not adequately addressed by the measures in the program set.
- Definition:
  - *The measure addresses the broad aims and one or more of the six National Quality Strategy priorities; or*
  - *The measure is responsive to specific program goals and statutory or regulatory requirements; or*
  - *The measure is can distinguish differences in quality, is meaningful to patients and providers, and/or addresses a high-impact area or health condition.*
- Outcome:
  - *Yes: Review can continue.*
  - *No: Measure will receive a Do Not Support.*

MAP Preliminary Analysis Algorithm

- Assessment 2: The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.
- Definition:
  - *For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented can lead to the desired outcome(s).*
  - *For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is influenced by healthcare processes or structures.*
- Outcome:
  - *Yes: Review can continue.*
  - *No: Measure will receive a Do Not Support.*

MAP Preliminary Analysis Algorithm

- Assessment 3: The measure addresses a quality challenge.
- Definition:
  - *The measure addresses a topic with a performance gap or addresses a serious reportable event (i.e. a safety event that should never happen); or*
  - *The measure addresses unwarranted or significant variation in care that is evidence of a quality challenge.*
- Outcome:
  - *Yes: Review can continue.*
  - *No: Measure will receive a Do Not Support.*

MAP Preliminary Analysis Algorithm

- Assessment 4: The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.
- Definition:
  - *The measure is either not duplicative of an existing measure or measure under consideration in the program or is a superior measure to an existing measure in the program; or*
  - *The measure captures a broad population; or*
  - *The measure contributes to alignment between measures in a particular program set (e.g. the measure could be used across programs or is included in. a MAP "family of measures") or*
  - *The value to patients/consumers outweighs any burden of implementation.*
- Outcome:
  - *Yes: Review can continue.*
  - *No: Highest rating can be refine and resubmit.*

MAP Preliminary Analysis Algorithm

- Assessment 5: The measure can be feasibly reported.
- Definition:
  - *The measure can be operationalized (e.g. the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care.)*
  - *The measure is fully developed and full specifications are provided.*
- Outcome:
  - *Yes: Review can continue.*
  - *No: Highest rating can be refine and resubmit.*

MAP Preliminary Analysis Algorithm

- Assessment 6: The measure is reliable and valid for the level of analysis, program, and/or setting(s) for which it is being considered.
- Definition:
  - *The measure is NQF-endorsed; or*
  - *The measure testing has demonstrated reliability and validity for the level of analysis, program, and/or setting(s) for which it is being considered.*
- Outcome:
  - *Yes: Measure could be supported or conditionally supported.*
  - *No: Highest rating can be refine and resubmit.*

MAP Preliminary Analysis Algorithm

- Assessment 7: If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.
- Definition:
  - *Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or*
  - *Feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and*
  - *Feedback is supported by empirical evidence.*
- Outcome:
  - *If no implementation issues have been identified: Measure can be supported or conditionally supported.*
  - *If implementation issues are identified: The highest rating can be Conditional Support.*

Q&A

Recommendations for Removal

Holistic Review of Measure Sets

- MAP has expressed a need to better understand the program measure sets in their totality:
  - *How MUCs would interact with current measures;*
  - *Endorsement status of current measures;*
  - *Experience with current measures*
- For the 2016-2017 pre-rulemaking cycle, MAP will offer guidance on measures finalized for use:
  - *MAP will offer input on ways to strengthen the current measure set including recommendations for future removal of measures.*
  - *This guidance will be built into the final MAP report but will not be reflected in the "Spreadsheet of MAP Final Recommendations."*

Coordinating Committee Guidance

- Desire for meaningful measures that matter to patients and clinicians
- Areas for Workgroup Focus:
  - *Removal of "topped out" measures*
  - *Integration with CDP process*
  - *Consider unintended consequences*
  - *Determine if measures are performing as expected*

Q&A

Review of the Voting Process

Key Voting Principles

- Every measure under consideration will be subject to a vote, either individually or as part of a consent calendar
- Workgroups will be expected to reach a decision on every measure under consideration
  - *There will no longer be a category of "split decisions" where the MAP Coordinating Committee makes a decision on a measure under consideration*
  - *However, the Coordinating Committee may decide to continue discussion on a particularly important matter of program policy or strategy in the context of a measure for a program*
- Staff will provide an overview of the process for establishing consensus through voting at the start of each in-person meeting

Key Voting Principles

- After introductory presentations from staff and the Co-Chairs to give context to each programmatic discussion, discussion and voting will begin using the electronic Discussion Guide.
- A lead discussant will be assigned to each group of measures.
- The Discussion Guide will organize content as follows:
  - *The measures under consideration will be divided into a series of related groups for the purposes of discussion and voting*
  - *Each measure under consideration will have a preliminary staff analysis*
  - *The discussion guide will note the result of the preliminary analysis (PA) (i.e., support for rulemaking, conditional support for rulemaking, refine and resubmit prior to rulemaking, or do not support for rulemaking) and provide rationale to explain how that conclusion was reached*

Voting Procedure

Step 1. Staff will review a Preliminary Analysis Consent Calendar

- Staff will present each group of measures as a consent calendar reflecting the result of the preliminary analysis using MAP selection criteria and programmatic objectives

Voting Procedure

Step 2. MUCs can be pulled from the Consent Calendar and become regular agenda items

- The co-chairs will ask the Workgroup members to identify any MUCs they would like to pull off the consent calendar.
  - *Any Workgroup member can ask that one or more MUCs on the consent calendar be removed for individual discussion*
  - *The member requesting discussion should be prepare to give a reason*
- Once all of the measures the Workgroup would like to discuss are removed from the consent calendar, the co-chair will ask if there is any objection to accepting the preliminary analysis and recommendation of the MUCs remaining on the consent calendar
- If no objections are made for the remaining measures, the consent calendar and the associated recommendations will be accepted (no formal vote will be taken)

Voting Procedure
Step 3. Voting on Individual Measures

- Workgroup member(s) who identified measures for discussion will describe their perspective on the measure and how it differs from the preliminary analysis and/or the recommendation in the Discussion Guide.
- Workgroup member(s) assigned as lead discussant(s) for the group of measures will respond to the individual(s) who requested discussion. Lead discussant(s) should state their own point of view, whether or not it is in agreement with the preliminary recommendation or the divergent opinion.
- Other Workgroup members should participate in the discussion to make their opinions known. However, in the interests of time, one should refrain from repeating points already presented by others.
- After discussion of each MUC, the Workgroup will vote on the measure with four options:
  - *Support for rulemaking*
  - *Conditional support for rulemaking*
  - *Refine and resubmit prior to rulemaking*
  - *Do not support for rulemaking*

Voting Procedure
Step 4: Tallying the Votes

- If a MUC receives ≥ 60% in any one decision category, the recommendation is that decision category
  - *E.g., If a MUC receives ≥ 60% for Support for Rulemaking, the recommendation is Support for Rulemaking*
- If a MUC receives ≥ 60% for the **sum** of Support and Conditional Support for Rulemaking, the recommendation is Conditional Support for Rulemaking
  - *Staff will clarify and announce the conditions at the end of the vote*
- If a MUC receives ≥ 60% for the **sum** of Support and Conditional Support, and Refine and Resubmit Prior to Rulemaking – the recommendation is Refine and Resubmit Prior to Rulemaking
  - *Staff will clarify and announce the refinements at the end of the vote*
- If a MUC receives < 60% for the **sum** of Support, Conditional Support, and Refine and Resubmit Prior to Rulemaking, the recommendation is Do Not Support for Rulemaking
- Abstentions are discouraged but will not count in the denominator

Voting Procedure
Step 4: Tallying the Votes

DO NOT SUPPORT	REFINE AND RESUBMIT	CONDITIONAL SUPPORT	SUPPORT
> 60% consensus of do not support	≥ 60% consensus of refine and resubmit	≥ 60% consensus of conditional support	≥60% consensus of support
< 60% consensus for the combined total of refine and resubmit, conditional support and support	≥ 60% consensus of refine and resubmit, conditional support and support	≥ 60% consensus of both conditional support and support	N/A

