NATIONAL QUALITY FORUM

Agenda

MAP Clinician Workgroup Web Meeting

November 14, 2018
2:00 pm – 4:00 pm ET

Streaming Playback Online

- **Direct your web browser to**: http://nqf.commpartners.com/se/Meetings/Playback.aspx?meeting.id=941675

Meeting Objectives

- Orientation to 2018-2019 MAP pre-rulemaking approach
- Overview of programs under consideration
  - Review goals of the program
  - Review and discuss critical program objectives
  - Identification of measurement gaps

2:00 pm	**Welcome, Introductions, and Review of Meeting Objectives** *Bruce Bagley, MD and Amy Moyer, MS, PMP, Workgroup Co-Chairs* *John Bernot, MD, Vice President, NQF*
2:10 pm	**MAP Pre-Rulemaking Approach** *John Bernot*
2:15 pm	**Overview of the Merit-Based Incentive Payment System (MIPS) Program** *Susan Arday, BSPH, MHS, CHES, Centers for Medicare & Medicaid Services (CMS)* *Joel Andress, PhD, CMS* *John Bernot*
2:45 pm	**Overview of the Medicare Shared Savings Program (SSP) Program** *Fiona Larbi, MS, RN, CMS* *John Bernot*
3:05 pm	**2017-2018 MAP Clinician Overarching Themes** *Miranda Kuwahara, MPH, Project Manager, NQF*
3:15 pm	**Update on Prior Measures Under Consideration** *Miranda Kuwahara*
3:25 pm	**Introduction to NQF's Rural Work** *Dr. Ira Moscovice, MAP Rural Health Workgroup Co-Chair* *Suzanne Theberge, Senior Project Manager, NQF*
3:50 pm	**Opportunity for Public and NQF Member Comment**
3:55 pm	**Next Steps** *Miranda Kuwahara*
4:00 pm	**Adjourn**

NATIONAL QUALITY FORUM

Measure Applications Partnership

Clinician Workgroup Web Meeting

November 14, 2018

Welcome, Introductions, and Review of Meeting Objectives

Agenda

- Welcome, Introductions, and Review of Meeting Objectives
- MAP Pre-Rulemaking Approach
- Overview of the Merit-Based Incentive Payment System (MIPS) Program
- Overview of the Medicare Shared Savings Program Program
- 2017-2018 MAP Clinician Overarching Themes
- Update on Prior Measures Under Consideration
- Introduction to NQF's Rural Work
- Opportunity for NQF Member and Public Comment
- Next Steps

MAP Clinician Team

- John Bernot, Vice President
- Miranda Kuwahara, Project Manager
- **Project email:** MAPClinician@qualityforum.org

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

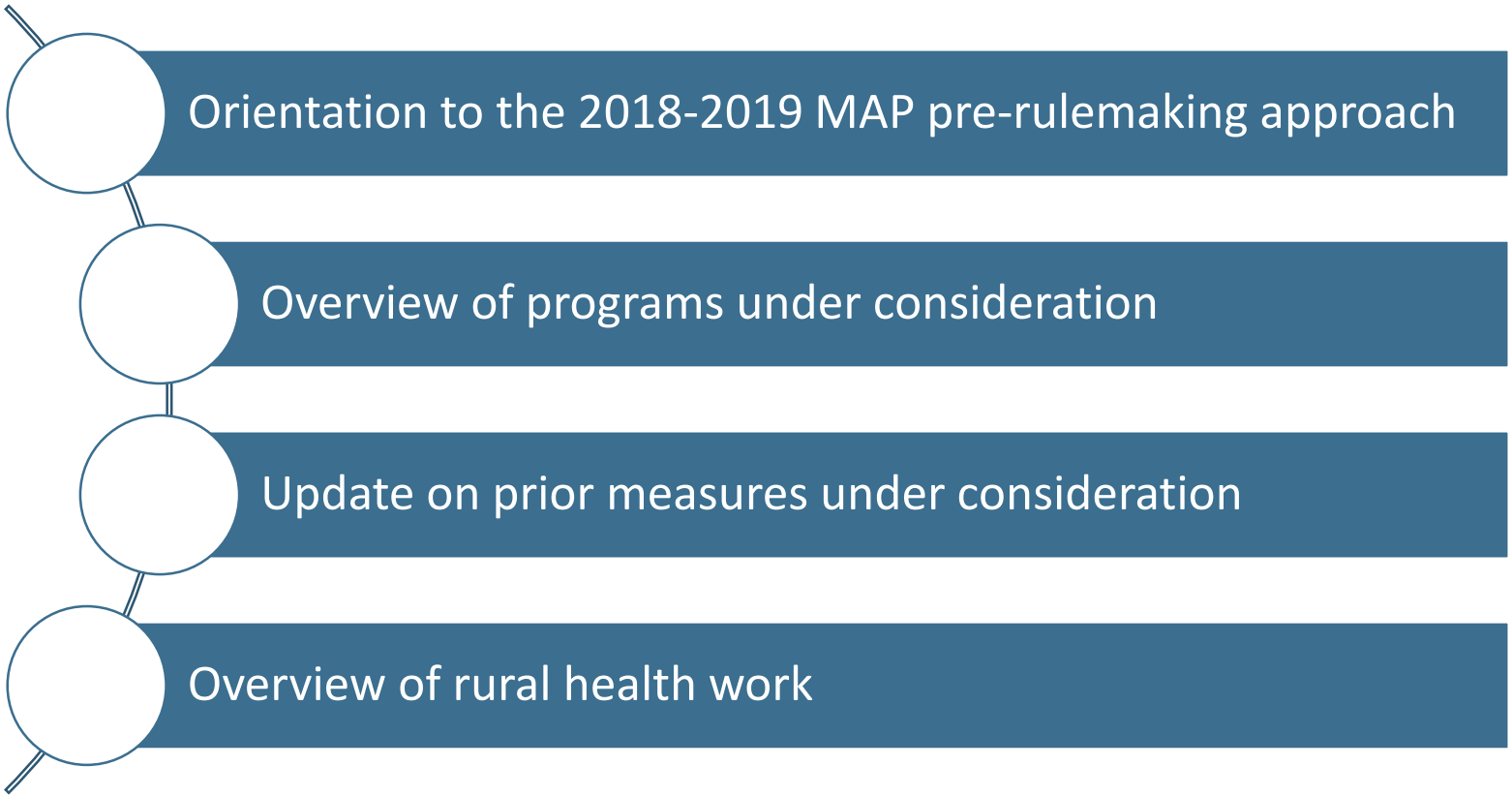
Subject Matter Experts (Voting)

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

Meeting Objectives



MAP Pre-Rulemaking Approach

MAP Pre-Rulemaking Approach

A closer look into how recommendations will be made

November

- The MAP Coordinating Committee examined key strategic issues to inform preliminary evaluations of measures under consideration
- During today's meeting, the Workgroup will familiarize themselves with finalized program measure set for each program

December

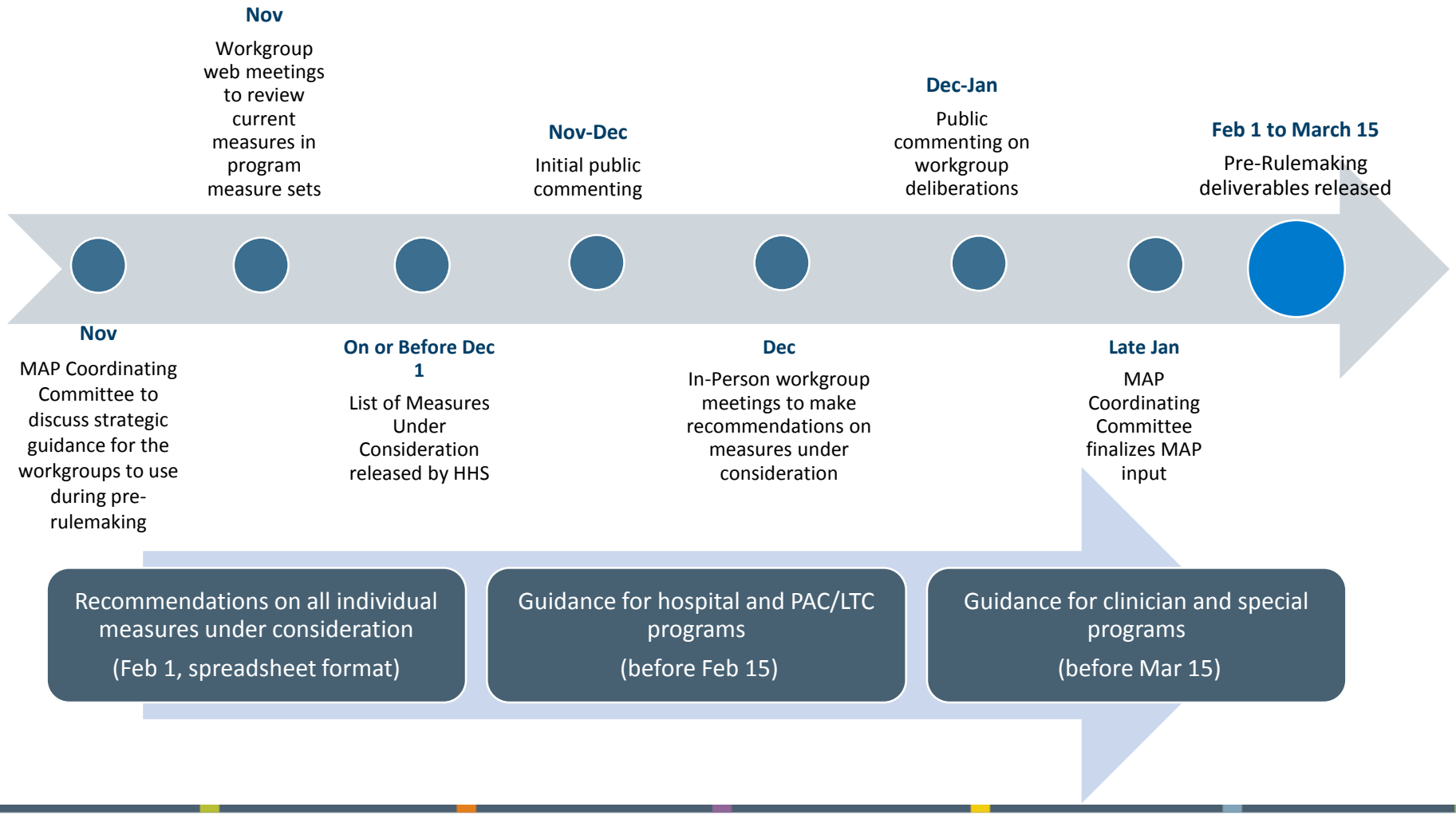
- The MAP workgroups will evaluate measures under consideration during their December in-person meetings informed by the preliminary evaluations completed by NQF staff

January

- The MAP Coordinating Committee will examine the MAP workgroup recommendations and key cross-cutting issues

MAP Pre-Rulemaking Approach

A look at what to expect



Programs to Be Considered by the Clinician Workgroup

- Merit-based Incentive Payment System (MIPS)
- Medicare Shared Savings Program

MAP Pre-Rulemaking Approach

Goals for today's meeting

- Review the goals and structure of each program
- Review the critical objectives of each program
- Identify measurement gap areas
- Provide input to the Rural Health group

Merit-Based Incentive Payment System (MIPS)

CMS Placeholder

Role of MAP for Merit-based Incentive Payment System (MIPS)

CMS Priorities and Needs for MIPS

- Outcome measures
- Measures relevant for specialty providers
- High-priority domains for future measure consideration:
  - *Person and caregiver-centered Experience and Outcomes (Specific focus on PROMs)*
  - *Communication and Care Coordination*
  - *Efficiency/Cost Reduction*
  - *Patient Safety*
  - *Appropriate Use*
- MACRA requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals prior to implementing in MIPS.

