NATIONAL QUALITY FORUM

Moderator: Benita Kornegay Henry
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2:02 pm CT

Samuel Stolpe: Hello, and welcome everyone to the Measures Application Partnership Orientation Web Meeting. My name is Samuel Stolpe, I'm a Senior Director here at NQF and it's my pleasure to welcome you all to this particular cycle.

This is the first of several orientation calls that we'll be doing this week. But we thought it would be important to get everybody together to do as an overarching view of MAP and processes associated with it.

But for our newcomers to the committee for whom we thank you very much for your participation and for those who are returning to or continue to work with MAP. Again, thank you very much for your continued service.

Just as a note the coordinating committee is continued with the same two co-chairs. We have both Bruce Hall and Chip Kahn will be continuing in those roles. Bruce, are you with us today? Bruce if you're speaking, you're on mute.

Okay. Well, hopefully he'll be joining us in just a moment. We had a number of things that we wanted to cover in this meeting. So I'll just start with an

overview of our agenda. Before we jump too far into that though, I would just ask you all to place yourself on mute during the course of this just to minimize the background noise. So the purpose of (unintelligible) is to do an overview of MAP as I mentioned and just a walkthrough of what we are going to look to cover.

First, we'll do an overview and review of the statutory authority for the measures application partnership. And we'll move through the creation of the measures under consideration list and described that in detail.

Following that we'll be doing a review of the MAP Pre-Rulemaking Approach. And then we'll move into four process-related areas but it's important for those of the committee who are returning to us to re-familiarize yourself with.

And for those who are new to get a strong understanding of how we conduct our processes on that and we would of course welcome your feedback on it. So the first of those is a preliminary analysis of algorithm.

The next will be the voting processes, that MAP uses. Next will be the discussion guide and lastly, we'll move be moving to public comment and then followed up by next steps.

Now, with that being said I wanted to make sure that we check once again to -- if Bruce Hall is able to join. Bruce, are you on?

Robert Krughoff: Hello?

Woman: Hello.

Robert Krughoff: Hello?

Woman: Hello.

Robert Krughoff: Hello. This is Robert Krughoff.

Samuel Stolpe: Hi.

Robert Krughoff: I was checking for Bruce Hall. Bruce Hall on the call, please?

Man: Not here yet.

Samuel Stolpe: Not here yet. Okay. Well, we'll hopefully get Bruce on the line shortly. But in the meantime, just wanted to offer a couple of words of welcome on behalf of the co-chairs.

First, to all those returning to the three settings statistic work, namely our Clinician, our Hospital and Tech LTC work groups, welcome. A big thanks to our CMS colleagues who are going to be around the table.

In particular, we wanted to know the addition of our colleagues from the Medicare Part C and D space. You are very welcome. We are excited to be including you as part of our discussions inside of the MAP admission work group.

Next, just a big thanks to our returning co-chairs and to the new appointees, co-chairs for each of those three workers. Also I wanted to recognize the role of hospital group and I want to thank them for their participation and also note their expanded broader cycle. Last cycle, they were largely an advisory capacity serving on the clinician work group.

But this year, we'll be hearing from the rural workers' perspective on each of the three work groups.

And with that, I'll just go ahead and turn it over to our CMS …

Bruce Hall: Hi, I'm Bruce Hall.

Samuel Stolpe: Hi, Bruce, we just handed it over to CMS. And then, we'll be turning to you but if you would like to offer a couple of opening remarks to greet the committee.

Bruce Hall: Yes, well, yes thanks. I apologize I had a clinical issue that delayed me. So I apologize for being a few minutes late. I'll just reiterate what you just said.

Thank you so much to each of the groups and to each of the leaders for the groups' staffs. That's the main message that I wanted to relay. So please let's keep moving.

Samuel Stolpe: Very good. Thanks very much for joining us Dr. Hall. And we'll go ahead and hand it over to our colleagues at CMS.

(Serena Phaedra): Okay. Hi, can you guys hear me?

Samuel Stolpe: Yes, we can.

(Serena Phaedra): Okay, great. Hi, I'm Dr. (Serena Phaedra), I'm the Chief Medical Officer of the Quality Measurement and Value Based Incentives Group here at CMS.

And I just wanted to say that first, you know, thank you so much for participating today as well as for the upcoming MAP meetings, you know. We at CMS really look forward to have - we are considering to implement into our Federal programs and understand the time that it takes from your schedules in participating and giving us those input. So again I just want to extend the thanks from CMS's perspective of your time for this.

We also want to welcome the MAP Rural Health Workgroup, it's now formally incorporated into the review process and we strongly believe having their presence, it will give us a valuable insight. In particular as we consider these measures under consideration into our programs from the rural perspective. So I just want to acknowledge (Rod) and look forward to that incorporation into the process this year.

And then just a couple of things from, you know, some framing thoughts. I know there are some new members in the MAP. But, you know, this process with the MAP inside is what we considered the pre-rulemaking process. So, this is really getting input from the workgroup on a selection of measures that we use in our public reporting, performance-based payment programs and other Federal programs as well as giving you some input on identifying gaps and measures for development, testing and endorsements.

And some of the critical things that we are working on lately that – well, hopefully we'll continue even in our in-person conversations is around measurement alignment. We at CMS are looking, you know, and working with our private peers as well in terms of, how do we align our metrics across settings, right? In terms of this concern of measure proliferation but also getting to a set of meaningful measures that are really driving toward value, whether they are in the context, in our public recording programs, in our

payment programs as well as our other potential levers as well as through our compare side.

And so I look forward to that conversation and you know, with those lens as you guys are considering our measures on a consideration list, once that gets published, hopefully not much longer at the beginning of November. But I'll leave with just again, thanking all of you for your time and I'll turn it back to, I guess NQF to continue with the slide.

Katie Cannon: Thank you so much. We really appreciate those opening remarks. And this is just friendly housekeeping reminder. We really requests everyone who is not currently speaking to mute their lines, we are getting a fair amount of feedback.

As a reminder, muting is star, 6, to unmute star, 7. (Unintelligible). We are just getting a lot of noise from officers, other calls and so it's very helpful. So once again, to mute that is star, 6. So, I'm asking everyone to mute star, 6.

Sorry, someone's having a conversation right now. If they – I'm really asking everyone to mute. Thank you. So as we move in I'm going to - as I said, I'm Katie Cannon. I'm going to start with the statutory authority in the pre-rulemaking process.

So to move on, so the Affordable Care Act requires as to the Department of Health and Human Services contract with the consensus-based entity, which in this case is NQF to convene multi-stakeholder groups to provide input on the selection of quality measures for public reporting payments or other programs.

The Social Security Act establishes the pre-rulemaking process, the multi-stakeholder group and put the selection of quality measures. So, if we look on the next slide, we can see the role of MAP. NQF identified four major roles of MAP, which is to inform the selection performance measures to achieve improvement, transparency value for all.

Additionally, the role is to provide input to HHS on the selection of measures for public reporting, performance-based payments and other Federal programs. The MAP identifies measure gaps for development testing and endorsement. And lastly included measurement alignment across public and private program setting levels of analysis and populations in order to promote coordination of care delivery and reduce data collection burden.

On the next slide, you can see some of the process of what we are making referrals to and it's the process that government agencies such as a HHS used to create regulation. Here we can see the three steps process.

And then if we move on to the next slide, this really indicates, is really provides us a really great illustration of where the MAP recommendation falls within the pre-rulemaking process. As you can see here comes the life cycle of a pre-rulemaking process. And between CMS selecting the measures under consideration.

We see that the MAP recommends and CMS considered MAP inputs and then issues, it's proposed in final rules. So this is just a really great illustration of the importance of the MAP process.