Voting Procedure
Step 4: Tallying the Votes

25 Committee Members
2 members abstain from voting

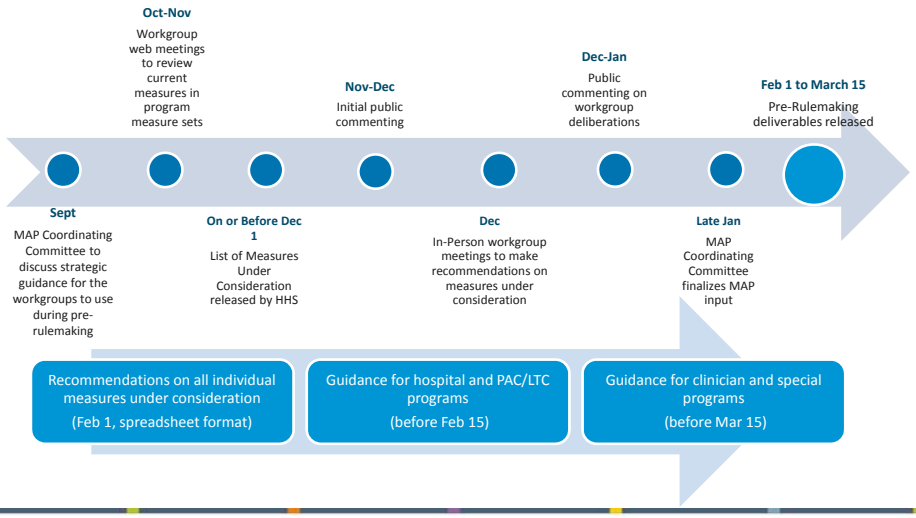
Voting Results	
Support for Rulemaking	10
Conditional Support for Rulemaking	4
Refine and Resubmit for Rulemaking	2
Do Not Support for Rulemaking	7
Total:	23

10+4 = 14/23 = 61%
The measure receives a recommendation of Conditional Support for Rulemaking

Q&A

Review of the Pre-Rulemaking Discussion Guide

MAP Approach to Pre-Rulemaking
A look at what to expect



Q&A

Public and Member Comment

Timeline of Upcoming Activities

Release of the MUC List – by December 1

Public Comment Period #1 – Timing based on MUC list release

In-Person Meetings

- Hospital Workgroup – **December 8-9**
- Clinician Workgroup – **December 12-13**
- PAC/LTC Workgroup – **December 14-15**
- Coordinating Committee – **January 24-25**

Web Meetings

- Dual Eligible Beneficiaries Workgroup – January 10, 2017, 12-2pm ET
  - *Reviews recommendations from other groups and provide cross-cutting input during the second round of public comment*

Public Comment Period #2 – December 21-January 12

Resources

- CMS Pre-Rule Making Webinars:
  - *April 5, 2016: 2016 Measures Under Consideration (MUC) Kick Off*
  - *April 7, 2016: 2016 JIRA Open Forum Discussion*
  - *April12, 2016: 2016 Program Measurement Needs and Priorities Session*
  - *April 14, 2016: 2016 JIRA Open Forum Discussion*
- CMS' Measurement Needs and Priorities Document:
  - *Final_4_12_2016_MUC_Program_Priorities_Needs*
- Pre-Rule Making URL:
  - *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html*
- MAP Member Guidebook:
  - *2016-2017 version forthcoming*

Adjourn

NATIONAL QUALITY FORUM

Moderator: MAP Coordinating Committee
November 16, 2016
12:00 p.m. ET

OPERATOR: This is Conference #71938245.

Erin O'Rourke: Good afternoon, everyone. This is Erin O'Rourke here at NQF. I'm joined by the staff supporting the MAP as well as Harold Pincus, co-chair of the Coordinating Committee. We'd like to thank you all for taking the time to join us this afternoon.

We'd convened this web meeting so that we could cover some of the process that you'll use to make these pre-rulemaking recommendations at the workgroup level. We wanted to get you all together so that we could ensure that the decisions are being made as consistently as possible. We also wanted to take some time to update you on what happened at the September Coordinating Committee meeting and let everyone know about some changes to the process that we've made this year based on feedback we've received from all of you as well as other stakeholders.

So with that, I'd like to welcome Harold Pincus, Co-Chair of the Coordinating Committee, to share a few thoughts as we get ready to kick off our six-year pre-rulemaking.

Harold Pincus: So welcome, everybody. I also want to send my regards from (Chip) who is unable to make it. He's actually on a trip for a major anniversary with his wife. And he regretfully can't make it, but I'm sure he's having a great time.

So, you know, we are preparing for the sixth round. And I think it's really important that we understand that there's actually going to be some changes

that make it a bit different from what we've done previously. In part, it's due to sort of the issues that we've actually requested as the MAP to have more involvement with in terms of thinking about the broader context in which the measures under consideration are being introduced. So that while we'll be going over this list of measures under consideration, we will also be considering a number of other issues in terms of what measures are also going to be sort of in these different programs, what measures are being eliminated. And also we're going to be thinking about measures in a more, I wouldn't say, complicated, but in a more thoughtful kind of way in which we respond to the measures; both measures that are being considered for immediate implementation into these programs, but also measures that are moving more forcefully along the pathway to become measures included in the programs.

So, I'll stop there because we have a limited amount of time, but we want to really orient everybody to the kinds of activities and decision-making processes that we're going to be undertaking over the next several months.

So, Kim?

Erin O'Rourke: Great. Thank you so much, Harold. So with that, I would like to introduce Pierre Yong from CMS to give you an overview of how the MUC list is created. So, thank you so much, Pierre, for joining us today.

Pierre Yong: Thanks, Erin. And as Erin said, my name is Pierre Yong. I am the Director of the Quality Measurement and Value-Based Incentives Group here at CMS. And we have a responsibility for compiling the MUC list and want to, first of all, thank all of you for taking time from your busy schedules to engage in the entire MAP process. We know that folks are engaged in lots of other activities and really do appreciate all the time and effort that you put in to really providing CMS with really thoughtful and thought-provoking advice and discussions. It's really something we have come to value tremendously as we have grown throughout this process over the past six years as Harold mentioned. I also do want to thank NQF staff for also helping us facilitate this entire process.

But this first slide just – we included just to give you a sense of how we are organized within this particular group, the Quality Measurement and Value-Based Incentives Group here at CMS. Maria Durham, (it says in) the bottom left-hand corner is the Division Director for our Division of Program and Management (sic - Measurement) Support. She probably – you probably may be familiar with her name as she and her staff actually are the coordinators of the MUC process for the agency. And so, I really do want to thank her and her staff for all the efforts they do in terms of getting this ready for public input.

The other divisions both across Chronic and Post-Acute Care, Division of Quality Measurement, Electronic and Clinician Quality, Health Information Technology, and then Value Incentives and Quality Reporting, all focused on different aspects of programs, of the quality programs that we lead, which include all the Medicare Quality Reporting and Value-Based Incentives Program (list) towards the end of my few slides that will show you the list of programs that both are included in the MAP discussions, most of which are housed within this particular group.

And then Reena Duseja, who I just wanted to mention in particular, just joined us two weeks ago as our new Director for the Division of Quality Measurement, who you'll get to know and we'll be interacting with many of you, so.

Can I now move on to the next slide, please? I'm not going to read this in its entirety, but we did want to just acknowledge that the origins of what we call this pre-rulemaking process that has evolved into the MAP and the MUC process originated in the Affordable Care Act in Section – under Section 3014, which is 1890 of the Social Security Act.