CMS Priorities and Needs for MIPS

- Available for public reporting on Physician Compare
- Measures are fully developed and tested and ready for implementation
- Not duplicative of measures in set
- Identify opportunities for improvement – avoid “topped out” measures

MIPS Current measures

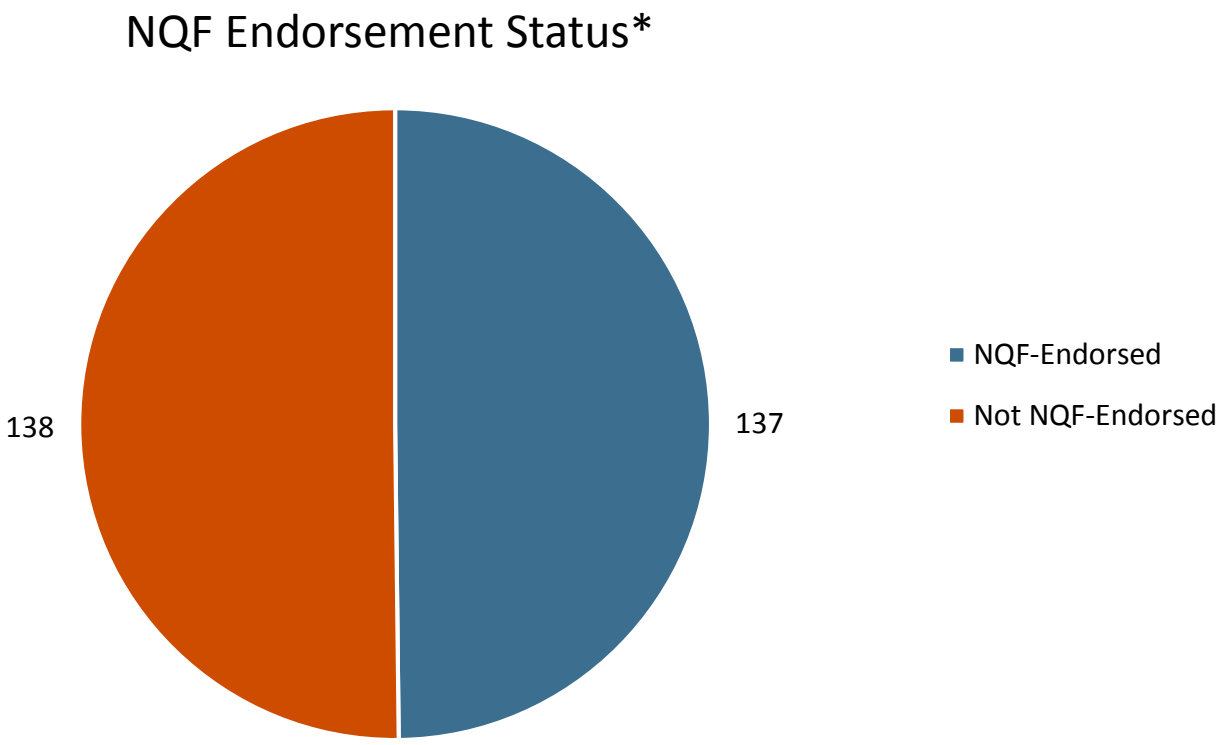
Divided by MIPS Measure Domain

Domain	# of Measures
Effective Clinical Care	130
Patient Safety	45
Communication/Care Coordination	43
Community/Population Health	16
Efficiency and Cost Reduction	21
Person and Caregiver-Centered Experience and Outcomes	19
Patient Safety, Efficiency and Cost Reduction	1

Total measures = 275

*Status as of October 2018

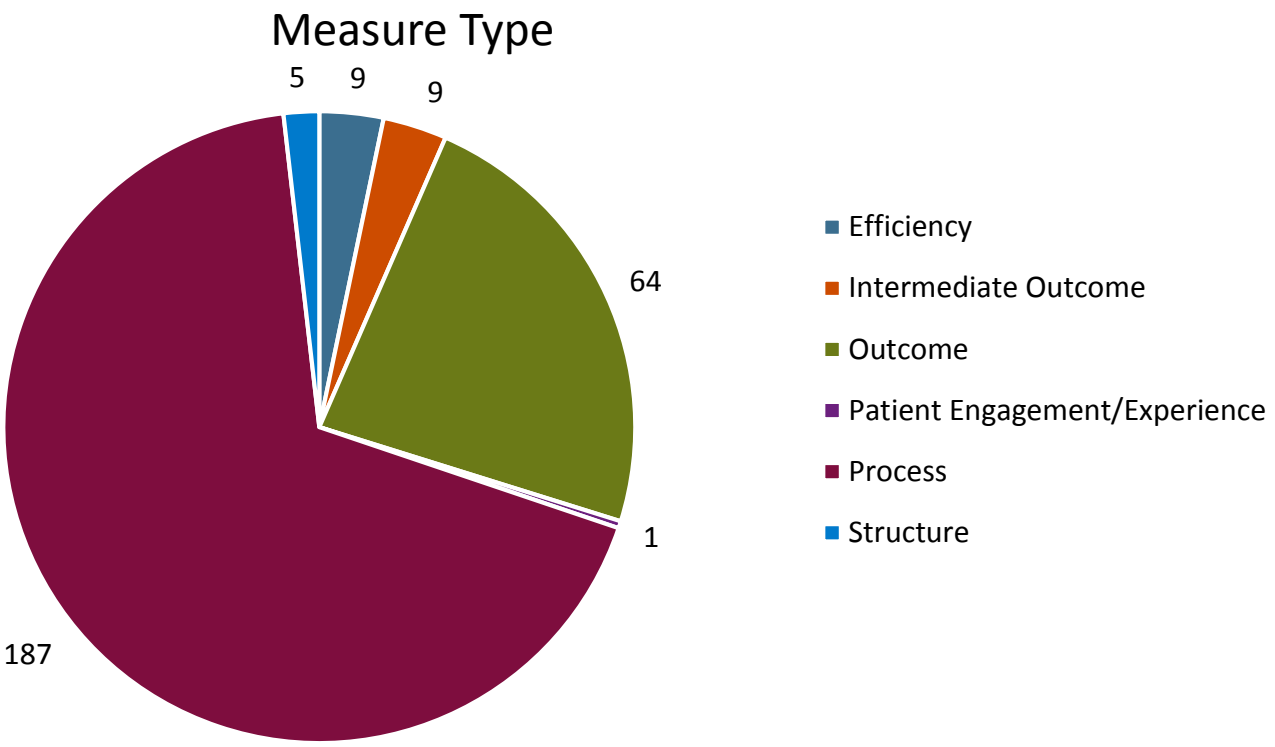
2018 MIPS Measures



*Status as of October 2018
Total Measures = 275

Source: Centers for Medicare & Medicaid Services. Quality Payment Program. https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Quality-Measure-Specifications-supporting-documents.zip

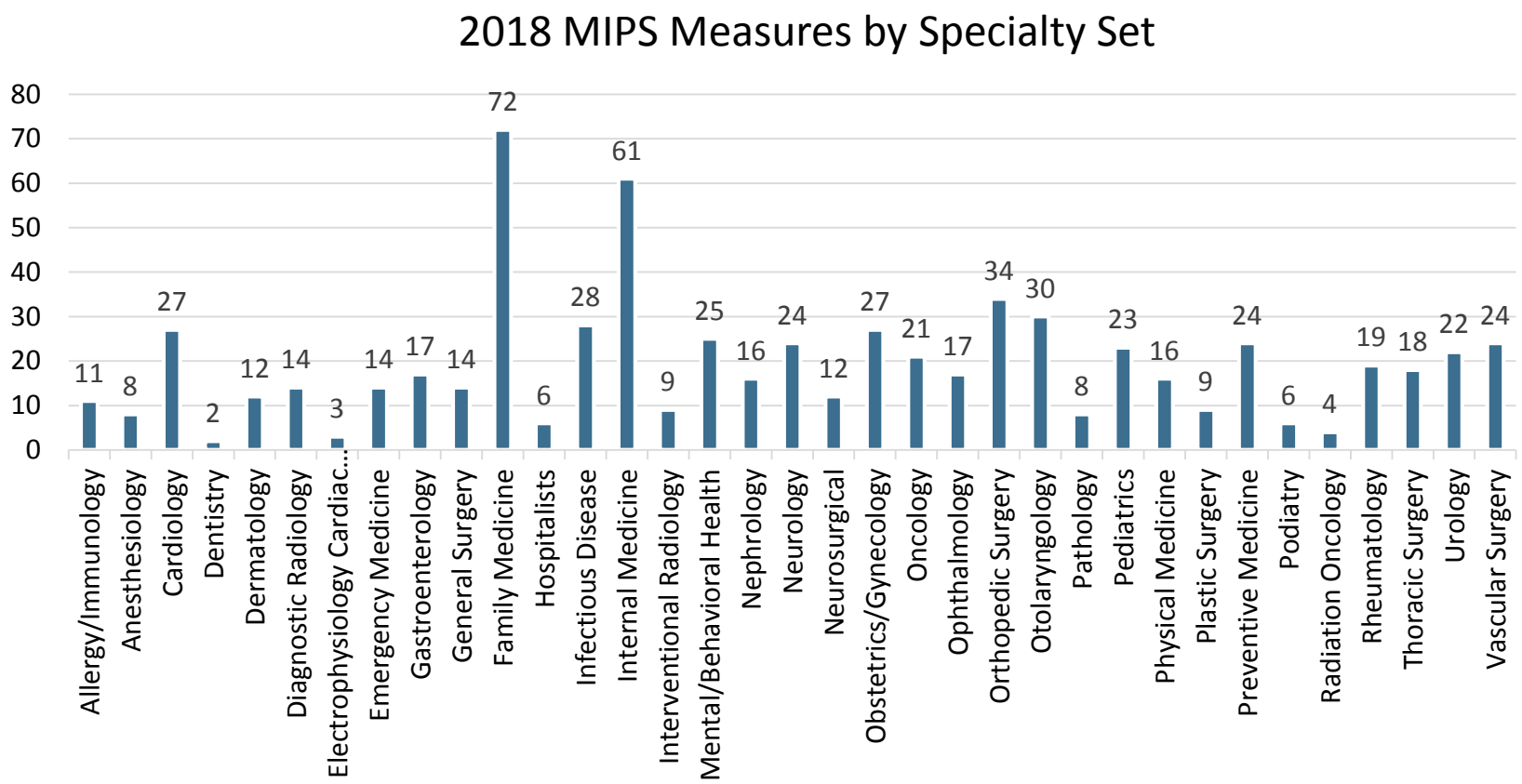
2018 MIPS Measures



*Status as of October 2018
Total Measures = 275

Source: Centers for Medicare & Medicaid Services. Quality Payment Program. https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Quality-Measure-Specifications-supporting-documents.zip

2018 MIPS Measures



*Status as of October 2018; measures may be included in more than one specialty domain
Total Measures = 275

Source: Centers for Medicare & Medicaid Services. Quality Payment Program. https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Quality-Measure-Specifications-supporting-documents.zip

Medicare Shared Savings Program (Shared Savings Program)

MEDICARE SHARED SAVINGS PROGRAM

Overview of Medicare Shared Savings Program

- For the Measures Application Partnership

- November 14, 2018

- Fiona Larbi, MS, RN
- Division of Program Alignment and Communications

Agenda

- Medicare Shared Savings Program Overview
- Promising Results
- Overview of Quality Measurement Approach
- Quality Measures
- Quality Performance Assessment
- Future Measure Considerations

Shared Savings Program Overview

- Medicare Shared Savings Program (Shared Savings Program) is mandated by Section 3022 of the Affordable Care Act.
- Accountable Care Organizations (ACOs) create incentives for health care providers to work together voluntarily to coordinate care and improve quality for their patient population.
- As of January 1, 2018, 561 Shared Savings Program ACOs were serving approximately 10.5 million Medicare FFS beneficiaries.
- CMS assesses ACO performance annually based on quality and financial performance to determine shared savings or losses.

ACO Quality Performance Highlights

- Over 98% of ACOs continue to satisfactorily report quality measures on behalf of their clinicians annually
- ACOs that reported quality in 2016 and 2017 improved on 93 percent of the quality measures that were reported in both years.
- In 2017, 93 percent of ACOs received bonus points for improving quality performance in one of the four quality measure domains between 2016 and 2017. That is, more than 90 percent of ACOs in a second or third performance year or second agreement period during 2017 increased their overall quality performance score through Quality Improvement Reward points in at least one of four quality measure domains.

Overview of Quality Measurement Approach

MEDICARE SHARED SAVINGS PROGRAM

- The quality measurement approach in the Shared Savings Program is intended to:
- Improve individual health and the health of populations
- Address quality aims such as prevention, care of chronic illness and high prevalence conditions, patient safety, patient and caregiver engagement, and care coordination
- Align with the Quality Payment Program
- Proposed in Calendar Year 2019 Medicare Physician Fee Schedule proposed rule to refine the ACO core quality measure set to reduce the number of measures by 7, to make the measure set more outcome oriented, and reduce burden on ACOs and providers

Overview of Quality Measurement Approach

MEDICARE SHARED SAVINGS PROGRAM

In Performance Year 2018, there are 31 quality measures separated into the following four key domains:

- Patient/Caregiver Experience
- Care Coordination/Patient Safety
- Preventive Health
- At-Risk Population

Quality data is collected via the following mechanisms:

- Patient Survey (CAHPS for ACOs)
- Claims
- Quality Payment Program Promoting Interoperability data
- CMS Web Interface

Quality Performance Assessment

- CMS designates the quality performance standard for each ACO based on its performance year. It does not vary based on track.
- ACOs earn points based on individual measure performance and up to 4 quality improvement points per domain. All domains are weighted equally and an overall quality score is determined.
- Performance benchmarks are set for 2 years to support ACO quality improvement efforts.
- New measures added to the quality measure set are set as pay for reporting for two years before being phased into pay for performance (unless finalized as pay-for-reporting for all performance years).

Performance Year	Pay-for-Reporting or Pay-for-Performance	To be eligible to share in savings, if earned, the ACO must:
1	Pay-for-Reporting	Completely and accurately report all quality measures.
2 and 3, and subsequent agreement periods	Pay-for-Performance	Completely and accurately report all quality measures and meet minimum attainment on at least one measure in each domain.

