NATIONAL QUALITY FORUM

Measure Applications Partnership

Clinician Workgroup In-Person Meeting

December 12, 2018

Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives

Clinician Workgroup Membership

Workgroup Co-chairs (Voting): Bruce Bagley, MD and Amy Moyer

Organizational Members (Voting)

American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
American Association of Nurse Practitioners	Diane Padden, PhD, CRNP, FAANP
American College of Cardiology	J. Chad Teeters, MD, MS, RPVI, FACC
American College of Radiology	David J. Seidenwurm, MD
American Occupational Therapy Association (AOTA)	Trudy Mallinson, PhD, OTR/L, FAOTA
America's Physician Groups	Amy Nguyen, MD, MBA, FAAFP
Anthem	Kevin Bowman, MD
Atrium Health	Scott Furney, MD, FACP
Consumers' CHECKBOOK	Robert Krughoff, JD
Council of Medical Specialty Societies	Helen Burstin, MD, MPH, FACP
Genentech	Dae Choi, MBA, MPH
Health Partners, Inc.	Susan Knudson
National Association of Accountable Care Organizations (NAACOS)	Robert Fields, MD
Pacific Business Group on Health	Stephanie Glier, MPH
Patient-Centered Primary Care Collaborative	Ann Greiner, MS
St. Louis Area Business Health Coalition	Patti Wahl, MS

Clinician Workgroup Membership

Subject Matter Experts (Voting)

Dale Shaller, MPA
Michael Hasset, MD, MPH
Eric Whitacre, MD, FACS
Leslie Zun, MD

Federal Government Members (Non-Voting)

Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Reena Duseja, MD
Health Resources and Services Administration (HRSA)	Girma Alemu, MD, MPH

MAP Clinician Team

John Bernot, MD
Vice President, Quality Initiatives

Miranda Kuwahara, MPH
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Senior Vice President

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Agenda

- Welcome, Introductions, Disclosures of Interest and Review of Meeting Objectives
- CMS Opening Remarks and Meaningful Measures Update
- Overview of Pre-Rulemaking Approach
- Opportunity for Public Comment
- Pre-Rulemaking Input
- MAP Rural Health Workgroup Recommendations
- Pre-Rulemaking Input
- Opportunity for Public Comment
- Summary of Day and Next Steps
- Adjourn

Meeting Objectives

Review and provide input on measures under consideration for use in federal programs

Finalize input to the MAP Coordinating Committee on measures for use in federal programs

Identify gaps in measures for MIPS and MSSP quality programs

CMS Opening Remarks

Michelle Schreiber, QMVIG Group Director, CMS

Meaningful Measures

MAP Meeting December 2018

Michelle Schreiber, MD
Director QMVIG, CMS
(Quality Measurement and Value Based Incentive Group)

A New Approach to Meaningful Outcomes

What is Meaningful Measures Initiative?

Launched in 2017, the purpose of the Meaningful Measures initiative is to:

- Improve outcomes for patients
- Reduce data reporting burden and costs on clinicians and other health care providers
- Focus CMS's quality measurement and improvement efforts to better align with what is most meaningful to patients

A New Approach to Meaningful Outcomes

Why Implement the Meaningful Measures Initiative?

- There are too many measures and disparate measures
- Administrative burden of reporting
- Lack of simplified ways to focus on critical areas that matter most for clinicians and patients

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Empower patients and doctors to make decisions about their health care

Usher in a new era of state flexibility and local leadership

Support innovative approaches to improve quality, accessibility, and affordability

Improve the CMS customer experience

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Meaningful Measures Objectives

Meaningful Measures focus everyone's efforts on the same quality areas and lend specificity, which can help identify measures that:

Address high-impact measure areas that safeguard public health

Are patient-centered and meaningful to patients, clinicians and providers

Are outcome-based where possible

Fulfill requirements in programs' statutes

Minimize level of burden for providers

Identify significant opportunity for improvement

Address measure needs for population based payment through alternative payment models

Align across programs and/or with other payers

Meaningful Measures: Measures Under Consideration by MAP

MUC Lists

- Last year, narrowed the initial **184 measures** submitted during the open call for measures to **32 measures (83% reduction)**; this reduced stakeholder review efforts
- **The 32 measures:**
  - *Focus on achieving high quality health care and meaningful outcomes for patients, while minimizing burden*
  - *Have the potential to drive improvement in quality across numerous settings of care, including clinician practices, hospitals, and dialysis facilities*
- This year, experienced lower measure submissions because CMS was able to articulate the specific types of measures we were looking for; this reduced CMS and stakeholder review efforts

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MAP Pre-Rulemaking Approach

Miranda Kuwahara, Project Manager, NQF

Approach

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

- Provide program overview
- Review current measures
- Evaluate MUCs for what they would add to the program measure set

Evaluate Measures Under Consideration

- 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*

Preliminary Analysis of Measures Under Consideration

To facilitate MAP's voting process, NQF staff has conducted 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

Tools Used to Guide Measure Review

MAP's Measure Selection Criteria (MSC)