Generally, essentially, it says that we will get multi-stakeholder input into measures we potentially may consider using in our quality programs, that this list of potential measures for inclusion in our programs will be published no later than December 1st of each year. So we very much strive to try and get it out as early as possible to allow for as much public input and review as possible. And that by no later than February 1st of each year, there's report

that's generated from this multi-stakeholder input that will be then be considered by the agency and by CMS when we do our final selections in terms of the rulemaking.

So, next slide. As I mentioned before, we have really appreciated the input that's been provided by the MAP and the public throughout this entire process and really have seen the value of the comments offered and the discussions at the MAP meetings. And they had helped us become more, I think, thoughtful. They have challenged us to think about sort of the hard questions and, really, I think, forced us to be a more strategic in thinking about how we approach quality measures and their use in our program.

In particular, we wanted to highlight that this entire process really did provide an earlier chance to get public input into these potential measures that we might want to include. We, as part of this process, also have come to think about measures in terms of alignment as we develop the MUC list, how we fill measurement gaps and what are those measurement gaps. And we also think about the potential impact of these measures might have once they're implemented. So that becomes part of the discussion as well. And I think that's pretty valuable to have those kinds of discussions upfront.

So, next slide, please. This, I'm sure, is familiar to all of you who are able to join us today. It is the CMS quality strategy aims and goals. But the center you'll see, the triple aim of better care, healthier people, healthier communities, and smarter spending, which is surrounded by the goals.

And if you go to the next slide. These goals, again, I'm sure, are pretty familiar with all – to all of you, including safer care, strengthening person and family engagement, promoting effective communication and coordination of care, promoting effective prevention and treatment of chronic disease, working with communities to promote best practices of healthy living and making care affordable. And grounding all of that, you can see in the center, things that we really do take to heart and as part of our sort of consideration is limiting racial and ethnic disparities, strengthening infrastructure and data systems, enabling local innovations and fostering learning organizations as our foundational principles.

Next slide, please. So we often get asked what we think of or what are our criteria when we pull together the MUC list each year. And so, we wanted to share those with you and are happy to answer questions about these. But one of the first considerations is really to respond to specific program and statutory requirements. And sometimes there are very specific requirements in statute and in legislation in terms of the types of measures that we need to include in certain programs. And so, we do need to meet those goals and statutory requirements.

But we also want to consider addressing important topics where there are gaps in measures, where there's demonstrated performance gaps or variation in quality, so there's opportunity for improvement and areas where there are measures which are evidence based. We do, as I've just mentioned, focused and aligned our measures to areas where – that align with the National Quality Strategy priorities.

We do want to do our best in avoiding duplication with measures already implemented in programs. But we also look forward and see if there are better measures out there. We sometimes move those forward for discussion with sometimes if – and if those sort of more advanced measures get put into programs, we may remove the sort of lower bar or topped out measure to sort of have this newer measure and the program replace the older measures.

We also look for measures that are as fully developed as possible that have numerators, denominators, exclusion that have clearer data collection mechanisms that have reliability, validity testing, risk adjustment as appropriate. And so, we look for all of those elements as we evaluate measures that are considered for the MUC list.

And the final element is really alignment of the measures as I mentioned previously, not just within a program, meaning duplication, but across the programs, right, across the hospital setting programs, for example, or across hospital in the post-acute care setting program. We look for alignment and consider alignment not just at the public programs, but also private programs. And I think many of you might also be aware of efforts we've been working

with AHIP and many of the specialty societies, and as well as consumer and provider groups on the Core Quality Measures Collaborative, which identified seven measure sets for – core measure sets in seven different areas. And so we've taken those into account in developing the MUC list as well.

Next slide. Just a few things just to make sure we're on the same page, but the way we've approached the MUC list or that measures on the current list. We do not put them again on the MUC list. The exception to that is if there is some sort of substantive change to the measure. We certainly put those back on the MUC list for consideration. If that measure is being proposed and then you program, we certainly put those on the MUC list. But generally, if it's already in the program, we don't put the same measure if there are no changes back on to the MUC list.

Submissions will be accepted if the measure was previously proposed on a prior year's MUC list but was not accepted by a CMS program. And finally, again, as I mentioned, measure specifications can change. And if there's a substantive change, that to us is a reason to put it back on the MUC list.

Next slide, please. As you can see, we practically ran out of space on the slide, but these are the variety and list of the programs that are considered during the MUC list and the MAP deliberations. So thank you all to making the time to really provide us thoughtful feedback on all of these programs. But I won't read through the entire list.

Next slide, please. This just gives you a sense of time line. I think this is my last slide. But we – to develop the MUC list, it takes a considerable amount of efforts, both from our side as well as from the measure stewards out in the community as – and really it starts in January; as you could in this past year where we opened up our collection engine called JIRA for submissions for (inaudible) measures for the MUC list. And we've opened this up to the public, so any measure stewards or other interested parties can submit measures for consideration to our program. We also, as folks know, developed measures within CMS. And so we will put measures onto the MUC list as well.

JIRA closed this in July. And then between July and now is when we are reviewing and vetting all the submissions. And so, many of us reached out to, you know, the measure stewards as – with additional questions about testing, about (inaudible) obtain more clarity on the submissions to understand where the measure is in its development process to – and then really undergo some really in-depth conversations within CMS and with our leadership to make decisions about what measures we think best are suited and for the MUC list that year.

And it takes – and I should also mention that the process not only involves CMS input, but input from across the health – Department of Health and Human Services. So we work closely with colleagues in ASPE, which is the Office of the Assistant Secretary for Planning and Evaluation, with colleagues from CDC, from AHRQ, and really do work across the agency to obtain their feedback in formulating this final MUC list.

We engage stakeholders throughout best in process. And finally, begin the clearance process officially in August, and then do our best to try and publish the list by December 1st; though we really do try to get it as earlier as we can.

Next slide, please. So I will stop there. Turn it back to Erin. I don't know if there are any questions.

Erin O'Rourke: Sure. Operator, could you open the lines if any MAP members have any questions for Pierre?

Operator: Thank you. If you would like to ask a question, please press star one. We'll pause for just a moment.

And you do have a question from (Nancy Foster).

(Nancy Foster): Pierre, hi, it's (Nancy). Thanks so very much for this presentation. And I have to agree with you that things – that we've all had some learnings from the process over the last several years. Could you say a word about whether you anticipate you're going to make an early delivery date this year? And also, maybe (because it’s been) hanging over many people's heads these days is

since we're hearing a lot of conversation around repeal and replace of the Affordable Care Act, do you think this is a part of the Affordable Care Act that might be retained? Have you had any indication of such?

Pierre Yong: Thanks, Nancy, and thanks for the question. So, I wish I had definitive answers on both of those questions. But maybe I'll start with the first one. I do not have a specific date. We really are trying to get this released as soon as possible. I don't – unfortunately, I can't promise on a specific date, but we really are trying to get this out as soon as we can. So, that's probably as much as I can promise at this point. I think it's a good question about sort of what's happening sort of in the broader scheme of health care with all these sort of discussions that's happening around sort of the future of the Affordable Care Act.

You know, I think it's unclear to all of us, you know, what exactly, you know, actions will be taken, you know, in the Congress and by the Office of the President-Elect. So, I will tell you that we have valued this input. And so, hope that this will – we will be able to continue getting that input. But as to its future and whether it will be repealed, you know, your guess is as good as mine. We do not have any additional information than what we read in the news.

Erin O'Rourke: So we have a few other questions from the web chat. Pierre, if you could discuss what steps you take to ensure that performance associated with measures that have been removed because they are topped out (as not a road).

Pierre Yong: Right. So we do have monitoring and evaluation contracts that we – and efforts within our group. So we continue to monitor sort of the performance on the measures and sort of – and the overall sort of impact of the programs. As folks know, there's another part of the Affordable Care Act, which also does require tri-annual reports on the impact of our quality measures, and in terms of improving and changing sort of the landscape and outcomes in the United States. So, I think through this variety of mechanisms, that's how we monitor for (continuing) impact.