2017 and 2018 Quality Measures

- Aim 1: Better Care for Individuals

1. PATIENT/CARE GIVER EXPERIENCE *CAHPS for ACOs*
ACO-1 Getting Timely Care, Appointments, and Information
ACO-2 How Well Your Providers Communicate
ACO-3 Patients' Rating of Provider
ACO-4 Access to Specialists
ACO-5 Health Promotion and Education
ACO-6 Shared Decision Making
ACO-7 Health Status/Functional Status*
ACO-34 Stewardship of Patient Resources

- * Measure is pay-for-reporting all years

2017 and 2018 Quality Measures:

- Aim 1: Better Care for Individuals (continued)

2. CARE COORDINATION/PATIENT SAFETY
ACO-8 Risk-Standardized All Condition Readmission
ACO-35 Skilled Nursing Facility 30-Day All-Cause Readmission Measure
ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes
ACO-37 All-Cause Unplanned Admissions for Patients with Heart Failure
ACO-38 All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
ACO-43 Ambulatory Sensitive Condition Acute Composite (Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) #91)
ACO-11 Use of Certified Electronic Health Record (EHR) Technology
ACO-12 Medication Reconciliation Post-Discharge
ACO-13 Screening for Future Fall Risk
ACO-44 Use of Imaging Studies for Low Back Pain*

- * Measure is pay-for-reporting all years

2017 and 2018 Quality Measures

- Aim 2: Better Health for Populations

3. PREVENTIVE HEALTH
ACO-14 Influenza Immunization
ACO-15 Pneumococcal Vaccination
ACO-16 Body Mass Index (BMI) Screening and Follow-Up
ACO-17 Tobacco Use: Screening and Cessation Intervention
ACO-18 Screening for Clinical Depression and Follow-Up Plan
ACO-19 Colorectal Cancer Screening
ACO-20 Breast Cancer Screening
ACO-42 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*

- *Measure is pay-for-reporting all years.

2017 and 2018 Quality Measures

- Aim 2: Better Health for Populations (continued)

4. Clinical Care for At-Risk Population
Depression
ACO-40 Depression Remission at 12 Months*
Diabetes ('all-or-nothing' Composite)**
ACO-27 Diabetes Mellitus: HbA1c Poor Control
ACO-41 Diabetes: Eye Exam
Hypertension
ACO-28 Controlling High Blood Pressure
Ischemic Vascular Disease
ACO-30 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

- *Measure is pay-for-reporting all years
- **The Diabetes Composite includes ACO-27 and ACO-41

Future Measure Considerations

- Align across CMS programs and with other private payers including measures reported through the CMS Web Interface, the CAHPS for ACOs survey, and calculated from CMS administrative claims data
  - *Measures that are outcome focused*
  - *Measures that fit a high priority gap area*
  - *Measures that are meaningful and can be feasibly implemented by CMS and reported by ACOs.*
  - *Consider the amount of burden associated with a given measure.*
- Address Meaningful Measures Objectives

Role of MAP for the Shared Savings Program

CMS Priorities and Needs for Shared Savings Program

- Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients.
- Measures that are targeted to the needs and gaps in care of Medicare fee-for-service patients and their caregivers.
- Measures that align with CMS quality reporting initiatives, such as MIPS.
- Measures that support improved individual and population health.
- Measures that align with recommendations from the Core Quality Measures Collaborative.

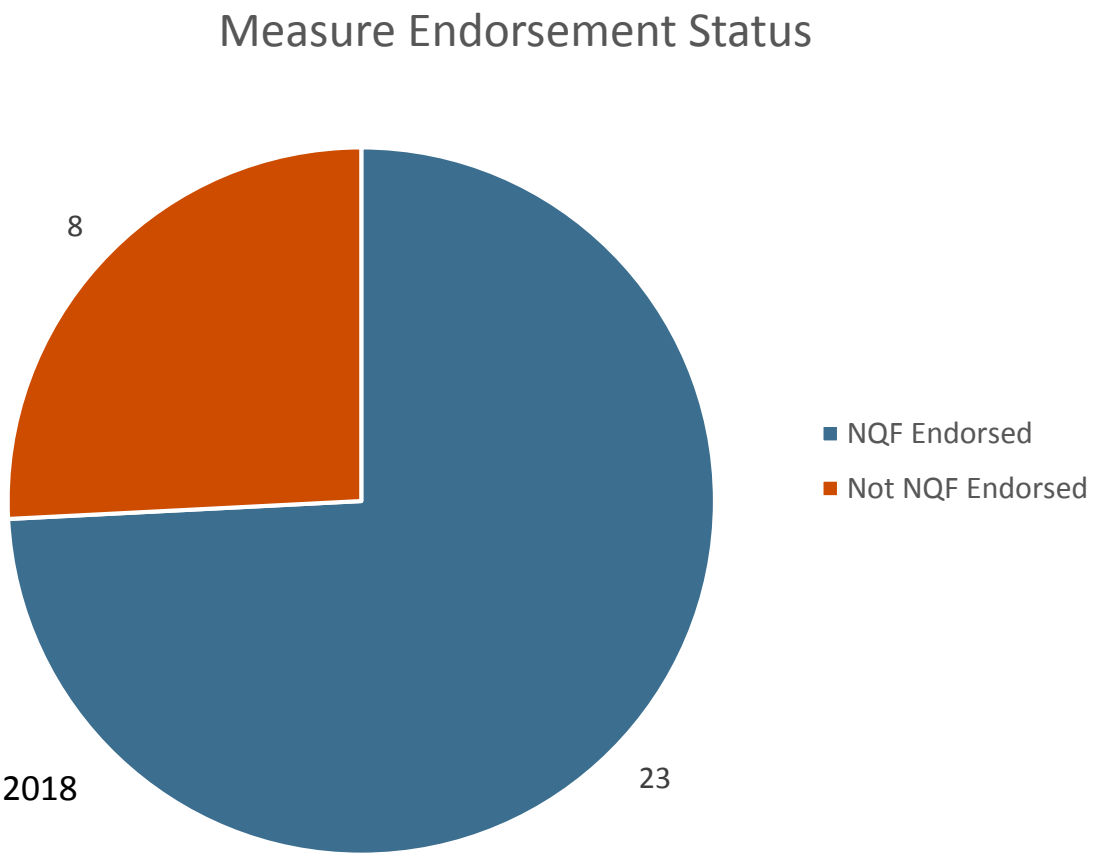
Shared Savings Program Performance Year 2018 Measures

Divided into 4 domains specified by ACA (31 Total Measures)

Domain	# of Measures
Patient/Caregiver Experience	8
Care Coordination/Patient Safety	10
Preventive Health	8
Clinical Care for At Risk Populations	5

*Status as of October 2018

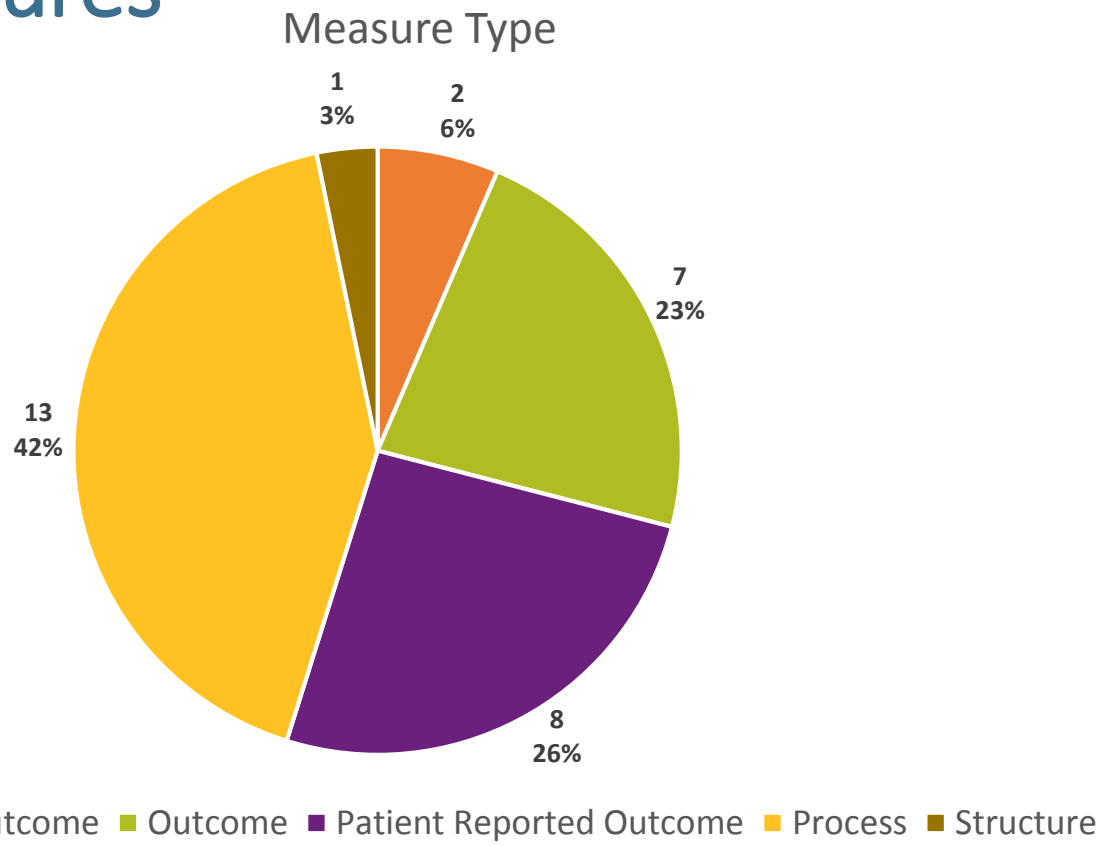
Shared Savings Program Performance Year 2018 Measures



*Status as of October 2018
Total Measures = 31

Source: Centers for Medicare & Medicaid Services. Medicare Shared Savings Program Accountable Care Organization (ACO) 2018 Quality Measures. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-reporting-year-narrative-specifications.pdf

Shared Savings Program Performance Year 2018 Measures



*Status as of October 2018
Total Measures = 31

Source: Centers for Medicare & Medicaid Services. Medicare Shared Savings Program Accountable Care Organization (ACO) 2018 Quality Measures. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-reporting-year-narrative-specifications.pdf

Workgroup Discussion

- Does the Workgroup have suggestions for refinement to future measurement in the high-priority domains?

2017-2018 MAP Clinician Overarching Themes

Overarching Issues

- Balance the need to assess costs while ensuring accurate measurement

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

MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for Clinician Programs

The MAP Clinician Workgroup reviewed measures under consideration for two federal programs:

Program	# of Measures
Merit-Based Incentive Payment System (MIPS)	22
Medicare Shared Savings Program	3

Clinician Workgroup Meeting Themes

Cost Measurement

- Importance of incorporating cost measures into value-based payment programs
- Cost measures should appropriately risk adjust to ensure clinical and social risk factors and evaluate a heterogeneous population
- Cost measures need to be routinely re-evaluated and tested during early stages of implementation

Clinician Workgroup Meeting Themes

Composite Measures

- Composite measures are well suited to capture the care provided for a condition and serve as a comprehensive view of performance

- Composite measures could pose additional challenges:
  - *Technical challenges in the measurement development process (i.e., target different target subpopulations; collection of data)*
  - *Challenge at the clinician level if a particular clinician or specialist does not have complete control over the care for that particular condition*

MAP 2018 Considerations for Implementing Measures in MIPS

MAP Clinician Workgroup Input:

- Desire to see more outcome measures
- Use of composite measures with consideration to attribution
- Importance of efficiency and cost reduction measures
- Encouraged the use of appropriate use measures with consideration of inappropriate use as well

MAP 2018 Considerations for Implementing Measures in the Shared Savings Program

MAP Clinician Workgroup Input:

- Desire to see more outcome measures
- Use of composite measures with consideration to attribution
- Importance of measures that align with other programs including MIPS

Update on prior measures under consideration

Merit-Based Incentive Payment System Workgroup Recommendations

Measure Title	Steward	MAP Recommendation
★ Continuity of Pharmacotherapy for Opioid Use Disorder	RAND Corporation	Conditional Support for Rulemaking
★ Average change in functional status following lumbar spine fusion surgery	MN Community Measurement	Support for Rulemaking
★ Average change in functional status following total knee replacement surgery	MN Community Measurement	Support for Rulemaking
★ Average change in functional status following lumbar discectomy laminotomy surgery	MN Community Measurement	Conditional Support for Rulemaking
★ Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture	Centers for Medicare & Medicaid Services	Conditional Support for Rulemaking
★ Average change in leg pain following lumbar spine fusion surgery	MN Community Measurement	Conditional Support for Rulemaking
Optimal Diabetes Care	MN Community Measurement	Conditional Support for Rulemaking
Optimal Vascular Care	MN Community Measurement	Support for Rulemaking

★ Measures proposed for use in the 2021 MIPS payment year and future years

Merit-Based Incentive Payment System Workgroup Recommendations, cont.

Measure Title	Steward	MAP Recommendation
Knee Arthroplasty	Centers for Medicare & Medicaid Services	Conditional Support for Rulemaking
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Centers for Medicare & Medicaid Services	Conditional Support for Rulemaking
Revascularization for Lower Extremity Chronic Limb Ischemia	Centers for Medicare & Medicaid Services	Conditional Support for Rulemaking
★ Zoster (Shingles) Vaccination	PPRNet	Conditional Support for Rulemaking
Patient reported and clinical outcomes following ilio-femoral venous stenting	Society of Interventional Radiology	Refine and Resubmit Prior to Rulemaking
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Centers for Medicare & Medicaid Services	Conditional Support for Rulemaking
Intracranial Hemorrhage or Cerebral Infarction	Centers for Medicare & Medicaid Services	Conditional Support for Rulemaking
Simple Pneumonia with Hospitalization	Centers for Medicare & Medicaid Services	Conditional Support for Rulemaking
★ HIV Screening	Centers for Disease Control and Prevention	Conditional Support for Rulemaking

★ Measures proposed for use in the 2021 MIPS payment year and future years

Merit-Based Incentive Payment System Workgroup Recommendations, cont.