Now, as far as the value of pre-rulemaking input there are several really high values that support brands. It facilitates multi-stakeholder dialogue that

includes HHS representative. It allows for a consensus building process amongst stakeholders and a transparent in open form.

The proposed laws become closer to the mark because the main provisions related to performance measurement have already been vetted by the affected stakeholders and it reduces the effort required by individual stakeholder group to submit official comments from proposed rule. So that was just a little bit of the background of the statutory authority.

Now I'm going to provide a brief overview of the MAP. So here you can see on the slide the MAP structure. We have four workers, the hospital, clinician, tech LTC and Rural Health Workgroup. They all provide input to the MAP Coding Committee, which will review the workgroup recommendations genuine every year and provide those recommendations to HHS.

And that numbers are slightly different from some of the other NQF that we constantly have. There are three types of MAP numbers. The first is, organizational representative and those constitute the majority of coordinating committee as well as the workgroup.

They include those that are interested in or accepted by the use of measures and the organization can designate their own representative. Do you want a highlight here?

In the event that a main organizational representative is unable to attend the in-person or web meeting, they are able to designate a substitute representative to that organization's perspective and still brought to the MAP.

We also have subject matter experts. SMEs serve as individual representatives from a topic specific knowledge to MAP deliberation. The

chairs and co-chairs of the coordinating committee as well as the workgroup are considered subject matter experts.

And another value add we have to the workgroup and coordinating committee, are our federal government liaison. And they serve as ex-officio non-voting members representing as federal agency.

Well, as we look to the MAP coordinating committee charge, the charge of this group is to advise HHS on the coordination of performance measurement strategy for a public sector program across settings of care and across public and private payers.

They set the strategic direction for the MAP and give direction to and ensure alignment across the MAP settings specific and advisory workgroup. And on this slide, you can see the coordinating committee staff. You've already heard from (Dr. Stalky) and myself (unintelligible).

And then if you look through the next slide, the MAP Hospital Workgroup provides input on measures to be implement to the Federal rulemaking process to the following nine program which you can see listed here. And if you go on to the next slide, you can see on that MAP Hospital Workgroup staff.

Now, the next slide has the Clinician Workgroup charge. As (Dr. Stalky) mentioned in the beginning of the call, we have been welcoming new colleagues and a new programs were under considerations of the pre-rulemaking process and that is Medicare for CMD star rating. I just wanted to let work group numbers sill that we attached a memo to the calendar invitation that has a little bit more information if they would like to create.

So, Medicare for CMD will be part of the upcoming 2019, 2020 cycle. Medicare Part C often known sometimes as Medicare Advantage is a Medicare health plan choice also by private companies approved by CMS. Medicare Part D provide prescription drug coverage.

On this next slide, you can see the Clinician Workgroup staff. So the but certainly not least of the setting specific workgroups is the MAP post-acute of long-term care workgroup. And here you can see the six programs that they provide input on. And on the next slide we have the Tech LTC staff.

So as our colleagues and Federal partners mentioned earlier, we are welcoming the MAP Rural Health Workgroup to the full pre-rulemaking process. Last year, we've highlighted rural to be back at the Clinician Workgroup. And this year the Rural Health Workgroup to provide input on the clinician, hospital and Tech LTC measures under consideration.

So the charge of the Rural Health Workgroup is to provide timely input on measurement issues to other MAP workgroup and committee and to provide rural perspective on selection of quality measures MAP. This is to help address priority rural health issues including specific challenge of low case volume.

On this next slide, you can see the rural health staff. So I want to turn it over to our compare Bruce Hall, if you wouldn't mind facilitating any questions that may have arisen. Christian may be on mute. It's star, 7 to unmute.

Bruce Hall: Hi, everybody. It's Bruce. Does anybody have any questions about the thoughts that have been presented? It doesn't sound like we have any just yet.

Katie Cannon: Great. So I will turn it over to our colleague Helen (unintelligible) to provide an overview of the creation of the MAP list. Helen?

(Helen): Yes, hi. Can everyone hear me okay?

Katie Cannon: Yes, we can.

(Helen): Awesome, great. Thank you. Again, my name is Helen (unintelligible). I am the core or the Contractor Officer Representative for this particular contract with NQF and I do work for CMS. And I'm here to really just talk very quickly about how we create this MUC list as Measures Under Consideration list. Thank you.

So, as you can see in front of you this particular slide just talks about our structure within CMS and CCFQ, which is - and within (Quimbee), which is home to the pre-rulemaking process. And as a group, we actually all work together to include our colleagues in the Centers for Medicare to comprise the various measures that make up the MUC list. Stay quiet please. Thank you.

And this is a statutory authority that dictates that HHS or CMS will inspect, establish a pre-rulemaking process to ensure that we do receive input from a multi-stakeholder group on the measures that we are actually considering for some of our Medicare program.

As noted here, the MUC list must be published no later than December 1 of each year. And each year no later than February 1, the CDE, which in this case is in NQF will provide the recommendations that were acquired during the MAP process. Thank you. Next slide.

And so, here we talk about some of the considerations for the selection of the measures that we put on this year's MUC list on the Measures Under Consideration list.

So one, the alignment with our meaningful measures initiative, we want to ensure that these measures are of high priority that meet the statutory requirements. We do prefer the outcome measures, process measures are still great but we'd like to start moving toward more than outcome measures arena. And we do always want to consider the amount of burden that's associated with each of the measures to ensure that we do not burden on those that are reporting on these particular measures.

Next slide, please. We obviously would love to ensure that every measure that makes it onto the MUC list is in fact a fully-backed measure that would complete specifications and ready to really be reviewed by the MAP.

Feasibility, we want to ensure that this can be implemented by CMS in our program. And as Dr. (unintelligible) already mentioned, the alignment that's a big part of what we are trying to do now is to ensure that our measures are aligned across all of these programs.

Next slide, please. So here's a list of the Medicare program that is currently reviewed to the statutory requirement of having to go through the pre-rulemaking in the rulemaking process.

And you can just see these very quickly. Thank you. And the notable addition is our Part C and D star rating partners in our center for Medicare, we welcome them. And we are really interested and can't wait to hear all the wonderful feedback that we are going to get on their particular measures.

Next slide, please. Thank you. This is a 2019 Pre-Rulemaking timeline. If you can see in 2019, in January we opened up what we are currently using (Akira) for the submission of our measures. We had some education outreach sessions in April. We closed here at the very beginning of June. That way we can start taking a look at what was submitted, what we think is appropriate for our program to place on to the MUC list.

We informed our Federal stakeholders, our partners in the various opted or operation divisions within HHS to kind of give them an idea of what we are thinking. And then we went through a very rigorous clearance process, which we still are going through and so we welcome the comments that we get from our Federal partners.

As you well know, the MAP rural health meeting will convene in November, we really look forward to seeing what feedback we get from that particular perspective. December, the setting specific MAP workgroup will meet and in January, with the coordinated committee adjudicating I guess the recommendations then we should hopefully be getting those recommendations published to us and we really look forward to that.

Next slide, please. And our 2020 pre-rulemaking timeline. The reason I put this out there is just to kind of inform the group that we are looking at possibly adjusting the timeline for next year's pre-rulemaking cycle, which then would obviously impact the timing of the MAP activity.

We may be looking to shift it a little sooner, a little earlier to allow more time for the rulemaking and for public comment period. So be sure to stay tuned for any updates that we may have. We look forward to a great 2019, 2020 cycle and always looking forward to what happens the years after. Thank you.

Samuel Stolpe: Hello, everyone. This is Samuel Stolpe. Thank you so much for that overview. Let's go ahead and move to the next portion of our agenda. And that would be a review of the MAP pre-rulemaking process.