Harold Pincus: Pierre, in terms of the tri-annual reports, when is the next one due and where are you with that?

Pierre Yong: I think – so we are – we have formed the (tap) on that. We are well on our way towards developing the next report. I believe the next report is due – and I will have to double check this, but I believe it's due in 2018.

Harold Pincus: OK.

Erin O'Rourke: So we have another web chat question. On slide 11, it says that submissions will be accepted if the measure was previously proposed to be on a prior year's list or prior year's published MUC list but was not accepted by any CMS program. If you could briefly (inaudible) (caveat) of it.

Pierre Yong: Oh, sure. So, for example, perhaps there was a measure that was submitted, you know, on – I'm just going to say, like a patient safety measure. Perhaps it didn't make it onto the MUC list or perhaps, you know, because – and I will – again, this is hypothetical situation, maybe it wasn't fully developed at that point or maybe it wasn't perfectly specified for the program or perhaps it was specified for hospitals that it was put on, you know, for MIPS, which is a clinician-based program.

There are a variety of reasons why, you know, measures may not make it onto the MUC list. So if that's the case and the measure steward does additional work, maybe it's completing the development, maybe it's re-specifying it for the appropriate level of analysis and for attribution for the program that they want to submit it to, then we welcome folks to resubmit those measures for consideration under the MUC list. Hopefully that helps.

Erin O'Rourke: Great. Thank you. Operator, you made a note that there's a question in the queue.

Operator: Yes, you have a question from (Beverly Court).

(Beverly Court): Hi, I was just trying to grasp for maybe a specific. So, for example, if AMA is going to be re-specifying the care transition measure within 24 hours, then it would go through this process. It's already an endorsed measure, but its

specification is a little bit problematic. So, if they were to go through that, can you just use that as an example?

Pierre Yong: So I don't know the details of the measure. So the measure is being re-specified, you said?

(Beverly Court): Right. Currently, the specifications are kind of wonky. The denominator is (all clients) where it should be discharges. There's clarification that it shouldn't aggregate inpatient and nursing homes. For example, it should be interpreted as an or rather than and. Anyway, there's multiple kind of clarifications of the measure. And so, is that considered a new measure? It would actually look – it would be nice if there were new measure just so that it not gets mixed up with the old one.

Pierre Yong: Right. And so, you know, it's hard to say without knowing a little bit more detail. But, in general, it sounds like those kinds of changes potentially – things like increasing the – or expanding the denominators, you know, specifications or including different settings of care, those kinds of changes generally are considered substantive changes. And measures that do have substantive changes from what's already in a program would go back on the MUC list or we would put them back on the MUC list for discussion by the MAP.

(Beverly Court): Thank you. But they have to be submitted to NQF for endorsement first?

Pierre Yong: So, I think it – sometimes it happens in parallel, sometimes it happens afterwards. Certainly, I think we have – value NQF endorsement, and I think certainly we've heard at the MAP discussions the – you know, that they value that process as well because during that process, there is rigorous for you of this being merits of that measure in terms of, you know, specifications, reliability, validity testing, risk adjustment, et cetera. But there's no specific requirement in terms of sequencing.

Harold Pincus: And as Pierre said, it often comes up in our discussions, you know, in the MAP and often is a reason for conditional recommendation.

Pierre Yong: Thanks, Harold.

Operator: And there are no further phone questions at this time.

Erin O'Rourke: Great. So thank you so much, Pierre, and thank you, everyone, for your questions.

With that, I'd like to introduce Kim Ibarra, one of our senior project managers here, to give everyone a debrief of the Coordinating Committee's discussion during our September meeting.

Kimberley Ibarra: Great, thanks, Erin. So on September 27th, the MAP Coordinating Committee met in person in Washington, D.C. to review and revise the process MAP will use to make recommendations on the measures under consideration. As Harold mentioned earlier, three changes are being made to the process. The first is that measure sets are going to be reviewed holistically. MAP will have the opportunity to look at the full measure set and make recommendations around gaps and removal of measures. The second is that all measures under consideration are going to be reviewed under one pathway. And the third is an update to the preliminary analysis algorithm. And we'll go into all of these refinements in more detail throughout the presentation.

The Coordinating Committee emphasized a number of points at their in-person meeting. The first was that MAP evaluates measures under consideration for their readiness for rulemaking and distinguish this from the process that the Consensus Development Process or CDP uses, which evaluates measures for endorsement. But given that these processes are different and distinct, they discussed the need for better integration between MAP and CDP. So that each of these processes are learning from each other and not siloed.

The MAP Coordinating Committee also discussed the need for better connections between the measures under consideration and measure end users, and the desire for more meaningful measures that matters to patients and to clinicians. In their discussions on refinement to the pre-rulemaking process, the Coordinating Committee stressed the importance of having open

discussions of the MUC list and MUCs, and being able to discuss disagreements with the rationale for a preliminary analysis decision category without necessarily disagreeing with the decision category itself. And finally, the committee discussed review of holistic measure sets and their recommendation of removing topped out measures where there's little or no improvement gaps.

Harold, before we open for questions about that, is there anything you wanted to add about the September in-person meeting for the Coordinating Committee?

Harold Pincus: Well, in some ways, probably the most important theme that came out of that was that, CMS really lets us know to a significant degree that while it's very important to them what our decisions are, what our recommendations for the different decision categories are, but even more important is the nature of the discussion that we have about it so that we actually are helping them to think through what are the issues that come up, what are the kind of concerns that people bring to the table, you know, what ideas people have for potential solutions and those kinds of things, and that kind of, you know, serious systematic thoughtful discussions are, you know, at least as important, if not, more than the actual recommendations.

Erin O'Rourke: Great. Thanks. Operator, can we open the lines if there are any questions about the September in-person meeting?

Operator: Thank you. If you would like to ask a question, please press star one.

And you have a question from (Rhonda Anderson).

Kimberley Ibarra: Hi, (Rhonda).

Operator: (Rhonda), if you're on mute, please unmute your line.

(Rhonda Anderson): Thank you. I just wanted to emphasize number two on the – (about) alignment (at the) meaningful part. I think we had a long discussion again, and we seem to have on every MAP meeting. So (when it appeared here) that we've really think it's important to have those, if you will, (inaudible) that are

going to make a huge change in health and in engagements of our population at large. So I just wanted to emphasize that.

Kimberley Ibarra: Thanks, Rhonda.

Operator: And there are no further audio questions at this time.

Kimberley Ibarra: And we don't seem to have any web chat questions about the debrief. So I will move on to review of the MAP pre-rulemaking approach. So MAP uses a four-step approach to analyzing and selecting measures in pre-rulemaking. The first step is to develop a program measure set framework that identifies the measures currently in the federal programs.

Next, MAP evaluates each measure under consideration for what they would add to the program measure set using the framework. MAP identifies and prioritizes gaps in measures for programs in settings. And finally, MAP develops recommendations for removal of measures from program sets.

So we wanted to reorient members or orient new members to the MAP Measure Selection Criteria. These have been in place since the first year of MAP. The Measure Selection Criteria are a tool that MAP uses to assess effective measures used in a quality initiatives program. They're intended to assist MAP to identify what an ideal set of measures would be for public reporting and payment programs. They evaluate the measure set as a whole, which is a key thing to remember as we go through the criteria.

Also to note, the criteria are not absolute rules, rather, they're meant to provide general guidance on measure selection decisions and to complement programs specific statutory and regulatory requirements. A central focus should be on selecting high-quality measures that address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment.

Although, competing priorities often need to be weighed against one another, the Measure Selection Criteria can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set and how adding an individual measure would contribute to the set. The criteria have evolved over time to reflect the input of a variety of stakeholders.