Measure Title	Steward	MAP Recommendation
★ Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication	MN Community Measurement	Conditional Support for Rulemaking
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Centers for Medicare & Medicaid Services	Conditional Support for Rulemaking
International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) change 6-12 months after diagnosis of Benign Prostatic Hyperplasia	Large Urology Group Practice Association In collaboration with Oregon Urology Institute	Conditional Support for Rulemaking
Screening/Surveillance Colonoscopy	Centers for Medicare & Medicaid Services	Conditional Support for Rulemaking
Diabetes A1c Control (< 8.0)	MN Community Measurement	Conditional Support for Rulemaking

★ Measures proposed for use in the 2021 MIPS payment year and future years

Medicare Shared Savings Program Workgroup Recommendations

Measure Title	Steward	MAP Recommendation
Optimal Diabetes Care	MN Community Measurement	Conditional Support for Rulemaking
Diabetes A1c Control (< 8.0)	MN Community Measurement	Conditional Support for Rulemaking
Ischemic Vascular Disease Use of Aspirin or Anti-platelet Medication	MN Community Measurement	Conditional Support for Rulemaking

Introduction to NQF's Rural Work

Recommendations from the 2018 MAP Rural Health Workgroup

NQF's MAP Rural Health Workgroup Project Team
and
Ira Moscovice, PhD, MAP Rural Health Workgroup co-chair

November 14, 2018

Overview of Presentation

- Overview of NQF's 2015 work in rural health and key activities of the MAP Rural Health Workgroup
- 2018 recommendations of the MAP Rural Health Workgroup
  - *Core set of measures, gaps in measurement, access to care*
- Next steps for the NQF and the Workgroup
- Discussion

NQF's 2015 Rural Health Project

Overarching Recommendation

- Make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers, but allow a phased approach for full participation across program types and explicitly address low case-volume

Some Supporting Recommendations

- Use guiding principles for selecting quality measures that are relevant for rural providers
- Use a core set of measures, along with a menu of optional measures, for rural providers
- Create a Measure Applications Partnership (MAP) workgroup to advise CMS on the selection of rural-relevant measures

MAP Rural Health Workgroup
Key Activities for 2017-2018

- Assemble MAP Rural Health Workgroup
- Identify a core set of the best available rural-relevant measures
- Identify gaps in measurement and provide recommendations on alignment and coordination of measurement efforts
- Make recommendations regarding measuring and improving access to care for the rural population

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

Rural Health Core Set
Hospital Setting

NQF #	Measure Name
0138	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
0166	HCAHPS (includes 11 performance measures)
0202	Falls with injury
0291	Emergency Transfer Communication Measure
0371	Venous Thromboembolism Prophylaxis
0471	PC-02 Cesarean Birth
1661	SUB-1 Alcohol Use Screening
1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure
1789	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

Rural Health Core Set
Ambulatory Care Setting

NQF #	Measure Name
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
0041	Preventive Care and Screening: Influenza Immunization
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
0097	Medication Reconciliation Post-Discharge
0326	Advance Care Plan
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Rural Health Core Set
Ambulatory Care Setting

NQF #	Measure Name
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
0711	Depression Remission at Six Months
0729	Optimal Diabetes Care
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Additional Measures

Ambulatory Care Setting, Health Plan/Integrated Delivery System Level of Analysis (not clinician level)

NQF #	Measure Name
0018	Controlling High Blood Pressure
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
0032	Cervical Cancer Screening (CCS)
0034	Colorectal Cancer Screening (COL)
0038	Childhood Immunization Status (CIS)
2372	Breast Cancer Screening
2903	Contraceptive Care – Most & Moderately Effective Methods

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*

A Final Recommendation from the MAP Rural Health Workgroup

- CMS should continue to fund the MAP Rural Health Workgroup
  - *View the current core set as a "starter set"*
  - *Would like the opportunity to refine the core set over time*
    - » New measures continually being developed
    - » Measures often are modified
    - » Need to monitor for unintended consequences
  - *Would like opportunity to provide a rural perspective on other topics going forward*

Post-Report Activities and Next Steps

Subsequent Activities by NQF Related to Rural Health

- Organized a Capitol Hill Briefing on the report and recommendations (September 2018)
- NQF's "splash screen" focused on the work
- Positive media coverage (at least 6 publications including Modern Healthcare)
- Health Affairs blog article

Next Steps for the MAP Rural Health Workgroup

- NQF has received continued funding to convene the workgroup; key tasks include:
  - *Sharing recommendations with the Clinician, Hospital, and PAC/LTC Workgroups*
  - *Gather feedback from the Workgroup on clinician-specific measures included on the 2018 Measures Under Consideration (MUC) list*
  - *Convene a 5-person Technical Expert Panel (TEP) to develop recommendations on how to calculate healthcare measures when case-volume is low*
    - » First call with the TEP is scheduled for October 31, 2018 from noon-3pm ET

Discussion

Discussion

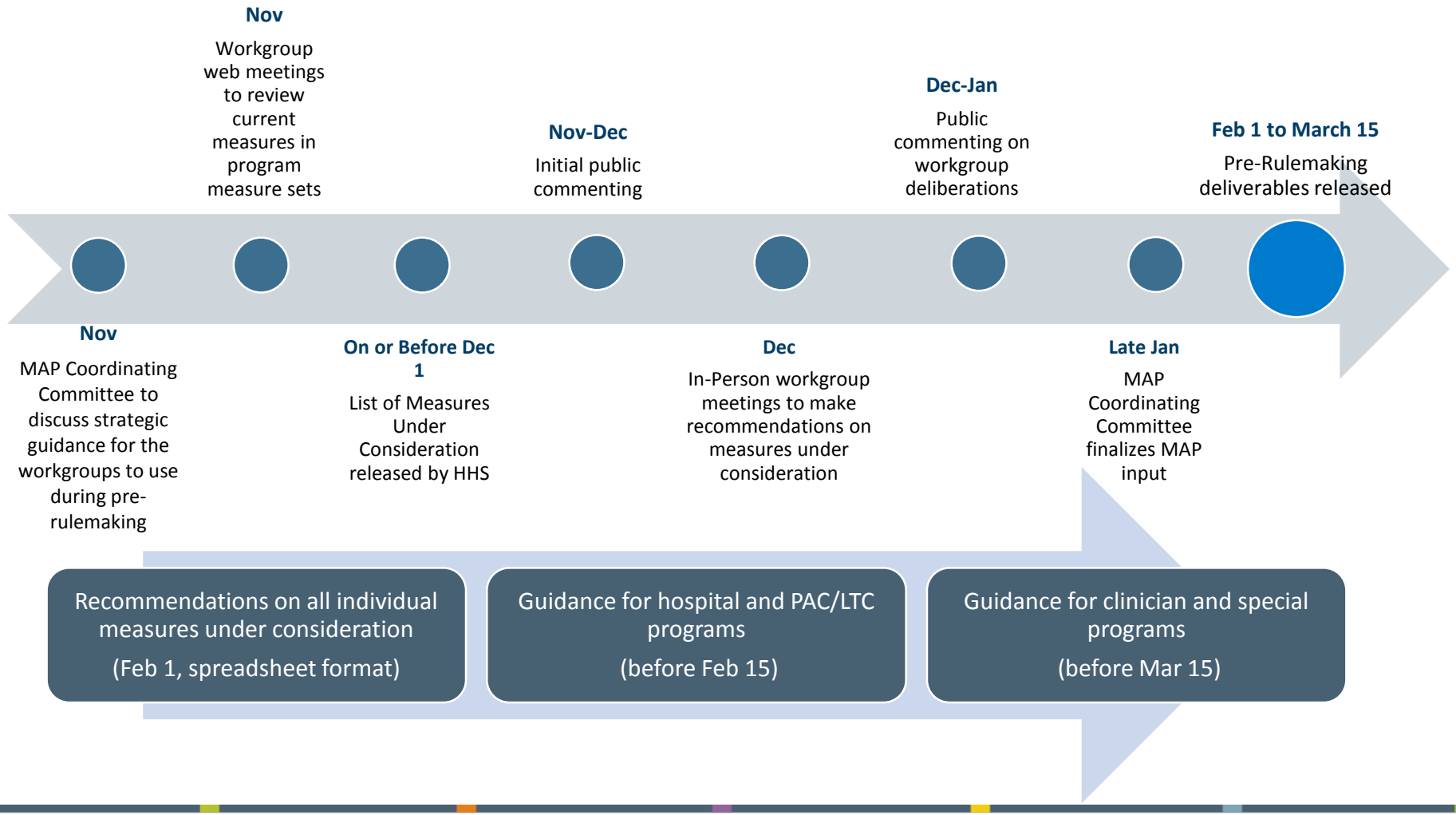
- Core set
  - *Do you agree with the overall topic areas that were covered?*
    - » Is anything missing?
  - *Do you have any particular concerns or questions about particular measures?*
- Gaps
  - *What are your initial thoughts on the identified gaps?*
- Access to care
  - *What did you think of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

Opportunity for NQF Member and Public Comment

Next Steps

MAP Pre-Rulemaking Approach

A look at what to expect



Next Steps: Upcoming Activities

- Release of the MUC List – by December 1
- Public Comment Period #1 – Timing based on MUC list release
- In-Person Workgroup Meeting – December 12
- Public Comment Period #2 – Following Workgroup In-Person Meetings
- Coordinating Committee – January 22-23

Resources

- CMS' Measurement Needs and Priorities Document: Final_5_29_2018_MUC_Program_Priorities_Needs
- Pre-RulemakingURL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html
- MAP Member Guidebook: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=80515

Questions?

Contact Information

- Project page
  - *http://www.qualityforum.org/Project_Pages/MAP_Clinician_Workgroup.aspx*
- Workgroup SharePoint site
  - *http://share.qualityforum.org/Projects/MAP%20Clinician%20Workgroup/SitePages/Home.aspx*
- Email: MAP Clinician
  - *MAPClinician@qualityforum.org*

NATIONAL QUALITY FORUM

Moderator: MAP Clinician Workgroup
November 13, 2018
2:00 p.m. ET

OPERATOR: This is Conference #: 1549923.

Erin O'Rourke: Good afternoon, everyone. This is Erin O'Rourke. I'm one of the senior directors here at NQF. I want to send regards on behalf of John Bernot who's unable to join us today due to a conflict with the NQF Board of Directors meeting. So I'll be pinch-hitting for him.

With that, I would like to turn it over and introduce our clinician workgroup co-chairs, Bruce Bagley and Amy Moyer to say a few words of welcome.

Bruce Bagley: Well, hello, everyone. This is Bruce Bagley. And Amy and I will be your co-chairs for not only this meeting but the meeting in December. I don't have a lot to say. I've been the co-chair for the last couple of the years and worked with the MAP and with NQF for many years. Very much looking forward to getting together with everyone in person in December.

Amy, do you have a few words of welcome?

Amy Moyer: Certainly. Hi, everyone. This is Amy Moyer. I'm the other co-chair of this group. And I'm really looking forward to working with everyone and going through our meeting in December. I think we accomplish a lot of terrific things last year and looking forward to building on that this year.

Bruce Bagley: Great.

Erin O'Rourke: OK. Thank you both. And thank you both for being willing to …

Bruce Bagley: Yes. This is Bruce. And in lieu of going around the table so to speak on the phone, I think what we'll do is have a roll call and we'll use slides four and five, if you will, to show the people on the committee when you're ready.

Erin O'Rourke: Perfect. Thank you. So I did just want to – before we dive in to the roll call, cover our agenda for today. We want to use this as a time to reorient the workgroup to both the approach we'll be using for pre-rulemaking as well as an overview of the two programs where the clinician workgroup may have measures under consideration, specifically the Merit-based Incentive Payment System and the Medicare Shared Savings Program.

We'd also like to share – refresh everyone on some of the overarching themes from your prior work to (ground) this year's recommendations. We'll also have an update from our CMS colleagues on some of the prior measures under consideration and how MAP's input has informed the development of those measures.

We will also share an introduction to NQF's rural health work from Ira Moscovice and Suzanne Theberge. This is an emerging issue and one that we've heard from MAP members is very important. So we wanted to make sure everyone was aware of that work and considering the potential implications for our pre-rulemaking work as we get started for this year.

Finally, we'll have an opportunity for member and public comments and share with you some of the next steps and what you can expect in the coming weeks and months as we embark on our pre-rulemaking work together.

So we can move on to the next slide. I did want to introduce everyone too this staff team here at NQF that will be supporting the workgroup this year. John Bernot will be leading the workgroup and he'll be joined by Miranda Kuwahara, a new project manager here at NQF as well as a new staff member who just joined our team and apologies for leaving (inaudible) off the slide.

And then I think with that, I can turn it over to Miranda to call the roll.

Miranda Kuwahara: Thank you, Erin. So before we get started, I just wanted to send a special welcome to two new appointees, the National Association of ACOs and the American Occupational Therapy Association. So, welcome.

We know that we have Bruce and Amy on the line. Thank you both for joining. Do we have Terry Adirim from the American Academy of Pediatrics?

All right. How about Diane Padden with the American Association of Nurse Practitioners?

Diane Padden: Yes, I'm here.

Miranda Kuwahara: Great. Thank you. Chad Teeters with the American College of Cardiology? How about David Seidenwurm with the American College of Radiology. Trudy Mallinson with the American Occupational Therapy Association? Amy Nguyen with America's Physician Groups?

Amy Nguyen: I'm here. Good afternoon.

Miranda Kuwahara: Good afternoon. Thank you for joining. How about Kevin Bowman wit Anthem? Scott Furney with Atrium Health?

Scott Furney: Yes, I'm here. Good afternoon.

Miranda Kuwahara: Excellent. Robert Krughoff with Consumers' CHECKBOOK?

Robert Krughoff: I'm here.