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2. Program measure set actively promotes key healthcare improvement priorities, such as those highlighted in CMS' "Meaningful Measures" Framework
3. Program measure set is responsive to specific program goals and requirements
4. Program measure set includes an appropriate mix of measure types
5. Program measure set enables measurement of person- and family-centered care and services
6. Program measure set includes considerations for healthcare disparities and cultural competency
7. Program measure set promotes parsimony and alignment

Decision Categories for 2018-2019

Decision Category	Definition	Evaluation Criteria
Support for Rulemaking	MAP supports implementation with the measure as specified and has not identified any conditions that should be met prior to implementation.	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP Preliminary Analysis Algorithm. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	MAP supports implementation of the measure as specified but has identified certain conditions or modifications that would ideally be addressed prior to implementation.	The measure meets assessments 1-3, but may need modifications. A designation of this decision category assumes at least one assessment 4-7 is not met. MAP will provide a rationale that outlines each suggested condition (e.g., measure requires NQF review or endorsement OR there are opportunities for improvement under evaluation). Ideally, the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to MAP prior to rulemaking.
Do Not Support for Rulemaking with Potential for Mitigation	MAP does not support implementation of the measure as specified. However, MAP agrees with the importance of the measure concept and has suggested modifications required for potentials support in the future. Such a modification would considered to be a material change to the measure. A material change is defined as any modification to the measure specifications that significantly affects the measure result.	The measure meets assessments 1-3 but cannot be supported as currently specified. A designation of this decision category assumes at least one assessment 4-7 is not met.
Do Not Support for Rulemaking	MAP does not support the measure.	The measure under consideration does not meet one or more of assessments 1-3.

MAP Voting Instructions

Key Voting Principles

- Quorum is defined as 66 percent of the voting members of the committee present in person or by phone for the meeting to commence.
  - *Quorum must be established prior to voting. The process to establish quorum is constituted of 1) taking roll call 2) Determining if a quorum is present 3) proceeding with a vote. At this time, only if a member of the committee questions the presence of a quorum is it necessary to reassess the presence of the quorum.*
  - *If quorum is not established during the meeting, MAP will vote via electronic ballot after the meeting.*
- MAP has established a consensus threshold of greater than or equal to 60 percent of voting participants voting positively AND a minimum of 60% of the quorum figure voting positively.
  - *Abstentions do not count in the denominator.*
- Every measure under consideration will receive a decision.
- Staff will provide an overview of the process for establishing consensus through voting at the start of each in-person meeting.
- After additional introductory presentations from staff and the chair to give context to each programmatic discussion, voting will begin.
- The in-person meeting discussion guide will 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 around programs (Hospital and PAC/LTC) or condition categories (Clinician).*
- Each measure under consideration will have been subject to a preliminary staff analysis based on a decision algorithm approved by the Coordinating Committee.
  - *The discussion guide will note the result of the preliminary analysis (i.e., support, do not support, or conditional support) and provide rationale to support how that conclusion was reached.*

Workgroup Voting Procedures

- Step 1. Staff will review the Preliminary Analysis for each MUC using the MAP selection criteria and programmatic objectives, and Lead Discussants will review and present their findings.
- Step 2. The co-chairs will ask for clarifying questions from the Workgroup. The chairs will compile all Workgroup questions.
  - *Measure developers will respond to the clarifying questions on the specifications of the measure.*
  - *NQF staff will respond to clarifying questions on the preliminary analysis.*
  - *Lead discussants will respond will respond to questions on their analysis.*
- Step 3. Voting on acceptance of the preliminary analysis decision.
  - *After clarifying questions have been resolved, the co-chair will open for a vote on accepting the preliminary analysis assessment. This vote will be framed as a yes or no vote to accept the result.*
  - *If greater than or equal to 60% of the Workgroup members vote to accept the preliminary analysis assessment, then the preliminary analysis assessment will become the Workgroup recommendation. If less than 60% of the Workgroup votes to accept the preliminary analysis assessment, discussion will open on the measure.*