I just want to emphasize a couple of things as an overview of the approach. The analysis and selection of measures really falls under what's essentially a three-step process.

The first is the development of a program measure that framework. And what we mean by that is a capture of the ideas, not the measures step in isolation. But as it relates to a systematic view of the measures in terms of the program goals, the incentive structure of the program, the population observes and other ideas associated with measurement systems.

Next, we evaluate the measures under consideration for what they specifically would add to the program measures set. And this has involved really two key steps.

First, consideration of the measures and comparison to the other measures on the list of measures within the system already and really scrutinizing the value add there. And next a close look at the measures themselves for their overall appropriateness for inclusion using a set of criteria which I'll discuss a little bit later.

And then the last step would be to identify and prioritize gaps for the programs and settings. So that's thinking about the measurement system in its totality, holistically and ways that it can be improved or enriched over time.

So I want to go through and talk about the measure selection criteria. We have a number of these but I just wanted to give a high-level overview of what these are intended to do. They identified characteristics that are associated with ideal measures as for public reporting and payment program.

The thing that's in mind is that these are not absolute rules. There are ways for us as workgroups and as a coordinating committee to think about the general guidance and to complement the programs specific requirements, both those that are laid out and statute and through the rulemaking process.

So our focus should be on high-quality measures, ensuring that those align with the National Quality Strategy three aims that we are filling measurement gaps and that we are promoting alignment between different measurement programs for the 19 quality and performance programs that we'll be considering in this measurement cycle.

Now these criteria serve as a reference so it's helping us to evaluate rate, the relative strengths and weaknesses of a given program as well as how the addition of that particular measure would make a contribution to the measure set.

So again, the MAP uses the selection criteria as a guide for its recommendations. These are not hard and fast but they do serve as a basis for what we call the preliminary analysis algorithm, which I'll go ahead and outline for you in a moment.

But first let's dive into each one of the measures selection criteria. So the first of which is that essentially that NQF endorsed measures are required for program measure set unless there is no relevant endorse measure available.

This is a fairly simple and straightforward criteria to understand but house within it are a couple of things that really explain why that endorsement is so critical. And it's related to the endorsement criteria, which MAP very closely to the criteria that we use. So this is – and when I say we, I mean MAP, what the map uses for consideration of measures inside these sets and systems.

So this is, you know, the importance for measure and report looking at the scientific acceptability and measure properties namely reliability and commodity.

Feasibility of implementation, usability and use, and then harmonization of those measures for competing measures. I'll look at the sub criterion here. Measures that are non-NQF endorse should be submitted for endorsement if they are selected to meet a specific program need. Measures have had endorsers removed or have been submitted for endorsement and were not endorsed should be removed from programs.

And then lastly, measures that are in reserve status which means that the performance has really been topped out. They should be considered for removal from progress.

Next up is Criterion 2. And this is the program measures set is actively promoting the key healthcare improvement priorities such as those highlighted in CMS's meaningful measures framework.

Now, this is simply taking a look at the programs set to ensuring that it promotes improvement in the key national healthcare priorities laid out such as that CMS has defined within the meaningful measures framework.

There's other potential consideration as well including emerging public health concerns, ensuring that set and addresses key improvement priorities by all providers and those that are outlined inside a Federal statute.

For Selection Criteria 3, we want to see if there's a program measures that is responsive to the specific program goals and requirements. So this is - that it's fit for purpose for any particular program. And we have five sub criteria that we want you to be aware of, the first being that the measures are applicable to appropriately tested for the programs intended care settings level of analysis and population certified program.

Second criteria is the measure steps for public reporting program, it should be meaningful for consumers and purchasers. And then evidence of that meeting is demonstrate. The third is that measure sets for payment set of programs should have measures for which this broad experience demonstrating usability and usefulness.

So one example of this would be measures that are used in other programs that have broad adoption in some Medicare clinic programs, for example, the value-based purchasing program for hospitals. There's some requirements that it'd be included in a public reporting program for designated period before implementation.

The fourth criterion is that we avoid selection of measures that are likely to create adverse consequences. So unintended consequences of measurement we look to avoid.

And lastly, there's inclusion of endorsed measures that have an e-measure specification available. So these are the five criteria for under Criterion 3.

Moving to our fourth criterion. Program measures that should include an appropriate mix of measured types. And what we mean by that is a mix of process, outcome, experience of care, costs, resource use, composite measures, structural measures, et cetera.

We want to see a good variety and appropriate mix for that particular system. Now, these won't be uniform. There isn't a prescribed number of outcome measures for example that we would expect in a given program that needs to be considered as what would be appropriate for that specific program.

As a sub-criterion, we have first in general preference should be given to measures that address specific program needs. Second, the public reporting measures that should emphasize outcomes that matter to patients.

And then lastly, program measure set should include outcome measures and cost measures to capture value.

Our next criterion, Criterion 5 is a program measure set that should enable measurement of person and family centered care. This is demonstrated when the measures set addresses issues related to access, choice, self-determination and community integration. And we have three sub-criteria associated with it.

The first is that the measure set addresses patient's family and caregiver experience. The second is that the measure set addresses shared decision making. And then the third is that measure set enable assessment of the person's care and services across providers' settings and time.

Moving to Measure Selection Criteria Number 6. The program measure set includes consideration for health care disparities and cultural competency.

Now this is demonstrated by a program measure set that promotes equitable access and treatment by considering health care disparities.

Now, there's a number of factors that would be included in that such as race, ethnicity, status, language, gender, sexual orientation, age, one certain geographical considerations as well. Now, program measure set should also address populations at risk for health care disparities.

We have two sub criteria for this criterion. And it's that these measures should directly access healthcare disparities. And the program measure set should have measures that are sensitive to disparity measure. And that facilitate stratification of results.

This is our last criterion, Criterion Number 7. As the program measure set should promote parsimony in alignment and what we mean by that is that the measure set should support efficient use of resources for data collection reporting and alignment across Federal program. Now, program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

The first sub criterion under this criterion is the program measure set should demonstrate efficiency. And the second being that the program measure set placed a strong emphasis on measures that can be used across Federal programs.

Well, I'll pause here for a moment to turn it over to Bruce to lead any discussion or a questions related to the measure selection criteria.

Bruce Hall: Sure thing. Thank you. This is Bruce. Does anybody have questions they would like to raise about the last two sections we've heard?

Gerri Lamb: Hi, Bruce. This is Gerri Lamb and I have a couple. Can you hear me okay?

Bruce Hall: You bet.

Gerri Lamb: Okay. This is related to the big picture context that Sam is setting forth as well as CMS's invitation to the discussions about meaningful measures and alignments. And this may anticipate Sam's next section so feel free to hold on it if it does.

First question is in preparation for looking at the measurement set, not the individual measures. Are there any updates from that we can read in advance on, excuse me, on meaningful measures and alignment? And I'll just lay out the others.

The other is, are there - when Sam goes through kind of the next process which strikes me as important is, as we review individual MUC measures, the context of the whole measurement set and how to prepare for that? So that we are not looking at things out of context as Sam said. So, most of my questions are related to getting up to the programmatic level and what CMS has requested that we think about.

And then last question is - the question of alignment is, as we are looking at programmatic kind of the programmatic set is, how does it happen at NQF or CMS - endorse CMS that we are looking at an alignment across our four committees? Because it strikes me that I co-chair post acute long-term care that we don't typically look at alignment with our fellow committees. How does that happen?

Bruce Hall: Great questions, Gerri. So one was, can NQF or CMS colleagues bring to bear any resources for our groups to understand the whole sets in the entirety? We just heard about the aspirations for the entire sets. So, are there any resources that committee members could use to be thinking along those lines?

And then second question to help think about those same whole set considerations when we are looking at each one. And then third, how the groups might align across groups?