Miranda Kuwahara: Helen Burstin with the Council for Medical Specialty Societies?

Helen Burstin: I'm here. Hi everybody.

Miranda Kuwahara: Hi. Dae Choi with Genentech? Susan Knudson with Health Partners, Inc.? Robert Fields with the National Association of Accountable Care Organizations?

Robert Fields: Present.

Miranda Kuwahara: Thank you. Stephanie Glier with the Pacific Business Group on Health? Ann Greiner with the Patient-Centered Primary Care Collaborative? Patti Wahl with St. Louis Area Business Health Coalition?

Patti Wahl: I'm here. Good afternoon.

Miranda Kuwahara: Good afternoon.

J. Chad Teeters: And hi. This is Chad Teeters. I'm on as well. Sorry, I wasn't in – logged in to the conference yet. I could see you but I couldn't hear you but you can hear me.

Susan Knudson: And this is Susan Knudson. I think I was on mute.

Miranda Kuwahara: Oh perfect. Thank you, Sue. And we have a note from Dae Choi indicating he is also on with us. Excellent.

How about Dale Shaller?

Dale Shaller: I'm here.

Miranda Kuwahara: Excellent. Michael Hasset? Eric Whitacre?

Eric Whitacre: I'm here. Hi, everybody.

Miranda Kuwahara: Hi there. And Leslie Zun? All right. And how about Peter Briss from the CDC? Reena Duseja with CMS?

Reena Duseja: I'm here.

Miranda Kuwahara: Great. And finally, Girma Alemu with HRSA?

Girma Alemu: I'm here.

Miranda Kuwahara: Wonderful. All right. So I will turn it over to Amy to review our meeting objectives.

Amy Moyer: OK. And just for the meeting objectives, I also got a note from David Seidenwurm saying that he is on the line but unable to – we can't hear him.

So the meeting objectives are to give an orientation to the 2018 and 2019 MAP pre-rulemaking approach. As Erin mentioned, we'll talk about the programs under considerations for this committee. We'll receive an update on the prior measures under consideration and then as well an overview of the rural health work.

With that, I will turn it back to Erin who will take off the MAP pre-rulemaking approach.

Erin O'Rourke: Great. Thank you so much, Amy. And just a quick – a few quick housekeeping items. Amy mentioned as David is also having some trouble with the phone. If you're having any issues, please feel free to e-mail us and we can try to work with our telecom partners to resolve your issues.

I did also want to remind everyone to please if you wish to speak either as a workgroup member or a member of the public to be dialed in to the phone number, our web platform does not have the ability to speak through the computer, so please use the phone number provided.

And with that, I can jump in to our MAP pre-rulemaking approach if we can move on to the next slide.

So the few key steps we'd like to point out to everyone, the Coordinating Committee met last week to provide some guidance on the process that the workgroups will be using to make fair recommendations on the measures under consideration.

As Amy was saying, our goal today is to familiarize everyone with the programs that you may have measures under consideration for as well as the measures that are currently in those programs.

December 1st is the MAP list must be released by. We'll have a public comment period that begins immediately after that. And we'll bring you all together in-person in December where you'll make your initial recommendations on the measures under consideration. After that, we'll have a second public commenting period. And then finally, in January, we'll bring

the Coordinating Committee together to review the workgroup recommendations consider the public comments and make MAP's final recommendations to CMS.

We move on to the next slide.

I just want to – I won't belabor this in the interest of time, but we did want to show you graphically the exchange between the public commenting, the workgroup meetings and the Coordinating Committee and then the series of reports that we'll be issuing based on your feedback. We'll have the spreadsheet of recommendations by February 1st. More specific guidance for the hospital and post-acute care and long-term care programs February 15th. And then guidance for the clinician programs on March 15th.

If we can move to the next slide.

There are two programs where we may ask this workgroup to review measures under consideration specifically the Merit-based Incentive Payment System or MIPS and the Medicare Shared Savings Program.

Next slide.

So as Amy was saying, our goals for today's meeting are to review the goals and structure of each program. You may see measures. Review the critical objectives for each program. Consider any measurement gap areas and domains where the workgroup would like to see measures in the future. As well as review the MAP Rural Health Workgroup and provide some input to that group.

Next slide.

So with that, I'd like to turn it over to Susan Arday from CMS to provide an overview of the Merit-based Incentive Payment System.

Susan Arday: Hi, good afternoon. Thank you for the opportunity to speak with you today regarding the Quality Payment Program. My name is Susan Arday. I'm an epidemiologist and I work at CMS in the Quality Measurement Value-Based

Incentives Group headed by Dr. Michelle Schreiber. And I'm in the Division of Electronic and Clinician Quality. It's a pleasure to be here with you today.

I'm trying to see if I can coordinate this with the slides. Next slide please.

What I'm going to talk about today is the Quality Payment Program 2019 overview. And this is our standard disclaimer just so folks know. I think the takeaway from this is quite simply that Medicare policy changes frequently, though the information provided during this presentation is intended to be a general (subject). It does not take the place of written law or regulations. And CMS encourage you to review the specific statutes, regulations and other interpretative material.

Next slide, please.

OK. Sorry. I'm trying to coordinate. The resource library, this is a pretty brief slide. This provides a wealth information for the Quality Payment Program and it can be found as well on this slide which for those of you that might not be able to see it, just go to qpp.cms.gov/about/resource-library.

Next slide, please.

The Medicare Access and CHIP Reauthorization Act of 2015, what we call MACRA, requires CMS to implement an incentive program, referred to as the Quality Payment Program, QPP, that provides two basic tracks. Those two tracks include the Merit-based Incentive Payment System, MIPS. And if you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

The other track is the Advanced Alternative Payment Models, also refer to as Advanced APMs. And if you decide to take part in an Advanced APM, you may earn a Medicare Incentive Payment for sufficiently participating in an innovative payment model.

Next slide, please.

So on this slide, what I'd like to emphasize to you is that under the Quality Payment Program, there's key considerations or goals. And just to go over what's on the slide here, there are to improve beneficiary outcomes, to reduce burden on clinicians, to increase adoption of Advanced APMs, to maximize participation, to improve data and information sharing, to ensure operational excellence in program implementation, and to deliver IT systems capabilities that meet the needs of users.

For more information on all of this, as I mentioned previously on this Quality Payment Program, please visit qpp.com.gov at the link provided.

Next slide, please.

As a remind, MIPS stands for the Merit-based Incentive Payment System. And as shown here on this slide, MIPS combined three legacy programs into a single, improved program. Those programs include the Physician Quality Reporting System or what we called PQRS, the Value-Based Payment Modifier or VM Program, and the Medicare EHR Incentive Program or EHR Program for Eligible Professionals.

We are currently in year two of MIPS under the Quality Payment Program. So 2019 would – will be what was referred to as year three of the MIPS.

Next slide, please.

We'll get to more details around year three of MIPS for 2019 in the following slides, but as a reminder, MIPS is made up of four performance categories which include quality, cost, improvement activities, and promoting interoperability as displayed on the slide.

Eligible clinicians have the opportunity or the 100 possible points across all of these categories. In calendar 2019, Physician Fee Schedule Final Rule, we finalized that the weight of the quality performance category will be reduced from 50 to 45 points. And the weight of the cost performance category is increasing from 10 to 15 points. While the points awarded to the other two categories are same thing, 15 points for improvement activities and 25 points for promoting interoperability.

All the performance categories are calculated for MIPS Final Score. And the points from each performance category are added together to give you a MIPS Final Score.

Next slide, please.

Eligible clinicians for MIPS include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Additionally, for year three of MIPS starting in 2019, the following clinicians have been added to that list, physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, registered dieticians, nutritional professions – professionals. CMS is very excited to include more specialists as we work to make reporting for MIPS more comprehensive and inclusive.

Next slide, please.

Yes. There was a change in the low-volume threshold for 2019 as you can see on the slide. The threshold now only includes MIPS eligible clinicians billing more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule and furnishing covered professional services to more than 200 Medicare beneficiaries a year and providing more than 200 covered professional services under the Physician Fee Schedule.

The purpose of this threshold is to reduce the burden on smaller practices and on clinicians who do not have a large Medicare patient population.

Next slide, please.

This slide highlights those who are exempt from MIPS in 2019, including those who are newly-enrolled Medicare, including those who enrolled in Medicare for the first time during the performance period. They will be exempt until the following performance year.

The other exemption is those who fall below low-volume threshold as described on the previous slide. And those who are significantly participating in Advanced APMs which would mean they receive 25 percent of their Medicare payments via Advanced APMs.

Now, there's also or here. Or for these physicians, they see 20 percent of their Medicare patients through an Advanced APM. So you can either be 25 percent of your Medicare payments via an Advanced APM or 20 percent of your Medicare patients through an Advanced APM.

Next slide, please.

The opt-in policy for MIPS allows clinicians who are excluded from MIPS based on the low-volume threshold determination to not be excluded. This option is available for MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria.

And the slide illustrates possible opt-in scenarios to give you a feel for what we're talking about here. So line one is an example of a clinician who meets all three low-volume threshold criteria and therefore would not be eligible to opt-in.

Line two on the slide of this (prescriptive) chart shows clinicians who meet the first two low-volume threshold criteria, but not the third criterion which represents clinicians who have more than 200 covered professional services. These clinicians could opt-in.

Line three of the chart shows clinicians who meet the last two low-volume threshold criteria but not the first criterion. Representing clinicians who have more than $90,000 in Medicare Part B allow charges for professional services in a year. These clinicians could opt-in as well.

Line four represents eligible clinicians who meet the first criterion but not the last two low-volume threshold criterion, which represents clinicians who provided covered professional services to more than 200 Medicare Part B patients during the year. These clinicians could also choose to opt-in.

And finally, line five represents eligible clinicians who do not meet any of the low-volume threshold criteria and therefore would not be eligible to opt-in or out as they would be required to participate in MIPS.

Next slide, please.

So for the MIPS 2019 Performance Period, also referred to us year three, we at CMS finalized the following minimum performance periods for each of the performance categories. For the quality and cost categories, the full 12 months is required. However, for the improvement activities and promoting interoperability performance categories, 90 days is the minimum performance period.

Next slide, please.

In year three of MIPS, a virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually", no matter what specialty or location, so that they can participate in MIPS for a performance period of a year.

So the eligible to join or form a virtual group, you would need to be a solo practitioner who exceeds the low-volume threshold individually, and are, you're not a newly Medicare-enrolled eligible clinician or Qualifying APM Participant, which we call a QP or a Partial QP choosing not to participate in MIPS. Or to be eligible to join or form a virtual group, a group that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

Nest slide, please.

And what this slide highlights is the quality performance category starting with the basics which includes the change in the percent of the final score which is affected by the – I got some feedback there. Again, the weighting of the quality performance category has been lowered in year three from 50 percent of the final score in 2018 to 45 percent of the final score in 2019.

Additionally, a clinician under this would have to select six individual measures with one being an outcome measure or a high-priority measure. And if less than six measures apply to that particular clinician situation, then the report on each applicable measure and CMS will evaluate their Medicare Part B covered services to determine measure applicability validation. The clinician may also select a specialty-specific set of measures to report.

In addition to the weight given to the final score, it's important to mention that the data completeness requirements for the quality performance category in year three of MIPS. And these requirements are the same as year two which required 60 percent of data for all submission mechanisms exempt for We Interface and CAHPS.

And as a reminder, the measures that do not meet the data completeness criteria earn one point. And small practices that do not meet the data completeness criteria will receive three points.

Next slide, please.

This slide highlights the changes from year two to year three of MIPS from a scoring perspective for quality – the quality category. In year three, the scoring requirements are the same exempted. CMS is adding a small practice bonus of three points for MIPS eligible clinicians and small practices who submit data on at least one quality measure.

The scoring criteria from year two will be congruent including giving a three-point floor for measures scored against the benchmark. Giving three points for measures that do not have a benchmark or do not meet case minimum as well as giving two bonus points for outcome or patient experience measures, and one bonus point for other high-priority measures, and for each measure submitted using electronic end-to-end reporting.

CMS still plans to cap bonus points at 10 percent of the categories denominator for the 2019 performance period.

Next slide, please.

Additionally, I'd like to cover the policy of CMS with the topped out measures, which is addressed in the 2019 Physician Fee Schedule Final Rule, sometimes we also called the QPP Final Rule.

CMS finalized a four-year life cycle to identify and remove topped out measures. A scoring cap of seven points applies for topped out measures. Topped out policies do not apply to CMS Web Interface measures, but this is going to be monitored by CMS for differences with other submission options.

The topped out policy does not apply the CAHPS for MIPS Summary Survey Measures or SSMs. And once a measure has reached extremely topped out status, which is indicated by having an average mean performance in the 98th to 100th percentile total range, CMS may propose the measure for removal in the next rulemaking cycle.

Additionally, the Qualified Clinical Data Registry Measures, QCDRs, will not qualify for the topped out measures cycle and special scoring.

Now for more information on CMS's topped out policies for MIPS quality measures for MIPS program year three, please refer to the 2019 Physician Fee Schedule Final Rule or what we also called, like I said before, the QPP Final Rule.

Next slide, please.

Now, let's discuss the cost performance category. Unless Joel Andress, are you on? Dr. Andress?

OK. I can cover this. It's not a problem. The cost performance category is now worth 15 percent of the total weighted score for MIPS. It's important to note that the Medicare Spending for Beneficiary and Total per Capita Cost measures are included in the calculating cost performance category score for the 2019 MIPS performance period. So these measures were used in the Value Modifier, in the MIPS transition year, and in MIPS year two which was this current calendar year 2018.