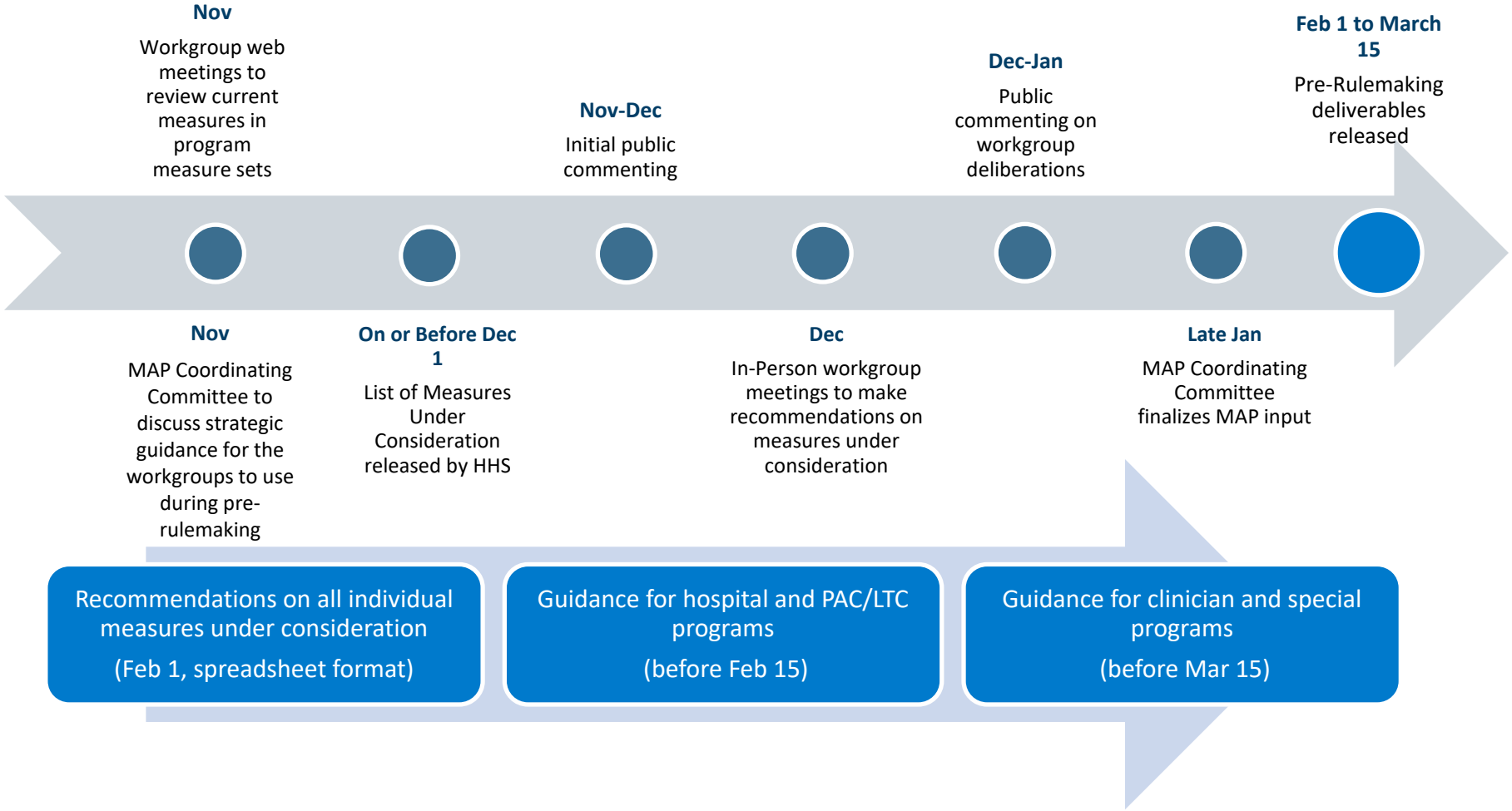
Workgroup Voting Procedures

- Step 4. Discussion and Voting on the MUC
  - *The co-chair will open for discussion among the Workgroup. Workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.*
  - *After the discussion, the co-chair will open the MUC for a vote.*
    - NQF staff will summarize the major themes of the Workgroup's discussion.
    - The co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions.
    - If the co-chairs do not feel there is a consensus position to use to begin voting, the Workgroup will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with potential for mitigation, then do not support.

Workgroup Voting Procedures

- Step 5: Tallying the Votes:
  - *If a decision category put forward by the co-chairs receives greater than or equal to 60% of the votes, the motion will pass and the measure will receive that decision.*
  - *If no decision category achieves greater than 60% to overturn the preliminary analysis, the preliminary analysis decision will stand. This will be marked by staff and noted for the Coordinating Committee's consideration.*

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



Opportunity for Public Comment

Break

Pre-Rulemaking Input: Medicare Shared Savings Program (SSP) Program Measures

Public Comment: Opioid Use Measures Under Consideration

Opioid Use Measures (SSP)

Measure Group 1:

- MUC2018-077: Use of Opioids from Multiple Providers in Persons Without Cancer
- MUC2018-078: Use of Opioids at High Dosage in Persons Without Cancer
- MUC2018-079: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
- MUC2018-106: Initial opioid prescription compliant with CDC recommendations

Public Comment: Immunization Status Measure Under Consideration

Immunization Status Measure (SSP)

Measure Group 2:

- MUC2018-062: Adult Immunization Status

Public Comment: Immunization Status Measure Under Consideration

Immunization Status Measure (MIPS)

Measure Group 3:

- MUC2018-062: Adult Immunization Status

SSP Workgroup Discussion

- Are there additional gap areas for this program?

Lunch

MAP Rural Health Workgroup Recommendations

Rural Health Core Set

- 20 measures in the core set
  - *9 measures for the hospital setting (facility level of analysis)*
  - *11 measures for ambulatory setting (clinician level of analysis)*
- 7 additional measures for ambulatory setting, but currently endorsed for health plan/integrated delivery system levels of analysis
- Apply to majority of rural patients and providers
  - *NQF-endorsed*
  - *Cross-cutting*
  - *Resistant to low case-volume*
- Includes process and outcome measures
- Includes measures based on patient report
- Majority used in federal quality programs

2017-2018 MAP Rural Health Workgroup
Measurement Gaps

- Access to care
- Transitions in care
- Cost
- Substance use measures, particularly those focused on alcohol and opioids
- Outcome measures (particularly patient-reported outcomes)