NQF colleagues, thoughts or comments?

Samuel Stolpe: Thanks very much. This is Samuel Stolpe. I'll take a crack at some of those and see how far we can get. And some of those I'll also welcome the comments of our CMS colleagues to piggyback after my initial foray here. So first, Gerri, thank you so much for that question. I think it's really important for the work at hand.

First, related to meaningful measurement and updates. I would welcome our CMS colleagues to point us towards any changes that have been done inside of the meaningful measurement framework. But we will be going through each of the specific programs line by line with the - in some cases proposed changes within the rules.

So proposed prioritization changes that are occurring within each of the programs and providing an updates to each of the workgroups for what's changing inside of the programs. But consideration for what measures are changing, what goals are changing, and what's inside a proposed or finalized rules plays a very important role for the committee considerations of each of the measures that come into the purview.

The next question for the whole set consideration. I don't think I understood this well as I might have liked. So, Gerri, do you mind rearticulating the second question that you had for me?

Gerri Lamb: Sam, I think the question was, what hit me as you were going through the criteria is that it requires that our MAP committee move between individual measures and the MUC reviews and looking in the context of the broader measurement set.

So, we are constantly kind of shifting between that to make sure that we have the fit that you've talked about in the six criteria from either, will you be talking about ways to help us think about that, so that we are constantly doing it?

My experience is the day meeting goes really fast. So how do we kind of keep both of those front and center so that we kind of really address the goals of the meeting?

Samuel Stolpe: That's such an important question, Gerri. So, thank you. And really, the onus is on each one of us to make an internal process for every measure that we are considering.

The main question that we are answering is, does this measure fit within the sets? Now, to answer that question of course, we have to know what measures they are already within the set.

So we provide that information upfront and we do need to do a good job of keeping that front and center of how we are thinking about the measures as we are running through them. So if there are opportunities for us as a staff to

improve how we are emphasizing that and keeping those measures in front of mind for everybody.

In those deliberations, we very much welcome the recommendations that you will put forward or anyone else on the committee. Minimally, what we do is, when we introduce those program measures and measure sets and systems to the group, we also present the measures that are included within them. For example, for the memo that we just sent out for the CNB star rating, we listed out measures that are inside those sets.

So we would welcome the committee to consider those. And so, thinking about the measures and you are certainly right that the whole set needs to be considered.

Bruce Hall: And this is Bruce again. If I could maybe just pile on to Jerry's comments. So would it be possible for NQF staff to provide the committee's with the grid?

You know, if what you just reviewed with us is looked at as an aspiration for the whole set. There's an aspiration that the whole set address disparity, there's an aspiration that the whole set address the patient-centered perspective.

Would it be possible for NQF to even to take an initial swipe and make a grid and say here are the measures in this particular set and here are the 12 criteria that Sam reviewed with us? And just put a checkbox across the grid so that members could say, hey, there's not a single measure in this set that addresses sub criteria, you know, 6.2, would that be a possibility?

Samuel Stolpe It is and it's not an unreasonable ask. I think that actually makes the case for exactly what we are looking to accomplish, which is balanced measure sets and having a well-defined and scientific approach for it. So it's something that we could definitely undertake the cycle. And thank you for the suggestion.

And now I'm listening to thread Gerri on the last one. So it was with for alignment ((Crosstalk)) committee…

((Crosstalk))

Gerri Lamb: Yes, the last one was simply, you know, you really helped me think about moving between measures and measurement sets and the CMS representative talk about the importance of alignment across settings. Where does that happen, Sam?

So if that is post acute long-term care and looks at post acute long-term care of measurement sets and the clinician one look at others and the hospital looks at others. Who's looking across at alignment? Where does that happen?

Samuel Stolpe: So the role for this has really lane as a charge for the MAP Coordinating Committee. There're certain parts of it that I would say, belong within the group's individual workers.

For example, Tech LTC, of course this is natural purview for the post acute care and long-term care settings. If that make sense for them to think about those measures especially as they pertain to each of the settings that they are - and one another especially as patient cycle between those settings.

And then when we are thinking about coalition and the populations that they serve those steps needs to work together. But there is a thread that unifies all of them that is important to consider as well. And this is what we would consider the role of the coordinating committee to do.

So there's some components of it where the scope falls within each of the workgroups to a certain extent. The broader charge lays at the doorstep of the coordinating committee.

Gerri Lamb: Thanks, Sam. That's great and Bruce I love your suggestion.

Bruce Hall: Well, thanks for the question, Gerri. I know we are sensitive to time. But does anyone else have a pressing question they would like to raise before we move on. I might make one trivial suggestion with respect to our CMS colleagues.

And years gone by some of the timelines resulted in some of our committees having to work over the second half of December holidays. And I would put in a plea to be sensitive to that. Anyone else with additional questions?

(Gene): Yes.

((Crosstalk))

(Gene): I think two of us are trying to get on.

Man: Hello?

(Gene): Sam, Bruce, this is Gene (unintelligible) (00:45:49). I'd like to call attention to Slide 40 and Slide 7. Slides 40, I think there's a good place good focus if

you want to roll back the screen. The question has to do with identifying the fit for purpose.

One of the experiences that I've had in the past on MAPs is that there's been a lot of discussion about, we think the measure work for public reporting, but not for value based purchasing or any kind of performance-based incentive program. Will the MAP and its December meeting have any opportunity to make that sort of recommendation regarding measures?

Bruce Hall: Thank you. That is – you are right. That's a perennial issue. NQF, CMS colleagues? The question is really, can the MAP endorse for particular use versus is an endorsement one-size-fits-all?

Samuel Stolpe: Thanks very much. This is Samuel Stolpe. Currently, we don't have that as a voting category per se but it is a recommendation that I think we could put forward. And certainly, Gene, it does make sense, especially for a certain measures.

I am thinking of the CDC recommendations, for example, on opioid, morphine equivalent, those things. Where they stated that certain measures aren't appropriate for incentives for clinicians per se. But were intended more for guidelines, just a recommendation from CDC.

So they were saying that they don't like the idea necessarily of that and I could see why MAP workgroup might have a comparable result in their consideration for how they think that measures should be applied.

Now, the question though, given that we understand the incentive structures of each of these programs, we can determine exactly how the measures would

likely be deployed. If it's being included inside of, say net for examples, then naturally it's going to be used in the way that the program is structured to do.

So the recommendation would of course, the fit for purpose just by nature of the program. So I'm not entirely certain that the distinction would be 100% necessary for each of these programs, given the incentive structures are fairly well understood.

(Gene): Thank you, I mean, just the term fit for purpose and the various specific sub criteria seemed to point out that there are different purposes for the different measures. And that is very difficult for a developer to create a multi-fit measure where it meets all the different criteria or usefulness purposes for reporting publicly, and or providing payment incentives for the providers.

Samuel Stolpe: Yes, you are 100% correct, Gene. And this is where we need to be careful to make a distinction between NQF endorsement process and what we do when we are considering the application of those measures.

So this is specific for applying them to a given program. Does that make sense inside of this program? And as such the level of analysis, the depth of it is a little bit different than we do inside of the endorsement process. And we need to be careful that we are not replicating that inside of MAP. But that will serves as a compliment for the work as we are making a recommendation to a specific progress.

(Gene): Thank you.

Bruce Hall: Does anybody else want to raise anything before we move on? If not, it sounds like we can move ahead and we'll take some more questions at the next counter.

Samuel Stolpe: Very good, thank you very much. For the next few moments, I'd like to run through what we had alluded to earlier in our presentation around the preliminary analysis algorithm. But first let me just stay with the preliminary analysis is.