There are new episode-based measures that were developed with significant clinician and stakeholder input including eight episode-based measures which will be added for the 2019 MIPS performance period. And CMS plans to propose new cost measures in the future rulemaking and we will provide feedback on episode-based measures prior to potential inclusion in MIPS to increase your clinician familiarity with them. So for more information regarding MIPS or the cost performance category of MIPS in particular, please refer again to the 2019 Physician Fee Schedule Final Rule.

Next slide, please.

So MIPS Scoring Improvements for Quality, they include the following. You've got eligible clinicians who must fully participate, in other words what is that mean, submit all required measures and have met data completeness criteria for the performance period. And if the eligible clinician has a previous year quality performance category score less than or equal to 30 percent, CMS would compare their 2019 performance to an assumed 2018 quality performance category score of 30 percent.

For cost, there will be no cost improvement scoring for MIPS in year three. The cost performance category percent score will not take into account improvement until the 2024 MIPS payment year.

Next slide, please.

I mentioned this previously, that 15 percent of the final MIPS score will be earned from improvement activities in the 2019 program year. And what you see on this slide, it gives you basic information regarding improvement activities for year three of MIPS as well as the number of activities available and information regarding nominating activities.

So to participate in improvement activities what you do is you select improvement activities and attest yes to completing the activity. The activity weights remain the same from year two, medium equals 10 points, high equals 20 points.

Small practices, non-patient facing clinicians, and/or clinicians located in rural or HPSAs continue to receive double-weight and report on no more than two activities to receive the highest score. For the 2019 program year, CMS is adding six new improvement activities. We've also modified give existing improvement activities and we've removed one existing improvement activity.

Additionally – excuse me, CMS is adding one new criterion and removing one existing criterion from the criteria for nominating new improvement activities and it's finalized by CMS. Improvement activity nominations received in year three will be reviewed and considered for possible implementation in year five of the program.

So as reminder, the submission timeframe or what we also called the due dates for nominations is February 1st through June 30th, which provides approximately four additional months to submit nominations. For more information on this, again please go and look at the 2019 Physician Fee Schedule Final Rule.

Next slide, please.

Now this slide provides details surrounding the promoting interoperability performance category, what we used to call HCI. And basic information requiring the promoting interoperability category for year three of MIPS is shown on the left of the screen in the slide. As shown, 25 percent of the final MIPS score will be earn from the promoting interoperability objectives and measures in 2019. Eligible clinicians must use the 2015 Edition of Certified EHR Technology to receive credit toward this performance category.

The promoting interoperability or PI transition measure set is no longer available. There is a new performance-based scoring methodology for this category, with the potential to earn 100 total points. For scoring, CMS finalized eliminating the base, performance and bonus scores. CMS proposed a new performance-based scoring methodology at the individual measure level.

Each measure with the exception of those associated with the Public Health and Clinical Data Exchange objective will be scored based on performance.

The Public Health and Clinical Data Exchange objective measures require a yes or no attestation. Scores for each of the individual measures will be added together to calculate the promoting interoperability performance category score of up to 100 possible points.

So I hope you found the summary of the 2019 changes performance category helpful. Please feel free to review the 2019 Physician Fee Schedule Final Rule for more details or you can contact the QPP service center at 1866-288-8292 Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Time or anytime you can contact them by e-mail at qpp@cms.hhs.gov for more information.

Next slide, please.

Now, I'd like to briefly mention some changes to the MIPS performance threshold and payment adjustments mentioned in the 2019 QPP Final Rule. Here's your major changes and they are as follows. The performance threshold is going from 15 points in year two to 30 points in year three starting in 2019, January 1st of 2019.

Also the exceptional performance bonus will set at 70 points but has been increased to 80 points for year three. And finally, the payment adjustment has been increased to plus/minus 7 percent for 2019. The payment adjustment and the exceptional performance bonus are based on comparing the 32:48 final score to the performance threshold and the additional performance threshold for exceptional performance.

Next slide, please.

Finally, I'd like to cover the extreme and uncontrollable circumstances policy for MIPS. Under this policy, CMS recognizes that areas have been effected by hurricanes and the wildfires, those areas that experienced devastating disruptions in infrastructure, possibly causing clinicians to face challenges in submitting data under the Quality Payment Program.

So starting with the 2018 MIPS performance period, if a MIPS eligible clinician is affected by extreme and uncontrollable circumstances, for example, hurricane, a natural disaster, or a public health emergency, the MIPS

eligible clinician, group or virtual group may qualify for reweighing of any, or all, of the four performance categories, which, as reminder, include quality, cost, promoting interoperability, and improvement activities.

This policy also hold true for MIPS year three in 2019, which I'd like to continue to discuss on the next slide.

Next slide, please.

So CMS has issued a policy for the calendar year of 2019 Physician Fee Schedule Final Rule for extreme and uncontrollable circumstances where clinicians are exempt from the quality, improvement activities and PI or what we also called advancing care information performance categories by submitting a hardship exemption – exception application.

OK. So what is that mean for year three 2019? It means that CMS will reweight the quality, cost, and improvement activities performance categories based on a request submitted by a MIPS eligible clinician, group, or virtual group that was subjected to extreme and uncontrollable circumstances.

And if a MIPS eligible clinician submits an application for reweighing based on extreme and uncontrollable circumstances, but also submits data on the measures or activities specified for the quality or improvement activities performance categories, he or she will be scored on the submitted data like all other MIPS eligible clinicians, and the categories will not be reweighted.

For groups, CMS will evaluate whether sufficient measures and activities are applicable and available to MIPS eligible clinicians in the group on a case-by-case basis and CMS will determine whether to reweigh a performance category based on the information provided. So this policy, I'd like to let you know, does not apply to APMs. So that's an important note.

For more information on the extreme and uncontrollable circumstances, the best place to go for that is the resource slide on the CMS website or, as I mentioned earlier, contact the QPP service center at the 1866-288-8292 phone number or the – e-mail Quality Payment Program service center at qpp@cms.hhs.gov.

Next slide, please.

All right. Next, we'll discuss the MAPS or the Measure Applications Partnership role for the Merit-based Incentive Payment System.

Next slide please.

As many of you already know, the MAP provides input on measures that HHS has placed under consideration for MIPS, following the annual call for quality measures. The input provided by the MAP is considered by CMS and other stakeholders in December prior to rulemaking for the following year.

So for more information regarding the MAP, please visit the NQF's website at www.qualityforum.org/map, M-A-P.

I would like to emphasize that the MAP is a multi-stakeholder partnership that guides the Department of Health and Human Services on the selection of performance measures for federal health programs. And Congress recognized in 2010 the benefit of an approach that encourages consensus building among diverse private and public sector stakeholders. And very importantly, it provides a coordinated look across federal programs at performance measures being considered.

Next slide, please.

Separately from the MAP, CMS reviews its needs and priorities prior to the annual call for measures. For the past couple of years, the items listed on this slide have been CMS's priorities including outcomes measures, measures relevant for specialty providers, and high-priority domains such as person and caregiver-centered experience and outcomes, communication and care coordination, efficiency and cost reduction, patient safety, appropriate use and opioid related measures.

For more information regarding CMS's needs and priorities, you can go look, it's posted on the CMS pre-rulemaking website which is quite like URL, the thing I would suggest to do is go to cms.gov look under Medicare then look

under quality initiative patient assessment instruments then look under quality measures. And under quality measures, you'll see a title, pre-rulemaking, and that's where you can find this information.

Additionally, MACRA requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals – bless you, prior to implementing in MIPS.

Next slide, please.

Additionally, measures implementing MIPS may be available for public reporting on physician compare. Measures must be fully developed and completed testing results at the clinician level and ready for implementation at the time of submission. This is how CMS internally evaluates measures. The measure should not duplicate other measures currently in the MIPS program.

Duplicative measures are assessed by CMS to see which would be the better measure for the MIPS measure set. And measure performance and evidence is – needs to identify opportunities for improvement. So CMS does not intend to implement measures in which evidence identified high levels of performance when little variation or opportunity for improvement, in other words, measures that we call topped out.

Next slide, please.

So as far as the current measures, there is 275 MIPS measures available for 2018. A hundred and thirty of those measures fall into the effective clinical care domain. Forty six are patient safety, 43 fall in the communication and care coordination category, 16 measures fit into the community and population health domain, 20 are efficiency and cost reduction related, and 10 fall into the person and caregiver-centered experience and outcomes domain. And there's one measure, not remember exactly which one it is but it's represented actually in two domains.

So for more information regarding our measures, please refer to the 2018 measures list posted in the (technical difficulty).

Next slide, please.

Additionally, CMS definitely prefers NQF endorsement for our measures but it is not required for inclusion in MIPS. Currently, approximately half of the measures in MIPS are NQF endorsed as this represented on the pie chart here on your screen.

Next slide, please.

So if CMS is intend to move toward having more outcome-based measures and it's depicted here on this particular pie chart. The majority of MIPS measures for 2018 are process-based measures with 23 percent representing outcome-based measures and an additional 3 percent is intermediate outcome. The remaining types of measure include efficiency, patient engagement and experience and structural measures which make up a minority of the overall universe of MIPS measures.

Next slide, please.

A little more complicated slide but not too much. Another breakdown of the 2019 MIPS quality measures is shown here on this particular slide. And what this slide shows is measures by specialty set. So I'd like you to note that measures can be part of more than one specialty set and would be represented in more than one column of this chart if they applied the more than one area.

The most represented areas include general practice and family medicine, internal medicine and then followed by orthopedic surgery, otolaryngology, infectious disease, cardiology and obstetrics/gynecology. Some of the specialty areas with under 10 measures include, electrophysiology/cardiac specialist, dentistry, radiation oncology, hospitalists, podiatry, pathology, plastic surgery and interventional radiology.

Next slide, please.

Now, we'd like to ask you – CMS would like ask you a question. Does the workgroup have suggestions for refinements to future measurement in the high priority domains? And what I'd ask is could you – you know, feel free to

provide your suggestions over the phone or I supposed we also have the option like we typically do of adding a comment on the WebEx.

I just would like to open the floor to that if anyone would like to have suggestions for refinements to future measurement in the high priority domains?

Bruce Bagley: Susan, this is Bruce. Not really a question but what is your strategy to move away from process and towards outcome?

Susan Arday: What is CMS' strategy from moving away from process toward outcome?

Bruce Bagley: Yes.

Susan Arday: Well, one of the ways we do that is through the measures under development and the measure development plan that we release every year. We signal pretty strongly in there where we would like folks to head. Most of MIPS measures are – the quality measures in particular, are not CMS stewarded. They are stewarded by other organizations and entities.

And so when entities submit under the measures under consideration list for measures that they would like to have adopted into the MIPS program, that would be the ideal time under the juries submission method that we have for them to indicate in there that these are outcome measures. We know that these are high, you know, very high priority for CMS and here's why this is an outcome measure.

So it takes a while. Like I'd like to say about things, it's kind of like turning the Titanic. If you can see that slight distance for quite a while, you could turn, you know, but you can't turn on a dime, so.

Amy Nguyen: Susan, this is Amy Nguyen from America's Physician Groups. Thank you for the presentation.

Susan Arday: Hi.

Amy Nguyen: Hi. So a potential suggestion or comment would, we would like to see that CMS embrace, and I think you've already started to do this, for the high

priority measures to have more crosscutting measures in the different categories for MIPS, SSP, ACO and then of course if it can lead to the stars to Medicare advantage as well.

As you look at having folks embrace more of the Advanced Alternative Payment Models, I think that would be helpful to reduce physician burden, administrative burden and reporting and collection.

Susan Arday: Well taken, thank you. Anybody else have any suggestions for refinement to future measurement and high priority domains?

Amy Moyer: This is Amy. If you have any questions about material presented, feel free to ask those. Now is a good time and opportunity to do that.

Susan Arday: We're always here. I know it's a lot to take in. So don't think this is your only chance.

In the interest of time, I think I should probably move forward because we'd like to review one of last years' MUC list measures as was done in previous years to see if there are any updates to share with those of you who reviewed those measures last year.

And the measure we'd like to bring up today, this would be the – probably last of my slides, number 36. It's the continuity of pharmacotherapy for opioid use disorder. It was MUC 2017-139 which was submitted by the RAND Corporation during the 2017 call for measure – quality measures, I'm sorry, and as since taken on new stewardship by the University of Southern California.

This measure followed Dr. Soeren Mattke to his new position at USC. And during last year's MAP clinician review meeting, it was decided that this measure should be refined and resubmitted prior to rulemaking.

The MAP acknowledged the public health importance of measures that address opioid use disorder and they noted the gap of measures in this area. The MAP encourages the relevant standing committee in the NQF

endorsement process to specifically examine the attribution method reliability and validity of this measure at the individual clinician and group level.

And I do believe, we have Dr. Soeren Mattke on the phone with us today to provide an update. So if Dr. Mattke is on, I would like to turn over to you for that update. Thank you all very much.

Erin O'Rourke: Operator, could you see if Soeren Mattke is on and if his line is open?

Operator?

Operator: Yes, I'm showing the lines are open.

Erin O'Rourke: OK. Do we have a Soeren Mattke on the line?

It seems, Susan, we may not have Dr. Mattke on the line.

Susan Arday: OK.

Erin O'Rourke: Should we move on to the Shared Savings Program or see if anyone has any additional questions?

Susan Arday: OK. I don't but more than happy to entertain anybody else.

Amy Moyer: All right. We will – one more brief thoughts or any questions or input from the workgroup? Not hearing any. We will move on to, I believe, it's Fiona Larbi who will be talking about the Medicare Shared Savings Program.