To determine whether a measure should be supported for rulemaking for a specified program, MAP evaluates the measures under consideration against the Measure Selection Criteria. MAP members are expected to familiarize themselves with the criteria and use them to indicate their support for a measure under consideration.

There are seven Measure Selection Criteria and I'll go through each one. I won't read out everything on this slide. The first criterion is that NQF-endorsed measures are required for program measure sets unless there's no relevant endorsed measures to achieve a critical program objective. Second, the program measure set adequately addresses each of the National Quality Strategy's aims, better care, healthier people and healthier communities, and smarter spending.

Third, the program measure set is responsive to a specific program goals and requirements that the measure set fits the purpose of the public reporting or value-based payment program. Fourth, the program measure set includes an appropriate mix of outcome, experience of care, cost and resource use, composite, process and structural measures necessary for the specific program with an emphasis on outcomes that matter to patients.

Fifth, this program measure set enables person- and family-centered care and services to be measured including access, choice, self-determination, shared decision-making, and community (inspiration). Sixth, that the measure set promotes equitable access and treatment by considering health care disparities and cultural competency. And finally, that the program measure set promotes alignment and balances the degree of efforts associated with measurement and its opportunity to improve quality.

After applying the Measure Selection Criteria to their program measure set as a whole, MAP reviews the measures under consideration for the current pre-rulemaking cycle. MAP reaches the decision about every measure under consideration. This means that every single measure on the MUC list will receive a recommendation from MAP. The decisions are standardized for consistency across the workgroups. Each decision is accompanied by one or

more statements of rationale that explains the decision – why each decision was reached. And as Harold mentioned, this is really some of the most valuable feedback from MAP.

I did want to highlight that MAP is evaluating all measures under consideration under one pathway using the following decision categories. Support for rulemaking, conditional support for rulemaking, refine and resubmit prior to rulemaking, and do not support for rulemaking. MAP may support a measure for rulemaking for a number of reasons that may address the previously identified gap in a program or help promote alignment. MAP may conditionally support a measure for rulemaking if MAP thinks it's ready for rulemaking but needs a condition like NQF endorsement.

The Refine and Resubmit category is new for this year. MAP implemented this category to allow a way to express its support for the concept of a measure, but to stipulate that, it needs modification such as testing before it's ready for rulemaking. And finally, MAP may not support a measure for rulemaking if it overlaps (with) existing measures or if a different measure better addresses the need of the program.

So, with that, I'll turn it over to Erin to walk through the preliminary analysis algorithm.

Erin O'Rourke: OK. Thank you, Kim. So, to facilitate the consent calendar voting process that we implemented a few cycles back to help speed up the meeting process and allow more time for discussion. NQF staff conducts a preliminary analysis of each measure under consideration. This is really a tool for our MAP's members and the public to give them that little snapshot of each measure and what it could potentially add to the program measure set.

So the preliminary analysis is an algorithm that asks a series of questions about each measure under consideration. This algorithm was developed from the MAP Measure Selection Criteria. It's really a way to operationalize the measure selection criteria at the level of an individual measure under consideration. This was approved by the MAP Coordinating Committee during their September 27th meeting. It's something that we bring to the

Coordinating Committee each year for their input and refinement, and, again, as I noted, an attempt to provide MAP members with a succinct profile of each measure and to serve as a starting point for discussion.

Next slide. So here you can see the preliminary analysis algorithm at a glance. With that, I'd like to dive into each of the seven assessments that we'll be conducting on each measure under consideration. So the first assessment asks if the measure addresses a critical quality objective not adequately addressed by the measures in the program set. We're defining this as the measure addresses the broad aims and one or more of the six National Quality Strategy priorities, or the measure responses to specific program goals, and statutory or regulatory requirements, or the measure can distinguish differences in quality as meaningful to patients and providers, and addresses a high-impact area or health condition. So, if the answer to this question is a yes, review can continue. If the measure does not meet these requirements, the measure would receive a preliminary decision of do not support.

With that, I do just want to pause and let everyone know that this might be what you'll receive from the staff in your initial discussions. Again, as it was last year, this is non-binding. It's really just a starting point for discussion. So, I don't want anyone to be alarmed when you see measures tagged with that decision by the staff as the result of the preliminary analysis. Again, it's – staff attempts to acquire this algorithm. And our best thinking combined with what MAP has said over the years to give you a starting point for discussion. But, again, the results of this algorithm are non-binding and it's for workgroup discussion. So …

Harold Pincus: But I think it's worth pointing out that it does require some homework for people before the meeting to kind of go over this. And, you know – and consider what things they may want to bring off the consent calendar.

Erin O'Rourke: Yes, thank you, Harold. That's a good point. We would ask that everyone reads the preliminary analyses on the measures under consideration sort of programs that your workgroup is reviewing and to spend some time thinking about why you would agree or disagree and which ones you'd like to pull off.

So, next slide. So the second assessment asks if the measure is evidence-based. And it's strongly linked to outcomes or is an outcome measure. So for this, we're defining their process and structural measures. The measure has a strong scientific evidence based that demonstrate that when implemented can lead to the desired outcome. And for outcome measures, the measure has a scientific evidence-based and rationale for how the outcome is influenced by health care processes or structures. Again, similarly here, if the answer is a yes, the review will continue. No, the measure would receive a do not support.

Next slide. So, assessment three asks if the measure addresses the quality challenge. This is defined as the measure addresses a topic with a performance gap or it addresses a serious reportable events, such as the safety event that should never happen. Or, the measure addresses unwarranted or significant variation in care that is evidence of a quality challenge. Again, here, if it's a yes, the review can continue. No, the measure will receive a do not support.

Assessment four asks if the measure contributes to efficient use of measurement resources, and/or supports alignment of measurement across program. This is defined as the measure is either not duplicative of an existing measure or the measure under consideration of the existing measure or measure under consideration in the program, or superior to an existing measure in the program, or the measure captures a broad population, or the measure contributes to alignment between measures in a particular program set. For example, the measure could be used across programs or is included in the MAP family of measures; or the measure – or the value of patients and consumer – value to patients and consumers outweighs any burden of implementation. So, again, here, if it's a yes, review can continue. If it's a no the highest rating would be refine and resubmit, and MAP would provide guidance about what changes you'd like to see to the measure.

Assessment five asks if the measure can be feasibly reported. We're defining this as the measure can be operationalized. So the measure is fully specified. The specifications used data found in structure data field. And data are captured before, during, or after the course of care. Again, yes, review will

continue. No, highest rating would be refine and resubmit. And, again, MAP would provide a statement noting what changes you'd like to see.

Assessment six asks if the measure is reliable and valid for the level of analysis program and/or setting for which it is being considered. And, again, I apologize there is a typo on how we're defining this. But, again, we can update this, but we're defining this as measures endorsed or a testing of the measure has demonstrated reliability and validity at the level setting and program for what is being considered. Here, if the measure is a yes, it could be supported or conditional supported. If no, again, the highest rating would be a refine and resubmit with a statement accompanying that decision of what changes MAP would like to see.

Also, the next slide, assessment seven, this one asks if the measure is in current use. No unreasonable implementation issues that outweigh the benefits of the measure have been identified. We're defining this as feedback from end users has not identified any unreasonable implementation issues that outweigh the benefit of the measure. Or feedback from implementers or end users has not identified any negative unintended consequences.

Some examples of this might be premature discharges, overuse or inappropriate use of care treatments, limiting access to care, and the measure is for the – this feedback is supported by empirical evidence. So the outcome here is no implementation issues have been identified, the measure could be supported or conditionally supported depending on the results of the prior assessment. If implementation issues are identified, the highest rating would be conditional support. Again, with a statement noting what those issues would be essential resolution.

So with that, I know we've covered quite a bit of the process. So I think we wanted to pause for any questions from MAP members here.

Operator: Thank you. At this time, if you'd like to ask a question, please press star one.