Considering Access to Care from a Rural Perspective

- Identified facets of access that are particularly relevant to rural residents
- Documented key challenges to access-to-care measurement from the rural perspective
- Identified ways to address those challenges

- Some key aspects of discussion
  - *Access and quality difficult to de-link*
  - *Both clinician-level and higher-level accountability needed*
  - *Distance to care and transportation issues are vital issues*
  - *Telehealth can address several of the barriers to access, but there are still limitations to its use*

Key Domains of Access to Care from a Rural Perspective

- **Availability**
  - *Specialty care, appointment availability, timeliness*
  - *Address via: workforce policy; team-based care and practicing to top of license; telehealth; improving referral relationships; partnering with supporting services*
- **Accessibility**
  - *Transportation, health information, health literacy, language interpretation, physical spaces*
  - *Address via: tele-access to interpreters; community partnerships; remote technology; clinician-patient communication*
- **Affordability**
  - *Out-of-pocket costs; delayed care due to out-of-pocket costs*
  - *Address via: appropriate risk adjustment; policy/insurance expansion; protecting the safety net; monitoring patient balance after insurance*

Discussion

- Core set
  - *Do you agree with the overall topic areas that were covered?*
    - » Is anything missing?
  - *Do you have any particular concerns or questions about particular measures?*
- Gaps
  - *What are your initial thoughts on the identified gaps?*
- Access to care
  - *What did you think of the approach?*
  - *Do the three domains seem like the right ones to focus on?*
  - *Was anything particularly surprising or intriguing?*
  - *Did we miss anything?*

Pre-Rulemaking Input: Merit-Based Incentive Payment System (MIPS) Program Measures

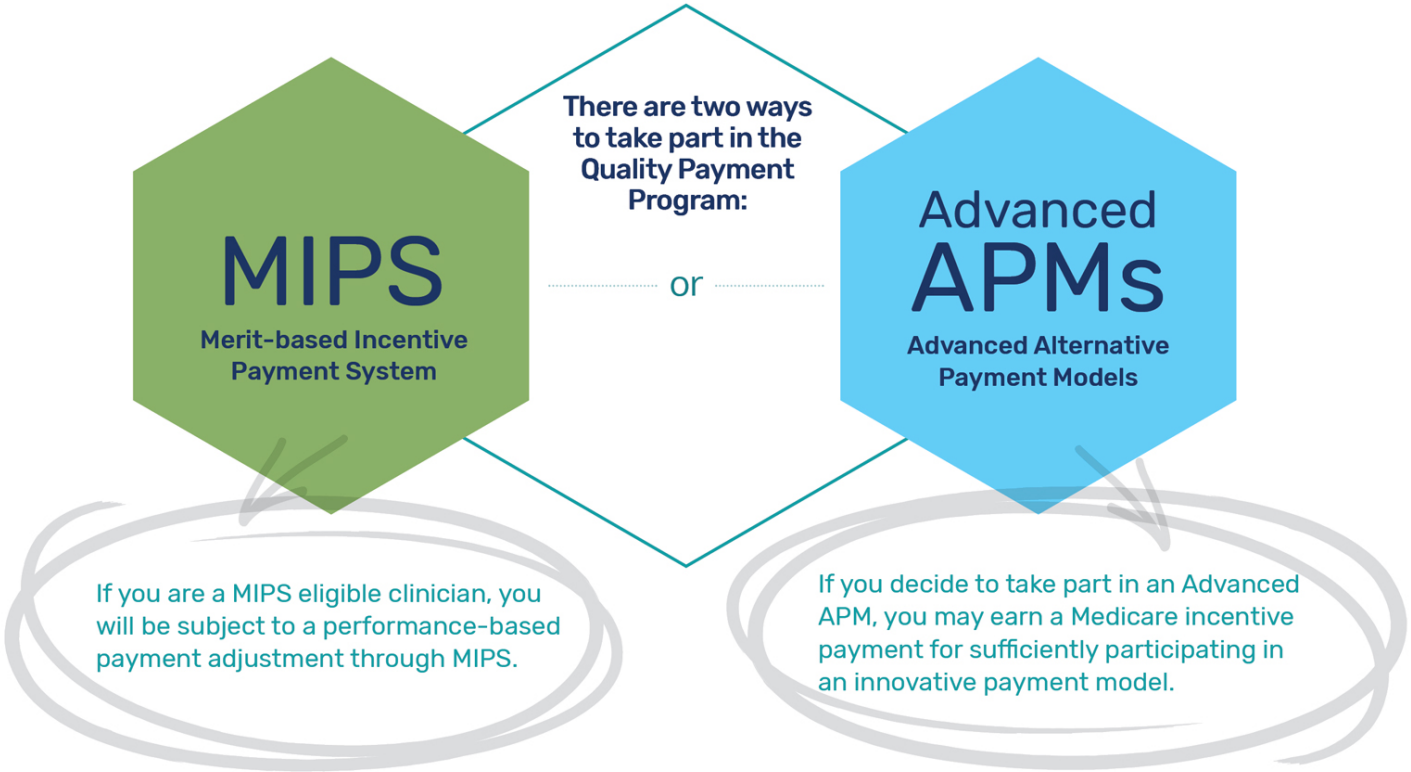
Quality Payment
PROGRAM

QUALITY PAYMENT PROGRAM YEAR 3 (2019)