Fiona Larbi: Thank you. My name is Fiona Larbi and I work at CMS in the Division of Program Alignment and Communication as a Shared Savings Program quality lead.

Today, I'm going to give a high level overview of the Medicare Shared Savings Program. The 2017 quality result, our quality measures approach and how we assess quality performance. And then finally, I will review all considerations for future quality measurements.

The Medicare Shared Savings Program is mandated by Affordable Care Act Section 3022. The Accountable Care Organizations, ACOs, create incentive to healthcare providers to work together voluntarily to coordinate care and improve quality for their patient population.

As of January 1, 2018, 561 ACOs across the nation were participating in the Shared Savings Program and serving approximately 10.5 million Medicare fee-for-service beneficiaries.

We at CMS assess ACO performance annually based on quality and financial performance to determine shared savings or losses. In order for ACOs to be eligible to share and savings, if earned, they must meet our programs quality performance standard. The approved quality scores is then integrated into the shared savings and losses financial calculation.

Next slide please.

This slide highlights some of the 2017 performance quality result. We had 472 ACOs participating in the Shared Savings Program in 2017. And 98 percent of ACOs completed quality reporting and met the quality performance standard to be eligible to share and savings if earned.

ACOs participated in the Shared Savings Program and reported quality measures in both 2016 and 2017 improved on 93 percent of the quality measures they were reported – were reported in both years.

Ninety three percent of ACOs received bonus points for improving quality performance in one of the four quality measure domains. Under our approach, we calculate quality improvement reward points when there are two consecutive years of reported data for a given measure.

So in 2017, more than 90 percent of ACOs who were in their second or third performance year of their first agreement or second agreement period increase their overall quality performance score through Quality Improvement Reward points in at last one of the four quality measure domains.

Next slide, please.

Focusing on our quality measurement approach, this is intended to improve individual health in the health of populations. Address quality aims such as prevention, care of chronic illness and high prevalence conditions, patient safety, patient and caregiver engagement and care coordination.

We also align with other quality reporting and incentive program, including the Quality Payment Program. This slide actually reflects our 2019 Physician Fee Schedule proposal, however, the PFS has now been finalized. So for performance year 2019, we finalized the Shared Savings Program quality measure set with 23 measures which reduced the measure set by a total of eight measures.

Next slide, please.

In performance year 2017 and 2018, there are total of 31 quality measures separated into the following four key domains, patient and caregiver experience, care coordination and patient safety, preventive health and at-risk population.

Quality data for the 31 measures are included through our – collected through four mechanisms which include patient survey, we use the CAHPS for ACO survey, claims data, advancing care information data and CMS Web Interface data that is reported by ACO.

Next slide, please.

OK. So the slides are out of sync. I actually have the – sorry. No, I'm out of sync, not you. Sorry. The quality performance standard for ACO is very based on the ACO performance year. I showed in the table on this slide for ACOs in the first year of the first agreement period, all measures are pay-for-reporting, which means that ACOs must completely and accurately report all quality measures to meet the quality performance standard and be eligible to share and saving.

For ACOs in the second and third performance year and subsequent agreement measures phase into pay-for-performance unless they are finalized

as pay-for-reporting all years. And ACOs must completely and accurately report all quality measures and meet minimum attainment on at least one measure in each domain to meet the quality performance standard and share and savings if earned.

Pay-for-performance measures are those in which we compare the ACO performance with the performance benchmark. We establish benchmarks prior to the performance year and set them for two years to support ACO quality improvement efforts.

When we do introduce new measures to the Shared Savings Program quality measure set, we designate them at pay for reporting for two years before phasing them into pay-for-performance.

Additionally, ACOs in the second or third performance year or subsequent agreement can earn up to four bonus points for improving quality performance. Finally, all four quality domains which I will review in the next few slides are equally rated and an overall quality score is determined for each ACO.

Next slide, please.

The first domain which is under our aim of better care individuals is the patient caregiver experience domain. This domain contains eight measures from the CAHPS for ACO survey. The CAHPS for ACO survey is actually based on the clinician group CAHPS survey.

Next slide, please.

The second domain is care coordination and patient safety and contains a total of 10 measures. Most of these measures are actually calculated by CMS using Medicare assigned data. ACO-11, Use of Certified EHR Technology is calculated using MIPS's care information data, now known as promoting interoperability. Data for ACO-12 Medication Reconciliation Post-Discharge and ACO-13 Screening for Future Fall Risk are collected by the ACO and reported through the CMS Web Interface.

Next slide, please.

The third domain which is under our second aim of better health for populations is preventive health and contains eight measures. The data for all of these measures are collected by the ACO and reported through the CMS Web Interface.

Next slide, please.

Finally, our fourth domain is clinical care for the at-risk population and contains five individual measures. The diabetes composite scored as one measure that contains two individual measures. Again, the data for all these measures are collected by the ACO and reported through the CMS Web Interface.

Next slide, please.

This slide shares our considerations when we develop the measure under consideration list. When the MAP reviews the measure list in December, we would appreciate input not only on our MUC list but also on potential future measures for the program. It is important for us to maintain alignment across various quality reporting initiative.

So when considering measures, we do our best to align with other value-based purchasing initiative such MIPS. Currently, though, measures within our measure set align with MIPS, the Million Hearts Initiative and Core Quality Measures Collaborative recommendations. Additionally, we are sensitive to administrative burden for reporting and do our best to leverage existing data collection methods to the measures.

Also, we want to continue to – more outcome focused measure set that includes measures to meet high priority gap areas that can be feasibly implemented by CMS and reported by ACO. We would appreciate input to help address meaningful measure objective.

Thank you. This concludes the Shared Savings Program presentation.

Is there any questions on …

Erin O'Rourke: OK. Thank you.

Fiona Larbi: Sorry. Go ahead.

Erin O'Rourke: Oh no. I just say thank you, Fiona, and I was just going to turn it to Bruce to facilitate any questions for you.

Bruce Bagley: Sure. Do we have any questions? Fiona, thanks for that. That was very helpful.

Fiona Larbi: You're welcome.

Bruce Bagley: OK. If there are no questions lets go on to the MAP clinician overarching teams. Miranda, you're going to update us on that?

Erin O'Rourke: So, Bruce, this is Erin. I have a few slides to share with everyone on the role of MAP for the Shared Savings Program. To build on Fiona's presentation, if we could go to slide 59 similarly to what Susan shared for the MIPS program, CMS has also identified needs priorities for the shared savings program.

Fiona touched on this so I won't belabor, but specifically a desire for outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients. Measures that are targeted to the needs and gaps in care of Medicare fee-for-service patients and their caregivers. Measures that align with other CMS quality reporting initiatives, such as MIPS. Measures that could support improved individual and population health. Measures that align with recommendations from the Core Quality Measures Collaborative.

If we can move on to the next slide.

Here you can see the breakdown of the measures into the four domains specified by the ACA. Again, I won't belabor this. Fiona covered much of this in her presentation. We can move on to the next slide.

Here showing you breakdown of the endorsed and – the NQF endorsed and the not endorsed. There are 23 endorsed measures in the set, eight of the measures are not endorsed. That status as of – is current as of October 2018.

We can move on to the next slide.

And, again, I'll show you the breakdown by measure types. Thirteen of the measures are process, eight are patient reported outcomes, seven are outcome, two are intermediate outcomes, and one is a structural measure.

With that, I'd like to turn it back over to Bruce for discussion on any requirements to the potential needs and considerations for the measures and high priority domains for future measurements in the Shared Savings Program.

Bruce Bagley: OK. Do we have any comments on that? I think you'll see more robust conversation in December after we've kind of worked our way through the measures. But anybody have any comments at this time?

Robert Fields: Hey, this is Robert Fields. Just a general question, I guess not specific to either, you know, one MIPS or MMSP. But to what degree does CMS have influence on the technology vendors and partnership in the reporting of these measures? So, one example might be the use of the CPT II coding for some of the measures in question can sometimes happen automatically depending on the EMR vendor. But that often is, you know, met with resistance depending on the vendor, some do it automatically, some do not.

And as was mentioned earlier that the ability of the federal government to apply some pressure in easing some of those burden by making it more automatic in the technology can really only happen effectively. That sort of pressure can only happen effectively from, in my opinion, from the federal government. Individual providers don't have enough power to leverage the vendors to improve their ability to report. Is there any one comment on the potential influence of CMS in that regard on the vendors?

Kimberly Spalding Bush: Hi. So this is Kimberly Spalding Bush from CMS and I am – it's a very good question. I'm not the expert on the area. I mean I can tell you from

the Shared Savings Program perspective, we do just align in general in the interest of reducing the burden on our participating ACOs and then the (teams) that participate within those ACOs on quality reporting.

So we just – we utilize the data that they're already reporting under the Quality Payment Program, making a little easier for them because they don't have to each report, their ACO can report on their behalf. And we also – they also get some automatic credit for improvement activities by virtue of participating in this organization that has, you know, voluntarily undertaken to coordinate an improved care.

I do know though and perhaps Susan or some of her colleagues could speak more to this that CMS has been exploring new ways to report Web Interface. I don't know particularly CPT II coding. I don't know what's going on in that world but I know that there are some other developments that hopefully and, you know, aimed at improving ease of interacting with our quality reporting programs.

Susan Arday: This is Susan Arday. I don't know if our (Inaudible) or any of my senior leadership is on. We are working …

Kimberly Spalding Bush: Yes, so …

Susan Arday: I'm sorry. Go ahead.

Kimberly Spalding Bush: I'm sorry. Go ahead. No, go ahead, Susan. I was thinking about like the API. I don't know …

Susan Arday: Oh yes, yes.

Kimberly Spalding Bush: … if we're looking to use CPT II codes but I know that you guys have done a ton of work and trying to let people come and test that new.

Susan Arday: Right. Right. Yes. Now, I'm on the same wavelength with where you're at. I'm not terribly familiar with the API, although, I am involved with it. I don't know that we have like Mindy Riley or so many other folks here that work on

that every day. Right now available to answer that question but that's a great question for example to send in at qpp@cms.hhs.gov.

Robert Fields: OK.

Susan Arday: That's also where we track what, you know, people are interested and what they're looking, what their concerns are.

Robert Fields: Sure. OK. Thank you.

Susan Arday: And, you know, some of that – some of what you might want might have to actually come out of the Office for the National Coordinator for Health Information Technology, which is another part of the Department of Health and Human Services but is not part of CMS. Although we do …

Robert Fields: Right.

Susan Arday: … a lot of collaborative work with them.

Robert Fields: Yes, sure. OK, thank you.

Susan Arday: Thank you.

Kimberly Spalding Bush: Yes. And as for the programming interface and CMS has, I think, it – I don't know if it's open right now for testing. I think it is, where developers can go in and work with real data, web interface submissions to try and simplify that process to take out some of the more manual approaches to reporting quality that some groups currently use to report to our web interface.

So in the interest of streamlining that and making it easier for developers to interact with CMS, and they have this API interface that they can register and get a role to go in and task and try to load data the web interface that way. It's not claims-based reporting, but we do think that this is – it's something we've heard people were interested. And, you know, in having the opportunity to utilize and so CMS has implemented that in the interest of reducing burden for quality reporting.

Robert Fields: That makes sense. It's just as we move into more outcomes-based measures, unless there's another methodology, it will be more and more difficult to rely on claims to fulfill that (aim).

And, so, then it almost, by definition, requires either manual reporting of a clinical outcome or attestation, take hypertension or diabetes as examples. There's no way in claims you will, unless someone is very specific and actually (10) coding whether they're controlled or not which is rather generic. But if you have a specific measure for a specific clinical target, unless you do CPT II coding, it becomes really difficult to do it any other way than manual. So, anyway, something to consider.

Susan Arday: Speaking of the API, there actually was today a public 2018 CMS Web Interface Quality Reporting for MIPS groups and ACO Web Interface User Demonstration presentation. So, some of those questions or interest in the API, we certainly could have those slides once they're remediated (inaudible) compliant shared with you folks.

Bruce Bagley: OK. Great. Erin, anything else before we move on?

Erin O'Rourke: No, thank you.

Bruce Bagley: OK. Well, let's move on to the comments by Miranda on the overarching themes.

Miranda Kuwahara: Thank you very much, Bruce. So, in this next section, we'll reflect on last year's themes in order to help inform the 2018-2019 review cycle.

Next slide, please.

So last year, two primary overarching themes emerged. The first was balancing the need to assess costs with measurement accuracy. And the second was implementing composite measures to drive cross-cutting improvement and provide patients with more digestible information.

Next slide.

Last year, the MAP Clinician Workgroup reviewed a total of 25 measures, 22 fell under MIPS and three fell under SSP.

So the next two slides provide additional context to the overarching themes. Last year, workgroup members recognize the importance of including cost measures into value-based purchasing models and trust the importance of appropriate risk adjustments for heterogeneous population.

Additionally, workgroup members suggested ongoing evaluation and testing in the early stages of implementation.

Last year, workgroup members viewed composite measures as having the potential to serve a more comprehensive and holistic view of performance. But members also recognize the technical challenges of composite measure development as well as potential challenges related to provider attribution.

Next slide, please.

So in order to translate last year's recommendations into the evaluation of 2018 MIPS measures, workgroup members should consider prioritizing outcome measures, composite measures while taking into account provider attribution, efficiency and cost reduction measures, and appropriate use measures with consideration of inappropriate use as well.

Similarly for Shared Saving Program measures, workgroup members should consider prioritizing outcome and composite measures. But members should also prioritize alignment with other programs including MIPS.