You have a question from (Beverly Court).

Erin O'Rourke: Hi, (Beverly).

(Beverly Court): Hi, thank you. Quick question, when you say that you review implementation issues, which I think is great, how do you gather the information about implementation issues? I know that the states, for example, in trying to work with many of the measures that CMS has adopted for a different program are struggling. And so how is that information – is it information that goes directly to MAP? How is that information gleaned?

Erin O'Rourke: Sure. So this is actually something we're really trying to build up. It's a place where we look to our MAP members to gather the feedback from their networks and what you're hearing from, you know, either the members of your association or those you're working within the fields. It's something we're building up the NQF processes as part of our strategic plan to better collect this data.

We know this is definitely a struggle and challenging to find this. So it's something we are working to build our capacity to do. And we'd welcome any thoughts or suggestions that you might have especially as we move through the process. So, any input here on sources we could look to would be most welcome.

(Beverly Court): That would be great. I think the states were kind of informally kind of structuring some self – or self-surveys of kind of the review of the measures for different CMS initiatives to identify what the implementation issues have been. But there are quite a few. And so I haven't seen that get incorporated yet in the MAP process. So, I would be excited to do that, in fact, those issues could be incorporated into the review. Thanks.

Erin O'Rourke: Great. Thank you.

Operator: Your next question comes from the line of (Nancy Foster).

Erin O'Rourke: Hey, Nancy.

(Nancy Foster): Hey, Erin. So, I, too, am a big fan of the assessment seven category. And I'm trying to dovetail that with the four categories of decisions that are on slide, I think, it's 30. Most member – most measures, when they first come to the

MAP, are not in current use, at least most in the hospital programs in which I'm familiar. And I – and oftentimes, in our discussions, we've said, essentially, this may be right for rulemaking, for public reporting, but we're a little concerned about it's link to a payment program unless we have further information about whether there are implementation issues or unintended consequences or a variety of other concerns we've raised.

So, help me understand, when we're endorsing something, are we endorsing it for rulemaking for the particular program under discussion? And how would we make clear that, gee, we might endorse it for public reporting now, but we'd like to at least have some of that feedback around implementation issues before giving a big thumbs up for link to payment programs.

Erin O'Rourke: Sure. So, to take your first question, MAP would be supporting the measure for rulemaking for that program. This is not a blanket moving forward into other programs; maintain the same process as we've always had. It needs to be reviewed for each specific program, and MAP would make a case-by-case determination. I think …

Harold Pincus: Yes, actually, just to point out that the process actually is organized by program, you know, as we go through it rather than by measured category.

Erin O'Rourke: And for your second program, I think that is something we definitely want to capture in the statement of rationale that go along with the measures and something we'd want to have a discussion about. Just using hospital as an example, I think that's a great type of rationale we could capture for, say, a measure for IQR that we want to see the type of implementation data before it moves forward for value-based purchasing.

Operator: Your next question comes from the line of (Lindsey Wisham).

(Lindsey Wisham): Good afternoon. So, I'm specifically kind of jumping back a couple of questions in regards to the definitions that are listed under each of the assessments. So, I'll use assessment seven as an example here, where the algorithm is being applied and specifically looking at criteria like whether or not there have been implementation issues. I know the earlier question has asked us where are we going to find that information. How much of these

criteria under the definitions will be gleaned from information submitted with the measure as it's submitted to the MUC list? Or will we just be, you know, basically opening it up for others to have input on the committee of whether or not they have personal or organizational awareness of issues throughout all of the assessments?

Erin O'Rourke: Sure. So, as part of your meeting materials, which we'll actually show you an example later in the program, we will provide these preliminary analyses. It's based information submitted to CMS through JIRA as Pierre noted. Also from what staff can find to our own research, we look to what's happened to these measures to the endorsement process, what's in the peer review literature, the gray literature, really any sources we can go through to glean information about these measures and what they're trying to address. But then, we really depend on our committee members to review that and as you're saying, provide your own experience, your own thoughts and what you know about these measures before these decisions are finalized. So, it's a starting point for discussion but we would welcome that type of additional input and discussion during the meetings.

(Lindsey Wisham): OK. So, it sounds like a combination of sources, most definitely.

Erin O'Rourke: Yes. It's really just an attempt for us to give you that succinct profile and all the snapshot to help MAP members prepare for the meetings. And then we look to you for your expertise on providing input before taking any final decisions.

Kimberley Ibarra: And just to jump in, we also encourage our members and the public to submit comments on any implementation feedback if the measure is currently in use.

Operator: Your next question comes from the line of (Bruce Hall).

Erin O'Rourke: Hi, Bruce.

(Bruce Hall): Hi. Thanks for connecting me and I'm thrilled to be serving in this capacity. New to the task, so I appreciate the orientation. I've been involved with NQF for many, many years. So I am very familiar with many of these challenges.

My question is very similar to the one was asked two questions ago, but was specifically targeting the assessment around reliability and validity. Even in the NQF process, that can be a challenging one and it can be one that is often kind of in the eye of the beholder. Reliability can be viewed as robustness of distinction or it can be reviewed as reproducibility and so on.

I'm just wondering, is there another level of guidance for us behind each of these slides that would go into more detail or even provide some examples of what's been accepted and not accepted in the past? Or is it going to be, again, kind of a group conversation and judgment?

Erin O'Rourke: Sure. So, again, this is a new criteria that we're adding for this year to really ask the MAP to have this conversations about reliability and validity. The main way we look to get you this information is through the endorsement process as we try to better integrate MAP and CDP. We don't provide any guidance about specific methods of testing or specific results similarly (so that we'd be) familiar with on the (CDP) guide. And, again, we're not really asking MAP to make that type of endorsement decision, but to rather use your judgment and the discussions to determine if you think the measure is appropriate for the program.

(Bruce Hall): OK, great. I think it'll probably circle back to the notion raised a couple ago where, you know, members will get it at comfort level with a particular use of a measure, but that the reliability and validity might not always support all uses of a measure. But, again, as you mentioned, we'd be considering a measure for very well delineated use.

Erin O'Rourke: Yes. And that's a great point, that this is – for those of you who might have served on our CDP committee that are new to MAP, that a big distinction between the MAP and the CDP processes where, for this review, it's for one very specific CMS program that we're asking you to consider the use of the measure.

Harold Pincus: Yes, I think the two differences between the two – I mean there are many differences between the two processes. But, clearly, this is not as much of a detailed process specifically with regards to the sort of evidence-based as it is

for the, you know, for the Consensus Development Process for endorsement. And, you know, and it's – and the reasons why everybody has been selected because they represent different experiences in stakeholders and so forth to provide that kind of input. And also with specific to the program, it's not for general – you know, we're making recommendations not for general use but specifically for the program.

Operator: And your next question comes from the line of (Beverly Court).

(Beverly Court): I think just (carrying) on this general discussion. In terms of testing of this prior to being adopted, I assume that you're doing this at very specific level. For example, it's been tested in the hospital setting, it's been tested at managed care plan level, it's been tested at the state level. And so those different tiers that you're taking input in making it specific just because I'm concerned about some of the measures that have been endorsed, then (I'd have) some serious implementation problems at different levels.

Erin O'Rourke: Hi, (Beverly), that's a great question and a very good point, and that's definitely something we will try MAP members to help us highlight what are these implementation challenges and when implementation may not match the level of testing, where NQF endorsement certainly is something we try to raise your attention in the preliminary analysis. But, again, we'd look to our members to provide that information about what you're experiencing on the implementation side or any issues you see about attribution challenges.

Operator: And we have a question from (Eugene Nuchio).