The preliminary analysis of any given measure which will be considered in this cycle will be performed by NQF staff. The idea is that the staff will use the algorithm that has been developed by the Measure Applications Partnership under the basic guidance of the measure selection criteria to give an evaluation of each of the measures.

The idea is that this will serve as a starting point, giving a succinct outline of each of the measures and give a comparison between that algorithm as dictated by MAP and staffs' evaluation of the measures fit according to that algorithm.

Now, couple of things to note is that this algorithm was approved by the coordinating committee and that there hasn't been any change from this last 2018, 19 cycle for the 2019, 2020 cycle.

So this, as I mentioned was conducted by staff, the algorithm has developed from the measure selection criteria and it's been approved for the valuation of each measures. And the idea just really emphasize is that it's supposed to be a starting point for discussions. And it's not the final stage by any stretch.

There is eight key steps associated with the preliminary analysis algorithm and I'll be outlining each one of these in detail. The first is that the measure addresses a critical quality objective, not adequately addressed in the

measures, in the program set so really getting to need. Measures evidence based and it's either strongly link to outcomes or is an outcome measure.

The measure addresses a quality challenge and it's not just a superfluous addition to a measure set. But the measure contributes to efficient use of measurement resources or supports alignment of measurement across programs. The measure can be feasibly reported, the measures is applicable to and appropriately specified for the care settings, levels of analysis and populations of the program.

And if the measures in current use that there's no unintended consequences that have been identified. And again if encouraged, the only implementation challenges that outweigh the benefit of the measure have been identified.

Now I'm going to go through these in some detail. So looking a little bit deeper at this first assessment point within the preliminary analysis algorithm. So that the measure addresses a critical quality objective, not adequately addressed by the measures in the program set.

So these would be that the measures are addressing the priorities such as those outlined in the meaningful measures framework or a specific program goal or statutory or regulatory requirement. And that the measure can distinguish differences in quality is meaningful to patients and consumers or addresses a high-impact area or health condition.

So next up, I'm going to discuss what the results could be from the preliminary analysis algorithm. Essentially, staff can arrive at one of two conclusions, yes or no that achieve this aim. If it does achieve it, then the review continues. If it does not, then the measure will receive a do not support.

Now, the MAP can provide a rationale for the decision to not support or make suggestions on how to improve the measure for any potential future support categorization. The second assessment point is that the measure is evidence based and is either strongly linked to outcomes or an outcome measure.

Now, the reason we make this distinction is that process and structural measures are expected by NQF criteria generally speaking to have a link through a desirable outcome that can be demonstrated through evidence, through research through studies and analysis.

For outcomes measures, this is slightly different. For outcomes measures, the assumption is that the outcome is desirable. And the rationale for the measure needs to include instead either direct evidence or an outline for a potential rationale for how the outcome could be influenced by some healthcare-related process structure or clinical intervention.

And the idea being that we wouldn't want to put an outcome measure in place, if it couldn't be influenced by those who are held accountable for it. The result of this are again, yes or no. If this is judged to let me to the second assessment point. The review continue is not the measure receives a do not support. And again, MAP can provide a rationale for this decision and make recommendations on how to improve the measure.

Third assessment point is the measure addresses equality challenge. Now, this is really related to performance gap and ensuring that we're not addressing a challenge that's already been solved for. So it's the measure analysis show that providers are topped out on the performance for example or that they all seem to be hovering around the same area of performance. Then, maybe

we're not seeing the necessary variation between providers to distinguish between the quality of care that they're providing.

So the results of the analysis can either be that the review continues under the measure meets assessment Criteria Number 3. And if it does not then the measure will receive a do not support. And once again, MAP can provide the rationale and make suggestions on how to improve.

The forth assessment point is around the measures contribution to efficient use of measuring resources and/or the support of alignment of measures across programs. Now, this is looking at whether or not measures are duplicative of existing measure or this could also be if there's a superior measure is considered to replace an existing measure set of program.

So we'll also want to see that the measure captures a broad population. What is if the measure contribute to alignment between measures and a particular measures set, so either within the program or across a MAP family of measures.

Lastly, the expectation is that the measure will demonstrate value to patients and consumers that outweighs any burden associated with implementation of the measure. Now, you'll notice that the results on this is slightly different. In the estimation of NQF staff, this meets the criteria, review can continue. And MAP can make the decision here that the highest rating could be and do not support with potential for mitigation.

Of course, you can just reject the measure outright for consideration and do not support it. But you can also say this measure could potentially move forward, once certain things have been met. For example, testing respecified for the appropriate level of analysis.

The fifth assessment point is that the measure can be feasibly reported and what we mean by that essentially is that it operationalize it. We expect the measures to be fully specified. The specifications to use data that can be found in structured fields and the data are captured before, during or after the course of care. So it's just a reasonable way of operationalizing the measure.

If the result is yes, then the review can continue. If no, the highest rating, once again can be do not support with potential for mitigation. And the MAP would presumably provide a rationale of what that mitigation would be.

Assessment Point Number 6 is that the measure is applicable to and appropriately specified for the programs intended care setting the level of analysis in population. And this could mean a couple of things, it could either mean that the measures NQF endorse, specifically for the care settings, bubble analysis and populations considered.

For that it's been fully developed and as those specifications have provided. And that the measure testing has demonstrated reliability and validity for the level of analysis program and/or settings for which is being considered. The results of this can be either yes or no. And if yes, the measure could be supported or conditionally supported. If no, the highest rating can be conditional support. And once again that can provide a rationale.

Assessment Point Number 7 is if a measure is in current use that no negative unintended issues to the patient have been identified. And just as a normal part of NQF's maintenance of endorsement process, we do this in our CDP Standing Committee.

And what we expect to see is that feedback from implementers or end users as an identified significant negative unintended consequences to patients. And that this feedback is supported by empirical evidence.

And we have the same expectation on MAP. If this has been implemented, we want to make sure that there hasn't been negative unintended consequences that significantly outweigh the benefits of its use. Now, if no negative unintended consequences have been identified, the measure can be supported or conditionally supported. And if they have been identified, the highest rating possible would be conditional support.

And now MAP can also choose to not support the measure with or without the potential for mitigation. And that may provide a rationale for the decision and recommends to the developer how the measure could potentially be in?

Now, our last assessment point -- Assessment Number 8. If a measure is in current use, no implementation challenges outweighing the benefits of measure have been identified. And this is just simply stating that as end users have not identified any unreasonable implementation issues that outweighed benefits of the measure.

And the feedback is probably supported by empirical evidence then the measure may be considered appropriate for implementation within the program. So it could be either supported or conditionally supported or its influence issue, patient issues are identified, the highest rating can be conditional support.

And once again that can choose, do not support the measure with or without potential for mitigation. And that may provide a rationale for the decision and

offer the measure developer information on how – in their view, the measure can be improved for a potential inclusion inside of the program considered.

So Bruce Siegel, I'll go ahead and hand it over to you at this point to facilitate any questions that the group might have related to the preliminary analysis algorithm.

Bruce Siegel: Great, thanks for very much, Sam. So, anybody with thoughts, concerns questions about what we just heard?

Sean Muldoon: Yes. It's Sean Muldoon from Kindred. Being that most of these measures have already been NQF endorsed, to what degree could we expect that these criteria will have already been considered and applied?

Samuel Stolpe: Hi, Sean. Thanks very much for your question. This is Sam. Well, you've stated that very well that there's a lot that goes into consideration for measures that have gone through the NQF endorsement process. Now, that being said, these measures that come under MAPs purview that do not.

So we do need to be meticulous on how we outline each of these criteria. Some of them will natively fallout from the endorsement process, we'll have the submissions that the developer has preferred to go through that process. And we'll be able to apply those in the preliminary analysis. So staff do take on that responsibility and they get elbow deep inside of those submissions and the reviews that were conducted by the standing committees through the measure endorsement process.