Reena Duseja. MD, MS
Chief Medical Officer
Quality Measurement and Value Based Incentives Group
Center for Clinical Standards and Quality, CMS

Quality Payment Program

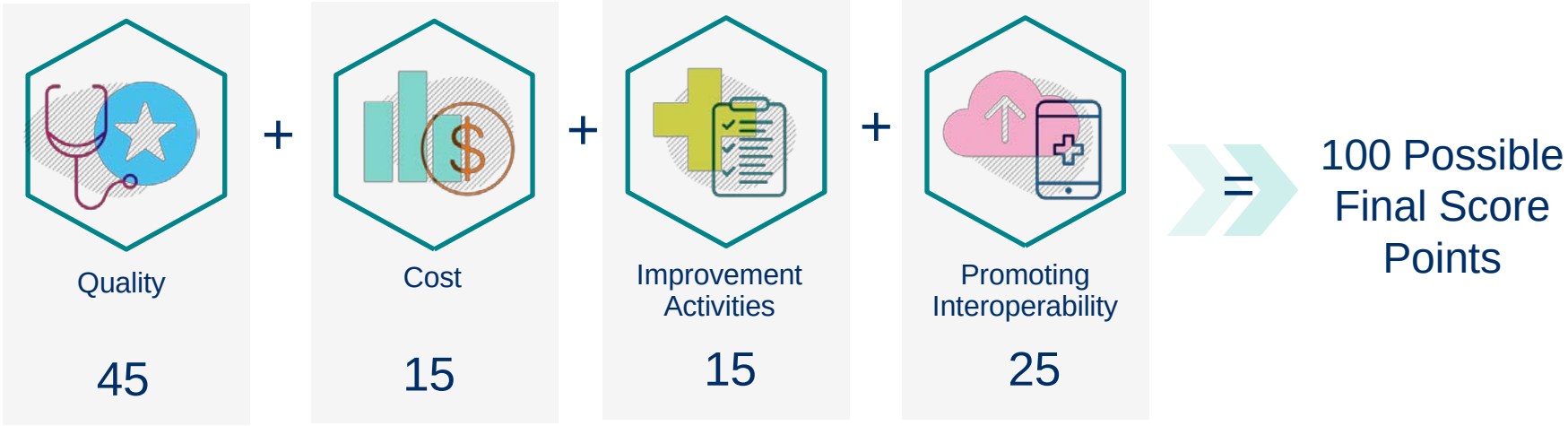
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program:



Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories for Year 3 (2019)



- In the CY 2019 PFS Final Rule, we finalized that the weight of the quality performance category will be reduced to 45, and the weight of the cost performance category is increasing to 15.
- All performance categories are calculated for MIPS Final Score.
- *The points from each performance category are added together to give you a MIPS Final Score.*

MIPS Year 3 (2019) Final

Quality Performance Category

Basics:

- **45%** of Final Score in 2019
- You select 6 individual measures:
  - 1 must be an outcome measure
    OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure.
- You may also select a specialty-specific set of measures.

Meaningful Measures

- Goal: The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes.
- For 2019, we are:
  - Removing 26 quality measures, including those that are process, duplicative, and/or topped-out.
  - Adding 8 measures (4 Patient-Reported Outcome Measures), 6 of which are high-priority.
- Total of 257 quality measures for 2019.

MIPS Year 3 (2019) Final

Quality Performance Category

Basics:

- **45%** of Final Score in 2019
- You select 6 individual measures:
  - 1 must be an outcome measure
    OR
  - High-priority measure
- If less than 6 measures apply, then report on each applicable measure.
- You may also select a specialty-specific set of measures.

Topped-out Measures

Year 2 (2018) Final	Year 3 (2019) Final
• A topped out measure is when performance is so high and unwavering that meaningful distinctions and improvement in performance can no longer be made. • 4-year lifecycle to identify and remove topped out measures. • Scoring cap of 7 points for topped out measures.	**Same requirements** as Year 2, with the following changes: • Extremely Topped-Out Measures: – A measure attains extremely topped-out status when the average mean performance is within the 98th to 100th percentile range. – CMS may propose removing the measure in the next rulemaking cycle. • QCDR measures are excluded from the topped out measure lifecycle and special scoring policies.

Merit-based Incentive Payment System (MIPS)

2018 MUC List Measures for MIPS

- MUC2018-32/34: Discouraging the routine use of occupational and/or physical therapy after carpal tunnel release
- MUC2018-31/35: Time to surgery for elderly hip fracture patients
- MUC2018-38/42: International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia
- MUC2018-48/65: Potential Opioid Overuse
- MUC2018-47/69: Multimodal Pain Management
- MUC2018-57/83: Annual Wellness Assessment: Preventive Care
- MUC2018-62/95: Adult Immunization Status
- MUC2018-63/94: Functional Status Change for Patients with Neck Impairments

Merit-based Incentive Payment System (MIPS)