(Eugene Nuchio): Yes, good morning. I'd like to go back to slides 21 and then to 30. In slide 21, you call out public reporting and payment as looking at ideal characteristics of these measures. And then in slide 30, you identify what the criteria or the recommendations are. Is it possible that the discussion will lead us to conditional support for public reporting but refine and resubmit to – for the payment component of that? So that's one question. And the other question is, the public reporting has a very lengthy list of scientific criteria for reliability, validity and, you know, that sort of thing. Are there similar set of criteria that NQF has drafted with regard to payment implications?

Erin O'Rourke: Sure. So we will ask MAP members to come to a decision about each measure under consideration for the program. So, we'd really ask you to look at what the incentive of that program is, whether it's reporting or payment. We'll look at each measure that's under consideration separately. So I think – if it's a reporting program versus the payment program, that's to the workgroups to make that decision about what of the decision categories you would want to see.

As far as set – criteria for payment programs, I – we don't really have that formally laid out. The Measure Selection Criteria is the guidance that the Coordinating Committee has put together around the characteristics of program measure sets.

(Eugene Nuchio): Thank you. I was taking more generally about how public reporting influences potential payment. For example, many of the metrics are put together as part of a value-based purchasing program. And so, while we might be evaluating it in terms of the measure's ability to identify higher quality agencies and for that purpose, we then say it's worth public reporting. The discussion often lapses toward the implications of selecting higher performing agencies for value-based purchasing awards versus penalizing those lower-performing ones. So, I was seeing the two items as sort of tied together as opposed to specific payment programs.

Erin O'Rourke: No, I think that's an excellent point. And thank you for raising that. We know sometimes it's hard to tease out the interrelationships here. We ask you to look at it in the context of the specific programs. But, again, it's to our MAP members who bring your knowledge and expertise to the table to help guide these discussions. And as we noted, the decision is accompanied by a statement of rationale, and we capture that discussion and pass that along to CMS. So, when you have those types of feedback that perhaps it's good for public reporting, the concerns about using it in payments, that goes along to CMS. And as Harold was saying, that's really something we heard from them that one of the more, if not, the most valuable outputs of the MAP process.

(Eugene Nuchio): Thank you.

Operator: And there are no further audio questions.

Erin O'Rourke: All right, thank you so much. So, if there are no further questions, I did just want to highlight something that Harold discussed at the beginning. One of the major changes that we'll be making for this year is that we'll be asking MAP members to look at the program measures in a more holistic manner. We've heard feedback from you all that you really need to understand how measures interact with current measures, what the endorsement status of measures currently in the program is, as well as we've been discussing the implementation experience.

So for the 2016-2017 pre-rulemaking cycle, MAP will offer guidance on measures that are finalized for use in the program. So we're looking for you to all to offer input on ways to strengthen the current sets, including recommendation about measures that might be potentially removed from the program. I know for how we'll be reporting this, it won't be in the final spreadsheet of deliverables, but rather will be in the reports that we issue throughout February and March, that provide that more in-depth guidance from the MAP on the measures and measures under consideration.

(Next slide). So this a topic we've got for the Coordinating Committee at their September meeting to provide some input on where they would like the workgroups to focus when reviewing the finalized measure sets. Some suggestions from the Coordinating Committee might be to consider the removal of topped out measures, to ensure integration with the CDP process, to consider any unintended consequences that have been identified (about each of) the measures that are currently in the program, and to really determine if measures are performing as expected. I think (Rhonda) raised a great point. But the Coordinating Committee really emphasized doing what we can to eliminate burden and ensure that the measures in the program are really driving us to high-quality health care for all.

So, with that, I can open for any questions on this holistic review of the program measure sets.

Operator: Thank you. At this time …

Erin O'Rourke: Apologies, operator. It looks like (Pam Owens) has her hand raised online. So, (Pam), if you could let the operator know.

Operator: Please press star one if you would like to ask a question or make a comment.

And there are no questions at this time.

Erin O'Rourke: OK. So we have no questions at this time. I'd like to introduce Yetunde Ogungbemi, who will be going through the voting process that we'll be using this year. Largely similar to what you've experienced in the past, but for new members, we do want to provide you some more information about what you can expect on how the decisions will be made.

Yetunde Ogungbemi: Thank you, Erin. Historically, MAP has reached consensus on recommendations of measures for federal use a number of ways. I want to walk you through how MAP comes to consensus on recommendations for measures under consideration. MAP has established a consensus approval threshold of greater than 60 percent of its participants. Using consent calendars, every measure is subject to a vote, and workgroups are expected to reach decisions with every measure presented.

There's no longer a pathway to reach split decisions. As the advisory body, the Coordinating Committee has the right to continue any discussion on important matters or strategies in the context of a measure for a specific program. NQF will review the process for reaching consensus through voting during each in-person meeting.

During the in-person meeting and after the opening remarks are made from staff and co-chairs about each programs, voting will begin. Members of all workgroups will be assigned as lead discussants for measures in different programs throughout the two-day in-person meeting. The discussion guide is organized (like that) and followed as such.

Measures under consideration or MUCs are divided into related groups. Each MUC will have a preliminary analysis or P.A. completed by staff. And the discussion guide will note the result of the staff P.A. and include rationale as to how the conclusion was reached. Now that I've covered the key voting

principles, I'm going to review the step-by-step approach that MAP uses to vote.

Voting procedure step one. Each group of related measures as noted in the consent calendar will be presented. The consent calendar will include the staff P.A., rationale, and results. Step number two, MUCs can be pulled from the consent calendar. Chairs of each workgroup will ask if members want to pull measures off the consent calendar for individual discussion. Once MUCs are removed or pull off a calendar, chairs will ask their group to accept or object the staff P.A. for the remaining measures on the list. If no objections arise, the remaining measures on the consent calendar and associated recommendations made by staff will be accepted as is and no formal vote will be taken.

Step three, voting on individual measures. Members who pulled MUCs for individual discussion will be asked to explain their thoughts on the measure, specifically how it differs from the (staff P.A.) (inaudible). The workgroup members will explain the rationale. Lead discussants for groups of measures will respond with their own opinion, and other workgroup members should also feel free to participate in discussion by adding new points without repeating those that have already been stated. After discussion, the workgroup votes with the four decision categories that are listed below.

Step number four, tallying the votes. If a measure received 60 percent or more votes for any single category, the recommendation is that category. This is what we anticipate happening in the majority of cases. But, in some cases, MAP may not reach the 60 percent threshold in a single category. In these occurrences, we look to the sum of decision categories to equal or be greater than 60 percent to reach a recommendation for rulemaking.

For example, if a measure receives more than or equal to 60 percent for the sum of support and conditional support, the recommendation is to conditionally support the MUC for rulemaking. If a MUC – similarly, if a MUC receives less than 60 percent for the sum of support, conditional support, and refine or resubmit prior to rulemaking, the recommendation is – do not support for rulemaking. Abstentions are discouraged but will not count

in the denominator. The table on your screen summarizes how the votes will be tallied. The first row is what we see in most instances, as I described before, where the 60 percent threshold is reached in one category.

The second row is less likely to occur. This is when votes across decision categories must be combined in order to reach the 60 percent or greater threshold. Here is a tangible example to show how the result would end in conditional support with an N of 25. Notice that two members abstained from voting so they are not included in the denominator. In this case, the 60 percent threshold was not reached in any single category, but when you combine support with conditional support, MAP reaches a 60 percent threshold, and this results in the measure being conditionally supported for rulemaking.

Are there any questions?

Operator: At this time, if you'd like to ask a question, please press star one. And we do have a question from (Pam Owens).

Yetunde Ogungbemi: Go ahead, (Pam).

(Pam Owens): Can you hear me now?

Erin O'Rourke: Yes, I can.

(Pam Owens): Can you hear – OK, sorry, I didn't get through the last time.

Erin O'Rourke: Oh …

(Crosstalk)

(Pam Owens): It's my fault because I don't know how to work technology. In terms of when a measure is recommended for removal from a program, as part of that recommendation, does another measure need to be recommended as a replacement?