So those have been very helpful as we're outlining the preliminary analysis algorithm. But nonetheless, the owners does lie on us to apply them. So we

need to think about them in consideration of the program itself. And just go through the stepwise process of checking all the boxes.

Sean Muldoon: All right. Thank you.

Karen Heller: Hello.

Bruce Siegel: Yes.

Karen Heller: This is Karen Heller from Greater New York Hospital Association. And I'm a brand new member of the hospital workgroup. This question might be far out of field. But given the comprehensiveness of these assessments, maybe someone from CMS could address whether MAP could provide similar input on mandatory participation, demonstrations from the Innovation Center?

Samuel Stolpe: You know, Bruce, this one is out of my purview. So I'll give it to our CMS colleagues. But let me just at least say, Karen, welcome. And thank you for a very thought-provoking question. (Helen), would someone from the CMS team like to try to tackle that one.

Bruce Siegel: (Helen), if you're talking you might be on mute.

(Helen): Hi. Yes, this is (Helen). Can you hear me okay?

Karen Heller: Yes.

(Helen): Hello. Can you repeat the question for me? I'm sorry.

Karen Heller: I'm very happy to see these assessment algorithms. I think, they're very powerful. And I was wondering if it would be helpful to the Innovation

Center to have MAP also weigh in on measures included in mandatory participation demonstrations. I know that's not a statutory obligation but it could be very helpful.

(Helen): Yes. And I appreciate that suggestion because the Innovation Center is under a different part of CMS, that is something that I would take back to them, if that's okay with the group at large? And just kind of, pose that to them and see what their reaction might be and see if they're interested and possibly, you know, just having a multi-stakeholder group weigh in on their particular measure. Yes, thank you

Karen Heller: Thank you.

Bruce Hall: Thanks. That was a great question. Anybody else like to raise any other issues before we advance? I'm not hearing anything else, Sam?

Samuel Stolpe: Very good. Thanks, Dr. Hall. All right, let's move forward with the decision category. This one is a little bit more straightforward, so you won't (unintelligible) to be talked for too much longer. Hang with me everybody.

So the decision categories are a very important part of our process. And just want to emphasize this for the sake of understanding what it actually means, once NQF MAP and the workgroups and committee come to a decision for the type of recommendations. We only have four categories but I'd like to walk through each one of those closely.

But first, let's emphasize one point. We must reach a decision about every measure that comes under consideration. So for consistency sake, the decision categories are standardized. And each decision must be accompanied

by one or more statements of rationale that explains why and how each decision was reached?

So this table that you see here, it's a little small type, so forget that part. But the thing I wanted to emphasize is these four decision categories noted in the column all the way to the left. The first decision category is support for rulemaking.

And what that means is that we as a MAP support the implementation of the measure as specified. And that we haven't identified any conditions that need to be met prior to rolling into the program that the measure was considered for.

Next up is the conditional support for rulemaking. Now, what that means is that the MAP support the implementation of the measure as it was specified, but has identified a couple of either conditions or modifications that would need to be addressed, in order to have a MAP's full recommendation prior to implementation.

The next decision category is again a conditional one. But this is do not support for rulemaking with potential for mitigation. So, MAP does not actually support the implementation of the measure as specified but what they agreed to is that the importance of the measure concept suggested that there could be modifications in the measure that would potentially support future use.

As such modification would be a material change to the measure itself. And this material change has a definition associated with it. And that any modification to the measure specifications that's specifically affect the measure result.

Now, it's likely going to be questions that arise around the difference between conditional support for rulemaking or do not support rulemaking with potential for mitigation. So I'll just refer you to last column, the evaluation criteria associated with it and which assessments align with which decision category.

So I won't go through those too meticulously but note that there is a clear distinction and what it means for conditional support for rulemaking and do not support rulemaking with potential for mitigation.

Now, the last category is again, a more of the one-zero type. That this is just it was simply the opposite of support for rulemaking. And this would be a do not support for rulemaking and that the measure did not meet some of the early assessment criteria, one or more of the assessments of criteria, one, two, three.

Dr. Hall, I'll hand it back over to you to facilitate any questions related to the decision categories.

Bruce Hall: Thanks Sam. Would you mind going back a slide and leaving that up for folks. And while people are mulling over it, especially for any folks who might be new to the group, I'll just reemphasize what Sam said here.

So in the conditional category, the Secretary does retain the discretion to move forward. What the committee is recommending is that ideally, some things would be addressed. Again, the Secretary has that discretion and even if certain things were to be addressed, it would not require resubmission whereas in the next category, do not support with mitigation.

The group is saying we really do not support this, we only because we know it's an important area or because this work almost gets to where it ideally should be. We are going to make some suggestions for future direction.

But those suggestions will be material changes that would require resubmission and so on. So there really is a very important distinction between these two categories. The former category really allows it to move forward. The latter category doesn't so to speak.

So with my experience that's an important emphasis. I'll stop talking, does anybody want to raise any other issues or concerns or comments? This has been an area in the past where I know, Coordinating Committee has spent a lot of time. And I believe that it was last year when we all as a group agreed to this version of language.

So this version of language was in place last year, seemed to work pretty well and definitely better than prior years. So this does represent the language that was in place last year. Okay. Any additional concerns, comments?

((Crosstalk))

Man: … CMS, can you hear me?

Bruce Hall: Yes.

(Alan): Okay. I just have a question. Is there any reason why assessment aid is not on this slide?

Bruce Siegel: I can't answer that. This is Bruce. Sam, can you answer that?

Samuel Stolpe: I think that we've got Dr. (Leblet) to answer a question?

Dr. (Leblet): Hi, (Alan). Thank you for your question. Just to remind everybody so the assessment aid, if a measure is in current, you know, implementation challenges outweighing the benefit of the measure has been identified. In my estimation Alan, I think this is just an oversight on our part. So we'll make sure that this is included in the feature.

We should probably Assessment 4 through 8 rather than 4 through 7. So apologies for the discrepancy. Thank you for providing that. I notice you're really good at flagging those types of things.

Man: I have a staff of thousands at CMS that look at every word of this slide.

Dr. (Leblet): I think so.

Bruce Siegel: Okay. Sam, this is Bruce. I hadn't heard any other additional comments.

Cristie Travis: Well, this is Cristie Travis from Memphis Business Group on Health.

Bruce Siegel: Yes, Cristie. Go ahead.

Cristie Travis: I just needed a little bit of clarification again, going back to the perennial issues related to conditional support and do not support with potential for mitigation. When you are summarizing it, you said that conditional support could move forward but do not support could not.

Was that meaning to refer to MAP, formal recommendations or to CMS, including them in the program?

Bruce Siegel: Well I'll invite our other colleagues to comment. So to the extent that MAP has the ability to forbid anything. And I said to the extent, do not support with potential mitigation means it has not been approved, whereas conditional support means it has been approved to draw a black and white line. But I'll invite our other colleagues to comment further.

Samuel Stolpe: Hi, Bruce. This is Sam. I think you hit it right on the head with the - I don't think I'm going to add too much. I guess, Cristie, to your point is that CMS certainly doesn't take this lightly. They take the recommendations with MAP very seriously.

But nonetheless, they do have the authority to make their own considerations. So the conditional support for rulemaking does give somewhat of a green light, whereas our graph is yellow. Whereas they do not support the rulemaking is just a hard job, unless certain changes are made.

Cristie Travis: Sure. I really liked the way that you all acknowledge that. I just wanted to be sure I was interpreting it correctly. So thank you.

Samuel Stolpe: Thank you, Cristie.