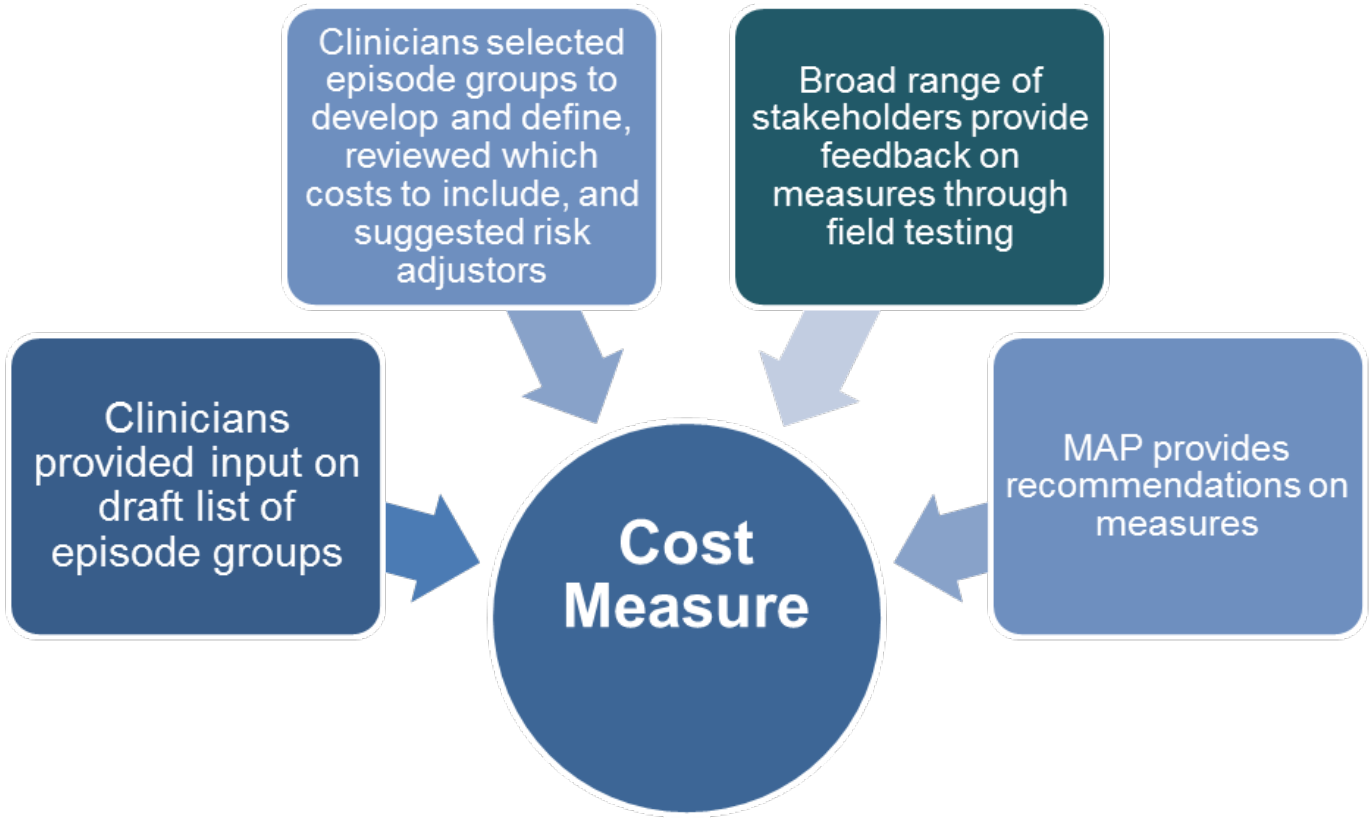
Cost Measures Address Key Criteria for Potential Use in MIPS

- Aligns with CMS's Quality Priority "Make Care Affordable" and Meaningful Measure Areas:
  - Patient-focused Episode of Care
  - Risk Adjusted Total Cost of Care
- Episode-based cost measures are developed to meet the mandate of MACRA section 101(f).
- Developed to incorporate detailed clinical input in each component.
- Fully specified measures can be operationalized using claims data for no additional clinician burden.
- Measures have demonstrated reliability and validity.
- Measures have been tested and refined based on feedback from clinician stakeholders.

Merit-based Incentive Payment System (MIPS)

Cost Measure Development Process Involves Extensive Stakeholder Input

- Broad range of stakeholders have provided input into each component of the cost measures throughout development
  - Input has been gathered through a Technical Expert Panel, Clinical Committees and Subcommittees, measure-specific workgroups, Person and Family Committee, public comment, and field testing



Merit-based Incentive Payment System (MIPS)

Cost Measure Development Involves Extensive Stakeholder Input on Each Component of Episode-Based Cost Measures

Technical Expert Panel (TEP)

- Serves a high-level advisory role and provides guidance on overall direction of measure development and re-evaluation
- Includes representatives recruited through public call for nominations from specialty societies, academia, healthcare administration, and person and family organizations
- Meetings in 2016-2018

Clinical Committee (Aug-Sept 2016)

- Provided expert input to develop draft list of episode groups and trigger codes for episode-based cost measures
- Draft list used as starting point for episode-based cost measure development
- 70+ clinical experts from 50+ professional societies recruited through public call for nominations