Erin O'Rourke: No, not necessarily. It's – no, that's really for the workgroup's discussion. It's – you see a measure under consideration that you think better addresses the

topic than what's currently in the program, you could use that as a reason to recommend removal. But there doesn't need to be a one-to-one replacement if, you know, something is topped out and doesn't necessarily need something to fill that spot.

Harold Pincus: But if you have an idea for one that, you know, it's certainly something that's worth bringing up in the discussion, just to alert CMS about potential.

(Pam Owens): Thank you.

Operator: And there are no further questions at this time.

Yetunde Ogungbemi: Thank you. I'll now turn it over to my colleague, Jean-Luc, who will review and demonstrate how the discussion guide will be used during the in-person meeting.

Jean-Luc Tilly: Thank you, Yetunde. So you'll see on the screen in front of you, what we're recalling the discussion guide, so (the veterans) of the MAP process will use (this prompt), maybe even the same document last year, especially the Hospital Workgroup's discussion guide.

So this is an HTML document, which means you'll be reviewing it in a web browser, and you could do it whether online or offline. And you can use the links in the document to navigate between the different sections. Because we have a lot of information that's collected in a lot of difference discrete bucket, we want to give you all an opportunity to be able to review the different information and how they relate to each other and (inaudible) the best way to do it.

And it really is designed to be a kind of one-stop shop. So you'll have the agenda is included here, all of the measure specifications are included here, the staff preliminary analysis is included here. And a summary of a measure's endorsement review, that's applicable to particular measures included, descriptions of the programs for which the measures are being considered or included. And finally, the public comments you received on measures, as well as general comments, are also included.

So I'm going to walk you through how to find information here. So you'll see that the discussion guide opens up with a kind of synopsis of the agenda with links to every individual section. So you'll see, for example, where you we had to click on the first consent calendar on day one. What you'll see for individual agenda sections is groups of measures and a – just little summary of what exactly the measure is all about. So you'll see a description of that measure, you know, so a little bit about specifications, the public comments received on the measure, and a summary of the staff analysis of that measure.

If you want to learn more, for example, you want to see the full measure specifications, you can simply follow the link. You'll see here the – you will have not just the description but also the numerator, the denominator exclusions, and, you know, the measure type steward …

(Off-Mic)

Jean-Luc Tilly: You can use the (back one) on your …

(Off-Mic)

Jean-Luc Tilly: … to navigate that to where you were; so maybe having seen those specifications or interest on what the staff had to say about them. So you can click on full P.A., and you would see the full staff analysis and a response to every individual question that Erin went over earlier.

And finally, since this measure was reviewed by NQF, there is a summary of the endorsement review that you can navigate to. So you'll will see in 2012 that the Population Health Project took a look at it and, you know, described its opinion of their – the importance of scientific acceptability, the feasibility, and the usability of the measure, as well as the public comments received at that time.

And finally, if you wanted to see the public comments that have been submitted on that measure for this round as part of the MAP process, you can click that little number three there and you'll see a few comments. And the submitter, you (would see) …

(Off-Mic)

Jean-Luc Tilly: So now, if you want to just look at the list of measures under consideration, you could click at the top, there's a little header here. You could click measures, and you'll see a list of all the measures under consideration by program. And the programs themselves are organized alphabetically. So here, for example, if you want to check out the topic, anterior segment syndrome measure, simply click there and then you'll be redirected back to that page with the specifications and preliminary analysis. (It also) navigates directly to the comments from here.

And then finally, the program section has its own tab and, again, organized alphabetically. So you could navigate individual programs, where you'll see information that was populated from the document that CMS put up every year, the program specific measure priorities and needs. This is the same document we used during our workgroup meetings earlier on October to review the programs. And of course, it's also included a link to the program's measure set, again, which we used during the web meeting. And finally, you can navigate to the public comment section to see comments as they pertain to each individual measure as well as general comments, which you won't be able to see (otherwise).

So finally, I would just say that this document is pretty difficult to print. So we've created a different document, which we're calling the note. And so this version of the discussion guide is really just the – that full agenda but with a little opportunity to write (notes) in between each individual measure. Of course, this document is also quite long, I think, it's several hundred pages, but if you feel like you really like a printed document, then you can go ahead and use this, and hopefully that'll (inaudible) for you.

So, now, I'm wondering, maybe I'll pause here and see if there are any questions about the discussion guide or the (note file) and the navigation.

Operator: At this time, if you'd like to ask a question, please press star one.

And there are no questions at this time.

Harold Pincus: This is Harold. It's worth pointing out, you know, that it's essential that people bring a laptop with them to the meetings.

Jean-Luc Tilly: Yes, that's right. Laptops, and also, I think, iPads or really anything that has a web browser is basically capable of running this HTML document. If you have questions, you can reach out and we'll …

(Off-Mic)

Jean-Luc Tilly: But I think that's all for me. So I'll turn it back over to Kim …

(Off-Mic)

Kimberley Ibarra: Thanks, Jean-Luc. I'm actually going to turn it over to Yetunde to go over time line and what to expect.

Yetunde Ogungbemi: Thanks, Kim. We are in the second dot on this visual time line that's on your screen. We expect to receive the MUC list on or before December 1st. After the MUC list is received, NQF will post the list for an initial public commenting period. We try to give stakeholders as much time as possible to review and comment on the MUC list. And though we haven't received it yet, we will use our time efficiently when we do in posting it publicly.

In December, workgroups will meet to make recommendations on MUCs. After that, the list with recommendations will be posted for a second public commenting period from December to January. The Coordinating Committee will meet to finalize input from the MAP in January. And from February 1st to March 15th, MAP delivers measure-by-measure recommendations to HHS.

Operator, could you please open the lines and check if there are any more public comments?

Operator: Thank you. At this time, if you'd like to make a comment, please press star then the number one on your telephone keypad.

And there are no public comments at this time.

Yetunde Ogungbemi: Thank you. So I've reviewed our time line in the previous slide, but a few things I'd like to call to your attention. The in-person meetings of the (setting) specific workgroups have the dates listed on the screen. The Dual Eligible Beneficiaries Workgroup will be hosting a web meeting to review recommendations from the other groups and provide cross-cutting input during the second round of public comment.

All MAP meetings are open to the public. Information on how to participate in meetings, including materials, are located on the public pages. We encourage members of the public to attend meetings and provide public comments in person, on the phone, and using the online commenting tool.

The links on this slide are resources from CMS on the pre-rulemaking process. Please note, the last bullet, that is supposed to have the MAP member guidebook, has been updated and we'll be sharing that in the coming days.

And I will turn it over to Erin and Harold for closing remarks.

Erin O'Rourke: Great. Again, thank you so much for taking the time to join us today. And, either orient or reorient yourself to the pre-rulemaking process. We'll be hopefully following up shortly with meeting materials as we get closer to those days. As Harold said, we strongly encourage everyone to review the preliminary analyses ahead of time. In particular, if you can let us know measures where you disagree with the staff's preliminary analyses and would like to have a workgroup discussion, that's very helpful in our meeting planning. So if you can – after you receive your workgroup materials, follow up with your staff contact and let us know measures where you'd like to have a discussion. Otherwise, we will be in touch once we have the measures under consideration list and can get you materials for the meetings.

So, with that, I'll turn it to Harold for any closing thoughts.

Harold Pincus: Well, we want to thank everybody. I mean this involves a lot of work. But, you know, it's also going to be, I think, a more interesting process, not just because of all of the other political kinds of things going on during this time, but really the process has been opened up, but we really can't take kind of

holistic look at these programs and the kind of measures that are being suggested or that are in place, and really have a broader basis for making decisions and recommendations. So I look forward to participating in the process with all of you and to seeing you along the way.

Erin O'Rourke: Great. Thank you so much. And thank you, everyone, and we'll speak with you all again as we get into our in-person meetings.

END