Bruce Siegel: Thanks, Cristie. Anybody else? Okay. Sam, back to you.

Katie Cannon: Great. Thank you so much. And this is Katie Cannon again. So as Bruce had mentioned, there have been a lot of questions and point of discussion about decision categories previously. I think there has been maybe even more of helping the voting process. We received very positive feedback from the coordinating committee as well as all the workgroups on the process of how we did it last year.

So we are going to keep that thing in process. But I do want to review it again for those who are either new to MAP or who have done that before, this is the first time, last year is the first time they had used this exact process.

So if we go to the next slide so there are couple of important things to keep in mind. We defined quorum as 66% of the voting members of the committee or workers present in person or by phone for the meeting. So we have both voting members as well as ex-officio federal liaison and we would say voting members referring to our organizations, as well as our subject matter experts.

And while we highly encourage attendance in person, we think that it really helps to facilitate more meaningful conversations. We, of course, will allow participation via phone with the understanding that schedules can at times be unpredictable. But quorum in all committee meeting to come at - they must have 66% of the voting members in attendance.

And we must establish quorum prior to voting. And so we do this through taking roll call. And then we determine if 66% of the voting numbers are there. And then moving forward to the rest of the meeting, what we do is we assume that quorum is there. But if a member of the committee or workgroup questions the presence of quorum, we will absolutely call another roll call, so just there are enough people there, the quorum is still present.

So we establish quorum at the beginning of the meeting with the assumption that we will not lose it. If a committee member or what group member become concerns that we may have they can ask to see if we still have quorum and we will count and ensure that we still do in order to move forward.

And in the event that we do not have quorum or we lose quorum at one point during the meeting, the MAP will have to vote, via electronic ballot after the

meeting. And this comprised (unintelligible) not happened. But if it were to happen, we do it in a very quick turnaround.

So that is in order, we must have 66% of voting members covered. And as far as agreement on any of the four-decision category that Sam's group were talking about previously. This is going to get to a slightly different number and a slightly different process.

So, we have two properties that has established a consensus threshold of greater than or equal to 50% of voting because it depends, voting positively on agreement of one of the categories.

In addition, a minimum of 60% of the quorum figure but must be voting positively. So here's what we're talking about there are the ability for certain organizational members or subject matter experts to abstain from a vote. And attention to our – in general needs, so they come up there as a concept of interest.

If your organization has subject matter expert you, for example, we're involved in development of the measure, you have to abstain. Now a abstention do not count in the denominator of the vote. But we do have to make sure as in the numerator of the vote that that is equal to 60% of voting.

So it's a little bit confusing but we just want to really - the goal is to ensure that the vote consensus agreement has a quorum, kind of voted on it. We want to make sure there's a real substance behind that and that the majority of the workgroup or committee has voted on that.

So as previously mentioned, every measure under consideration will receive a decision. Now I'm just going to run through a process of how it will go

during the in-person meeting. So as stated, we will establish consensus through voting, establish via a quorum.

Then there will be (unintelligible), some staff in the chair to give context to each program and voting will begin. The in-person meeting discussion guide, which we will talk about in a little while. We'll organize content as follows, measures under consideration will be divided into a series of related groups for the purposes of discussion and voting.

The groups are likely to be organized across program and the instances of Hospital Impact LCC or condition, any instance of coalition. Each measure under consideration will often suggests your preliminary staff analysis based on the decision algorithm approved by the coordinating committee.

And for the decision guide, we will note the result of the preliminary analysis support, do not support, their idea of support with preventive mitigation et cetera. And we'll provide rationale to support how the conclusion was reached. So here we move on to the five step process for (unintelligible).

So staff will review in the PA for each month, using app selection criteria and programmatic objective. And then we only define the discussing to review and present their findings. So what we do and this is just a little bit of a process then we'll reach out probably a week ahead of time, asking for a group to be responsible for either specific MUC or a set of MUC and really dig deep into the preliminary analysis. These people are designated as we discuss it.

The least discussion will review measure as well as preliminary analysis and provide an overview on their assessments, their assessment of the measure, their assessment of the preliminary analysis. Following this, so Step 2, the co-

chairs were asked clarifying questions from the workgroup. And the co-chairs will compile all workgroup questions.

Here we have several opportunities with different types of stakeholders to provide feedback. Measures developers will respond to clarifying questions on the specifications of the measure. So our measure developers will either attend via phone or they often attend in person. But we provide an opportunity for them to respond to question specification.

And with that they'll respond to clarifying questions on either the preliminary analysis or the workgroup decision. And then will lead discussions on the questions on their analysis. So the next step -- Step 3 -- is voting on acceptance of the preliminary analysis decision.

Now, I will note that the voting procedures are specific to the workgroup. For the coordinating committee, we will review there are a couple of slight differences through the coordinating committee voting procedure. And on our October 25 call, we'll really dive into two different…

For now this is very similar to coordinating committee voting process but it is the worker forum. So this is the voting on acceptance of the preliminary analysis decision. After clarifying questions have been resolved, the criteria will be open for a vote on accepting the preliminary analysis assessment and so it will be framed as a yes or no.

It's greater than or equal to 60% of the active members to accept PA assessment. And the preliminary analysis assessment will become the workgroup recommendation. If less than 50% of the group vote to accept the preliminary analysis assessment, discussion will open on the matters.

Now, for the coordinating committee, if the voting on acceptance through workgroup recommendations. So it's a similar process but it's not voting on the PA or the Preliminary Analysis decision is voting for the workgroup recommendation.

So if we move on to the next slide. Step 4 discussion voting on the MUC. So the co-chairs will open up discussion among the workgroup or group member should participate in the discussion to make their opinions known. However, one should be acquainted of competing points already presented by others in the interest of time.

After the discussion, co-chairs will open the MUC for a vote. And here they have a little bit more detail provided. And your staff will summarize major themes of the workgroups discussion. The co-chairs will determine what category will be put to vote first based on potential consensus emerging from discussion.

And that means that we don't just have to run down categories, so we don't have to automatically start with support rulemaking or conditional support. The co-chairs are really able to discern from the discussion where they think the work with the training and we can start with that category.

But in the event that the co-chairs would not be able to do with consensus progression the workers will take a vote on each potential decision category one at a time. And this is where we do go in order. So, with one support, conditional support, do not support for potential mitigation, and then do not support at all.

Step 5 is counting the vote. If a decision category put forward by the co-chairs to see if it's greater than or equal to 60% of the vote. The motion will

pass and the measure will receive that decision. If no decision category achieved greater than 60% to overturn the preliminary analysis, the preliminary analysis decisions will stand.

And then this will be marked by staff and notice that the coordinating committee consideration. For the coordinating committee, this is a little different. So if there was no consensus reached on the workgroup recommendation than the workgroup recommendations stand.

So that's just the difference there. For the workgroup at the preliminary analysis decision and for the coordinating committee it is the workgroup decision and so I will turn it over to Bruce to facilitate questions.

Bruce Siegel: Thank you, (Katie). This is always an area of have some initial discomfort as the meetings get going so I encourage people to please ask if any of it didn't make immediate sense to really important topic area. Anybody with questions?

All right, I'm not hearing anything. Okay, let's assume everybody is comfortable for now.

Katie Cannon: Sounds good, Bruce. And we will be reviewing this again at the beginning of every in-person meeting. So if you have questions between now and then, there will be an additional opportunity to ask. Thank you. I will turn over to my colleague Samuel.

Samuel Stolpe: So, we are going to walk you through the Measure Applications Partnership discussion guide, which is a tool that we use essentially to give you all a one-stop shop for all the information that you need to make decisions about the measure into consideration.

So you'll see on the screen that we are sharing an example of the discussion that we're using the clinician or production guide just because it has the most measures. So you'll see right at the top, it starts with an agenda that you can sort of an agenda synopsis, you can feel free to click through.