Clinical Subcommittees (CS)

- Provide detailed clinical input to build out all components of episode-based cost measures
- Wave 1 (May 2017-Jan 2018)
  - 7 Subcommittees, comprising approx. 150 clinicians affiliated with nearly 100 societies
  - Developed 8 measures
- Wave 2 (April 2018-Dec 2018)
  - 10 Subcommittees comprising over 265 clinicians affiliated with more than 120 societies
  - Measure-specific workgroups have developed 11 measures

Merit-based Incentive Payment System (MIPS)

Episode-based Cost Measures are Part of Continued Measure Development Process

- Episode-based cost measures represent the cost to Medicare for the items and services delivered to a patient during an episode of care
  - Cost measures have 5 components:

- CMS submitted 8 episode-based cost measures to 2017-18 MAP which recommended 'conditional support for rulemaking.'
  - Measures finalized for CY 2019 MIPS cost performance category
  - In line with recommendations from the MAP:
    - CMS intends to submit the measures for NQF endorsement in the Sprint 2019 cycle.
    - The measures will continue to be updated based on testing as part of measure maintenance.
- 11 episode-based cost measures submitted this year were developed in a continuation of the process used to develop the 8 measures last year.
  - These measures have been developed with extensive stakeholder input the meet the mandate of MACRA.

Merit-based Incentive Payment System (MIPS)

Two MIPS Cost Measures Re-evaluated as Part of Measure Maintenance

- A version of the MSPB and TPCC measures has been used in MIPS cost performance category since the 2017 performance period. Earlier versions of the measures were used in Value Modifier Program and reported through QRURs.
- Measures were re-evaluated as part of regular measure maintenance per the Blueprint for the CMS Measure Management System.

TEP provides overall guidance on direction of refinements

Public Comment	Technical Expert Panel	MSPB Service Refinement Workgroup	Stakeholder Feedback
Stakeholders submitted comments on MSPB and TPCC measures used in MIPS	Provided high-level guidance for both measures and suggested creation of MSPB Service Refinement Workgroup	Provided detailed guidance on cost assignment for MSPB Workgroup composed of 25 clinicians from a wide range of medical backgrounds	Stakeholders provided feedback on measures through field testing, which the TEP and Service Refinement Workgroup considered

Merit-based Incentive Payment System (MIPS)

Broad Feedback Received Through Cost Measures Field Testing in October – November 2018

- Field testing took place from **October 3 to November 5, 2018.**
- National Field Testing Webinar and specialty society office hours held.
- Key Areas of Feedback:
  - Stakeholders generally appreciated Clinical Subcommittee process.
  - Detailed suggestions regarding specific trigger and assigned services codes employed for episode-based cost measures.
  - General support for the re-evaluated MSPB clinician measure refinements
  - Recommendations for changes to service category exclusions for the re-evaluated TPCC measure.

Merit-based Incentive Payment System (MIPS)

Eleven Episode-Based Cost Measures Developed and Two Measures Re-evaluated for Potential Use in MIPS

- CMS is submitting 11 episode-based cost measures and 2 re-evaluated cost measures for the Merit-based Incentive Payment System (MIPS) for the MAP's consideration

MUC ID	Cost Measure Title
Episode-based Cost Measures	
MUC2018-115	Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
MUC2018-116	Femoral or Inguinal Hernia Repair
MUC2018-117	Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
MUC2018-119	Psychoses/Related Conditions
MUC2018-120	Lumpectomy, Partial Mastectomy, Simple Mastectomy
MUC2018-121	Acute Kidney Injury Requiring New Inpatient Dialysis
MUC2018-122	Lower Gastrointestinal Hemorrhage
MUC2018-123	Renal or Ureteral Stone Surgical Treatment
MUC2018-126	Hemodialysis Access Creation
MUC2018-137	Elective Primary Hip Arthroplasty
MUC2018-140	Non-Emergent Coronary Artery Bypass Graft (CABG)
Re-evaluated Cost Measures	
MUC2018-148	Medicare Spending Per Beneficiary (MSPB) clinician
MUC2018-149	Total Per Capita Cost (TPCC)

Public Comment: Cost/Resource Use Measures Under Consideration

Cost/Resource Use Measures (MIPS)

Measure Group 4:

- MUC2018-115: Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- MUC2018-116: Femoral or Inguinal Hernia Repair
- MUC2018-117: Lumbar Spine Fusion for Degenerative Disease, 1-3Levels
- MUC2018-119: Psychoses/Related Conditions
- MUC2018-120: Lumpectomy, Partial Mastectomy, Simple Mastectomy
- MUC2018-121: Acute Kidney Injury Requiring New Inpatient Dialysis
- MUC2018:122: Lower Gastrointestinal Hemorrhage
- MUC2018-123: Renal or Ureteral Stone Surgical Treatment
- MUC2018-126: Hemodialysis Access Creation
- MUC2018-137: Elective Primary Hip Arthroplasty
- MUC2018-140: Non-Emergent Coronary Artery Bypass Graft (CABG)
- MUC2018-148: Medicare Spending Per Beneficiary (MSPB) clinician measure
- MUC2018-149: Total Per Capita Cost

Break

Public Comment: Quality Measures Under Consideration

Quality Measures (MIPS)

Measure Group 5:

- MUC2018-063: Functional Status Change for Patients with Neck Impairments

Quality Measures (MIPS)

Measure Group 6:

- MUC2018-031: Time to surgery for elderly hip fracture patients

Quality Measures (MIPS)

Measure Group 7:

- MUC2018-032: Discouraging the routine use of occupational and/or physical therapy after carpal tunnel release

Quality Measures (MIPS)

Measure Group 8:

- MUC2018-038: International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia

Quality Measures (MIPS)

Measure Group 9:

- MUC2018-047: Multimodal Pain Management
- MUC2018-048: Potential Opioid Overuse

Quality Measures (MIPS)

Measure Group 10:

- MUC2018-057: Annual Wellness Assessment: Preventive Care

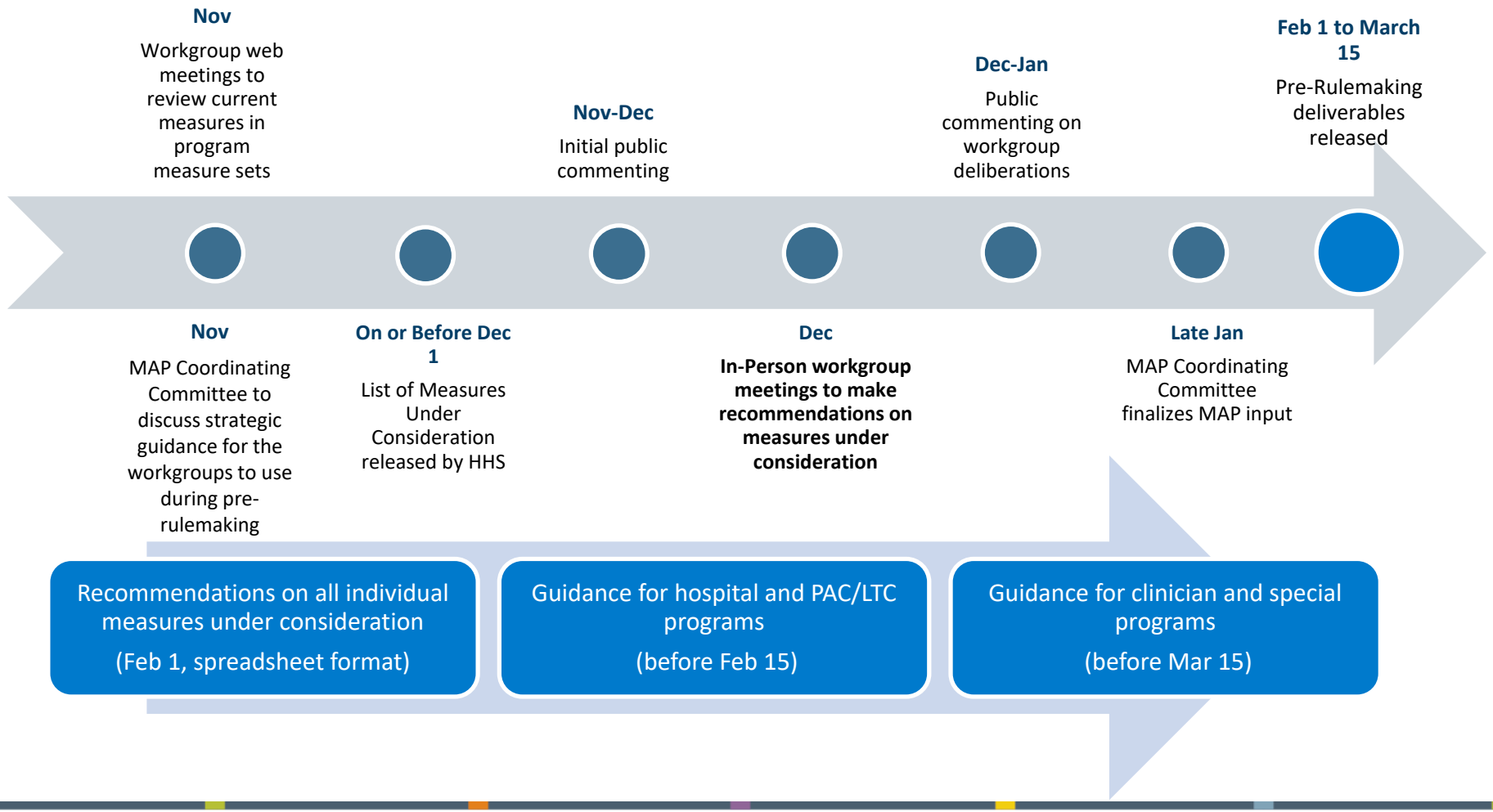
MIPS Workgroup Discussion

- Are there additional gap areas for this program?

Opportunity for Public Comment

Summary of Day and Next Steps

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



Next Steps: Upcoming Activities

In-Person Meetings

- PAC/LTC Workgroup – **December 10**
- Hospital Workgroup – **December 11**
- Clinician Workgroup – **December 12**
- Coordinating Committee – **January 22-23**

Public Comment Period: December 21, 2018 — January 10, 2019

Adjourn