The full agenda is structured so that for every session where measures are being discussed, there is kind of quick summary of the measure, there will be the description and the title as well as some links to key information. So, we'll link to measure sophistication and link to the summary of interest endorsement review if there is one surrendered case of measure class review in 2017 you can see, you know, the votes on interest on criteria and sort of comments received during the endorsement process the ultimate recommendation.

And as you can see, you can navigate back and forth on these links, using the back and forth buttons to document in HTML documentation. You can just load it here with browser. A link to the public comments received on the measure which includes which organizations feminism.

And finally a link to the analysis of the measure that Kate mentioned that stuff is done. So you'll see there, you know, the results of the analysis and kind of quick summary and then the individual responses to every question as well as sort of the full classification to the measures as they were submitted too.

Another way to use the discussion guide instead of going item by item through the agenda, all of that is through the typical use cases, you can look at if you use this sort of sidebar at the top there, which will follow you wherever you click through the documents. You can click on the Measures tab right at

the top to see a list of all the measures and consideration, sort of click between those.

If you click on the Program tab, you'll be some summaries of the programs, which includes, you know, a link to see a message measure parties needs document as well as a little bit about the history, domains of the program. It's one of the measure requirements. And then it also includes a link to this program measure set that spreadsheet that organizes the measures according to concept.

And sounds like, you know, that may even include a link this year to a kind of mega spreadsheet that wouldn't have all of them. So that would be an exciting development. And then finally, you can just sort of see all the public comments, you know, organized by measures, you can look through those.

So hopefully, a trillion through the documents used. We have, you know, over the years, it made relatively few updates (unintelligible), some of the cosmetic changes that might look a little different how to do with the side (unintelligible)

So yes, I mean, I think with that maybe we can just quickly proceed if there is any questions about it? Otherwise, I'll turn it over to - back to Katie.

All right. Well, so much to better (unintelligible) a chance for more tutorial for in the meeting, so Kate?

Katie Cannon: Thank you so much, Samuel. And as Samuel said, it's very intuitive. So for those who have not had an opportunity to use it yet, I think you'll be able to follow real quickly. As always, during the in-person meetings if anyone has

any difficulty in navigating or at least send us back week in advance, if there are any difficulties navigating please reach out.

We've received in general incredibly positive feedback about the discussion guides. So we are now going to open up for public comment. To unmute yourself, please hit star, 7. You can also type questions in the chat box. But we want to take an opportunity for those who have been able to join us, if they have any questions or if we can provide any clarity on the upcoming MAP cycle. And once again it's star, 7 to unmute yourself.

Okay. I'm not hearing anything and I haven't seen anything in the chat box. We'll add that the contact information for every workgroup is provided in this slide deck. So if you have any questions coming up, please speak, email us. We are happy to answer any question.

I'll now turn it over to my colleague to turn over to next step.

Scott Ferguson: I just have a …

Katie Cannon: Yes, please.

Scott Ferguson: Yes. This is Scott Ferguson. And I'm reading, how does MAP achieve its objectives? And it says, objectivism is a functional regulating high quality measures that address parties to over gaps and increase alignment of measures among public and private measurement programs.

And that's what I have the keenest interest in is, how can we increase the alignment of the measures between public and private measurement programs? That seems to be the biggest stumbling block that I come across

with physicians is, you know, they don't mind the measures and they're good and they improve their practice.

But every insurance company, every government organization has a different set of measures. So instead of making six measures, nine measures, they're making 60 and 70 measures. So, how do we do that?

Samuel Stolpe: Hi, this is Sam Stolpe. A couple of feedback points that we would give related to that. The first being that one thing that we have noticed is that what happens with CMS and federal programs tend to trickle into other programs that are administered by private entities.

Now, you're right to the proliferation of measures is an issue and the private entities do modify measures or do just to create their own and that is a widespread problem. And there are limitations to what we as MAP can do to influence that directly.

However with that being said, we do make a specific engagement with private sector entities such as the National Business Coalition Health and others to ensure that they have a season stable on MAP and that they are active participants in the discussion and consideration.

Scott Ferguson: And that's what I thought, we ought to see is you'd be a good convener of those groups to say, here's some measures, can you throw these in your mix? So like we don't have to pick so many. That would be great. Thank you.

Katie Cannon: Thank you so much. Are there any other questions that we have on the line? Okay. I'll turn it over to my colleague to turn over next step.

Woman: Good afternoon, everyone. I am going to review the next step of this (unintelligible) cycle. As you can see there is a timelime – and there seems a little bit from last year but currently we are in the first bullet and that coordinating committee will discuss the strategic guidance for the workers' views during the pre-rule making cycle that will happen during their web meeting on October 25, this Friday.

The remainder of this week and into next week, we're sending specific workgroup to have their web meeting. So again, we're setting specific workgroup, we'll meet this week and next to review the programs and the measures in each of the programs in the measure set. And the measures set are in each of the programs currently before the release of the MUC list.

We expect to receive the MUC list on or before December 1. We have an initial public commenting period. And the Rural Health workgroup meeting will happen in November. In December, we're studying specific workgroups for meet. I believe it's the first week of December 3, 4 and 5.

We will have a public commenting period that will be for members, NQF will present public participants to comment on the workers deliberations and their preliminary recommendations before they go to the coordinating committee. And in early, mid-January, January 15 to be exact, the coordinating committee will meet for a one day in person meeting that's different than every year in the past, always been two days.

So this year we have two days. One day in-person meeting, January 15. So, the MAP Coordinating Committee will finalize the input that the settings the different workers have provided to our colleagues at HHS.

One thing to note the in-person meetings will be held at our new location that address is included and it'll be included in all of our meeting serial at the top of our agenda. It's also located on our website, we are just couple of blocks away from where we were previously.

So here's a timeline of our upcoming activities. Again, the release of the MUC list before December 1 or on December 1 will have our public commenting period, the role workers web meeting, the setting specific inquiries will be in-person meetings and the public comment period for the second round of public comment period.

Here are a list of resources that CMS and NQF provides our stakeholders. We can go through these at your leisure. And last but not least, we have our annual conference, which will be held March 23, 24 and 25 of next year, 2020 at the Omni Shoreham Hotel in Washington DC.

There is a link at the bottom of the screen in a light blue, if you cannot see it, pardon me. If you'd like to know more about the annual conference. And if there are no other concerns or questions, we'd like to turn it back to the group for closing remarks.

Bruce Hall: Well, thank you. Are there any open or unanswered questions or concerns at this point? Okay, great. I'm not hearing anything.

First, let me thank again, all the members of the groups that are on the call and the leaders of those groups, who are really contributing to critical work as we've discussed today.

Let me thank our NQF colleagues for doing all this pre-work and all the pre-work that it represents that everyone has seen represented in slides and in the

discussion guide and everything else today. And our CMS colleagues for joining us in this conversation today to facilitate this work.

So, thank you to everyone. And we look forward to continuing to work together for these programs and for these aims of taking better care of all of our communities. I will throw it back to our NQF colleagues.

Samuel Stolpe: Very good. Thank you very much, Dr. Hall. This is Samuel Stolpe. And I'm on behalf of the NQF staff and leadership just wanted to offer again, our thanks to our CMS colleagues for your partnership, to Bruce and (Kate) for the leadership on the coordinating community, each of the co-chairs of the workgroups and for each of you for your active participation today.

We're very excited about this MAP cycle and looking forward to working with each one of you. We have a couple more orientation calls this week and we hope to see you on those webcasts. Thanks very much everybody. Please enjoy the rest of your afternoon.

Bruce Hall: Thank you.

Woman: Thank you.

END