And I'll pause here before moving on to the next section to see if anyone has any comments they'd like to raise. All right, then we can move on to updates on measures from the last review cycle.

Next slide, please.

So on the next three slides, we've showcased all 2017, 2018 MIPS measures and the workgroup recommendation. The stars on the left hand side denote that the associated measures were finalized for use in the 2019 MIPS

performance period and future years. So we'll slowly scroll through the next couple of slides.

And the next slide, please. And next slide.

This final slide presents the three Shared Savings Program measures reviewed last year. You'll notice that none of these measures were finalized for the 2019 performance year. And again, I will pause for any questions from the workgroup.

Amy Moyer: Hi, so this is Amy. I guess I'm frustrated to see that that set of measures was not adopted here or in MIPS. As I remember, the discussion from last year, there are measures currently in those programs that are very similar, however, do not have NQF endorsement. And so, the feeling of the workgroup, I believe, had been, if we have a preference for endorsed measured and they're inexistence, it would make sense to swap their (vote). So I'm not sure what happened then after the conditional support recommendation, but I'd be curious if someone can answer that.

Fiona Larbi: So this is Fiona from the Shared Savings Program. From our perspective, we actually aligned with MIPS, even though these measures were on the MUC list for the Shared Savings Program, because they would be implemented through the web interface. We have to align with MIPS and they would have to actually add them and finalize them for their web interface so that they could be utilized in the Shared Savings Program.

Bruce Bagley: So this is Bruce. So, that response implies that there was, and I think, fundamentally wrong with the measures, it was really an operational consideration.

Fiona Larbi: Yes, at least one of the measures, which I believe is the last measure, the IBD measure, was actually in the rule – proposed in the rule but they decided not to finalize it, and you would have to refer to MIPS for the reason why that one was not finalized. But that was definitely proposed. At one point, it was proposed for MIPS only and not for the Shared Savings Program, but it was proposed and not finalized.

Bruce Bagley: You know, it might be helpful for our group to have some kind of brief notation of why some of these weren't finalized. I mean, if there's a conceptual problem or a structural problem with the measure itself, we probably ought to know about that. If it's really just an operational consideration that, you know, it's not something that it's possible to do, we probably should know about that as well.

Susan Knudson: This is Susan Knudson from HealthPartners in Minnesota. So I'm new to the MAP, taking over for Beth Averbeck. I am not aware of anything that's structurally wrong with these measures. We've been using them for statewide public reporting here for years, and they're very well adopted. So I'd be hard-pressed to think it was anything to do with the measure itself.

Bruce Bagley: Thank you. We agree, just trying to understand what CMS is looking for.

OK. Any other comments or questions?

Dale Shaller: So Bruce, this is Dale Shaller. I guess …

Bruce Bagley: Go ahead.

Dale Shaller: … in terms of the slide that was for – I think it was slide 59 as (back aways) that was focusing on ways in which the ACO and the MIPS program are trying to achieve alignment. I was curious and I don't know if this is important or not, but some of the domain categorization schemes that are used with MIPS don't map exactly with the ACO categorization.

So, for example, I noticed that there's sort of outcome and process measures in the MIPS categorization and the ACO used kind of intermediate outcome and patient-reported outcome. So, just being able to kind of line up the MIPS measures by category and not just individual measures, but by category and sort of conceptually. Is there any need or interest or value and kind of thinking up those definitions? I think the domains are actually a little bit different too. It's kind of an observation.

Bruce Bagley: Anybody from CMS want to comment on that?

Susan Arday: Well, this is Susan Arday. We stated in the calendar year 2019 Physician Fee Schedule Proposed Rule that we do seek to align the changes made to the CMS Web Interface measures under the Quality Payment Program. In the 2017 Physician Fee Schedule Final Rule, CMS stated that we do not believe it is beneficial to propose CMS Web Interface measures for ACO quality reporting separately. So, in order to avoid confusion and duplicative rulemaking, we adopt the policy and the future changes to CMS Web Interface measures would be proposed and finalized to rulemaking for the Quality Payment Program. And that such changes would be applicable to ACO quality reporting under the Shared Savings Program.

So, in accordance with that policy adopted in calendar year 2017 Physician Fee Schedule Final Rule, CMS do not make any specific proposals related changes in the CMS Web Interface measures reported under the Shared Savings Program. I don't know Fiona or Kim Spalding Bush might have something more to say on that.

Kim Spalding Bush: Thanks, Susan. I think you covered it. And I would just – I guess, yes, maybe one thing to add is that some of the Shared Savings Program ACOs participate in tracks that are subject to MIPS. So they – all right, let's (inaudible) to avoid confusion. I mean, we're using a different web interface measure set potentially for the Shared Savings Program, you know, as compared to what they're being measured on under MIPS. So, it will be sort of like a conflicting priority for them, I think, to track to multiple sets of measures.

Dale Shaller: I do have one other question. And, you know, I guess it's just a point of information that would be helpful for me and hope maybe others is, again, on slide 59 in terms of wanting to align with recommendations from the Core Quality Measures Collaborative, I think that's great. Will we have any sort of information on how that's working? I mean, like will there be some information that describes the degree to which the recommendations or the measures through ACO and MIPS actually are in sync with the Core Quality Measures Collaborative? It'd be helpful to have kind of an update on what those are.

Susan Arday: Actually, I do believe – this is Susan Arday. I do believe a fair number of the MIPS quality measures are core collaborative measures. I don't have the …

Dale Shaller: I think they are.

Susan Arday: Yes.

Dale Shaller: But I think it would actually be helpful to have – I mean, I don't know if anybody is in that analysis or comparison but that would be actually kind of helpful to know.

Susan Arday: And what analysis in particular you're looking for?

Dale Shaller: Yes, just how …

Bruce Bagley: Well, I think we – yes, I think we should have at least have a list of the Core Quality Measures on our agenda just as a reference point.

Dale Shaller: Yes, I mean, it's an aim, so to see how close we are.

Bruce Bagley: It sounds like at some point a reconciliation you're looking for, right, like can we reconcile those three sets, what's common among them, so we have a sense of how much overlap which would (inaudible).

Dale Shaller: That's exact right. Yes, that's exactly right.

Bruce Bagley: That would be great, yes.

Jennifer Gasperini: This is Jennifer Gasperini with NAACOS. I know that AHIP has done that, so, you know, it's out there if you don't want to have to recreate the wheel.

Amy Nguyen: Yes, and this is Amy Nguyen from America's Physician Groups. I actually – we sit on the steering committee for the Core Quality Measures Collaborative. And just to let folks be aware that core measure set is an evolving measure set. So we anticipate working on this in 2018 to revamp the core measure sets. So, it will be changing.

And, so in the appendix of the final rule, CMS does do a good job in highlighting which measure does a good crosswalk. I can't remember which page on – but it is in the appendix for the Core Quality Measure sets. And if you want to see the current one, I'm happy to send that out to the group, the link for that.

(Inaudible)

Erin O'Rourke: This is Erin from NQF. We can – NQF is actually …

Amy Nguyen: Yes.

Erin O'Rourke: … acting as the operational host of the …

Amy Nguyen: Yes.

Erin O'Rourke: … core measures – the Core Quality Measures Collaborative. So we can help to facilitate exchange between the groups and we can – the clinician workgroup's meeting materials, share some information about the current sets and to see, to Jennifer's point, if that – if we can get that crosswalk from our colleagues at AHIP to share with everyone.

And it's really something we can highlight when the measures under consideration are available, if those are in the relative CQMC sets. But to Amy's point, we are going to be reconvening the CQMC groups to review and make potential changes to those sets to keep them up to date. But it's certainly a work we can contract with MAP's work.

Amy Nguyen: Erin, do you want to connect with the NQF team and then send that out to the – to our MAP group? For that (inaudible).

Erin O'Rourke: That sounds like a good path forward, I can connect with the clinician workgroup team and see what we can pull together for everyone to support your decision making.

Susan Arday: This is Susan Arday. One thing I'd like to note that under MIPS, CMS currently does try to align with the QCMC measures as much as possible. However, for a measure to meet the criterion of MIPS comparable, only

measures on the list of consensus endorsed measures maintained by NQF will currently meet the criterion that's being endorsed by consensus-based entity because NQF is a consensus-based entity that endorses the standardized healthcare measure. So, the CQMC endorsement does not currently meet the criterion for measure being endorsed by a consensus-based entity from us.

So if you don't see commonality there are times between what we have in MIPS and what might be on the CQMC list, there's a good chance that it's because the measure is not NQF endorsed that's on a CQMC list and so therefore, we don't necessarily pick it up.

Robert Fields: This is Rob Fields again, I apologize. I had to walk away from my desk for just a couple (inaudible) a while ago and I had a maybe more specific question. If it's not appropriate for this meeting, I'm fine to defer.

But in the spirit of trying to work to reconcile both MIPS and MSSP measures, is there any specific comment on the – what I know of as ACO-11, but the interoperability measure specifically with the new rule proposed that really – it's really two different measures, one is an attestation measure and MSSP, but it remains essentially unchanged in MIPS. And is there any conversation about that because it operationally creates a lot of confusion in our ACO population.

Fiona Larbi: So, this is Fiona from the SSP program. So, we – yes, we removed ACO-11 as of – for 2019. And we are allowing the ACOs to actually attest – to certify an annual recertification that they actually have or they actually use 2015 CERT. And whether you're a MIPS APM or an Advanced APM, there's a different percentage of your ECs that have to meet that standard.

We did actually say in the final rule that that did not take away from what they had to do for MIPS reporting and that for the MIPS APM at least. So they would still have to do the MIPS reporting as well as do the attestation for us.

Robert Fields: Yes, that's exactly my point. It's a confusing message to actually operationalize. Any thoughts or guidance as to how to make those things the same, again, in the spirit of trying to make things similar for both reporting platforms?

Kim Spalding Bush: So this is Kim. I mean, I think what the threshold does for the Advanced APMs is align them with other Advanced APM requirements under the Quality Payment Program. I think the one that you're asking about is the ACOs to participate in Track 1, which is the MIPS APM as you know.

And I think what we had realized there was that it was creating actually an additional level of complexity for us to have kind of an ACO level rollup of that ACI data, now promoting interoperability data, formerly known as ACI. It was rolled up in a different manner for the purposes of the MIPS APM scoring standard.

And so what they should do is simplify that. I mean, we took a look at the numbers of ACOs that we're using, certified EHR technology and it exceeded this threshold that we had put into place. So now, you'll just be –ACO is participating in Track 1, we'll just be subject to the regular MIPS requirements. But for Shared Savings Program, we don't have this additional measure that we're scoring in a slightly different way, and using to determine whether or not the ACO is eligible to (Shared) Savings.

So, I think from our perspective and what we put through rulemaking, that generally was supported, was that this is a simplification for the ACO and that was the intent.

Robert Fields: I hear you. Am I misunderstanding that, but I get that the scoring methodology is different and the rollup may be different, but actually completing the measure was the same, right?

So, in terms of – right, it was the same sort of – formerly known as MU kind of – or at least in process those kinds of measures. And so for my communication standpoint, actually operationalizing that at the ACO level not at the score – not at the CMS level of aggregating score in rolling up, but in communicating when providers ask us, what do we need to do, right? Then …

Kim Spalding Bush: Yes.

Robert Fields: … there's a singular message that I get it but it rolls up and scores differently in either program, but the messaging from our side in terms of telling providers how they should respond is the same? And now it's not. And so they – so you have a big confusion there and the actual messaging to the people doing the work. I understand the intent was (inaudible) …

Kim Spalding Bush: OK. Yes. So we can work with our counterparts in CSSQ about how best to kind of message to the ACOs, what it is that they need to be tracking to for MIPS. So that hasn't changed but we can work with them about a way to help communicate that.

Robert Fields: That'd be great. I mean one possible option like if it's – maybe I'm not understanding the point. Based on your analysis, it seemed like ACOs were performing well on that measure because they were already really meeting those requirements as a rule. Is there any reason why we couldn't also do attestation, the MIPS APM track in MIPS, for instance?

Kim Spalding Bush: I'm not sure I'm following the question. I wonder if this is something we could try to understand some more nuances of …

Robert Fields: OK.

Kim Spalding Bush: … offline and I certainly – we don't have the promoting interoperability experts for MIPS on the phone, I don't think. I'm sorry, I would certainly not want to, you know, venture to say anything about where they would consider heading with the MIPS requirements.

I mean, I think one big message might be that we use to require all of the SSP tracks to report ACI regardless of whether or not they were otherwise subject to MIPS so they had to go complete this process which they don't have to do anymore.

So think that that – for the Advanced APMs, it was, hopefully, a big burden reduction and then they don't think that we changed the burden level for the Track 1 ACOs, but I think what you're asking is whether they could be excused from ACI reporting from MIPS which …

Robert Fields: Right.

Kim Spalding Bush: … is a, you know, very separate question, we would have to certainly contemplate in, would have to do through rulemaking.

Robert Fields: Sure. Except that it's related in that, you know, most of our participants in ACO do also have to participate in MIPS as MIPS APMs, that's because of our track, right? So, the reality is that very few of our providers and I think it's true for most ACOs, and Jennifer who's on the call may be able to guide me in a different direction here.

But they both have to – in this scenario, they will receive a message but because they're an ACO among other benefits within MIPS, is that they don't have to report on those ACI measures, they can attest, right? But the reality is that that's not actually true for MIPS. You know, that satisfies the requirement for the SSP quality program but not for MIPS, they still have to do the same measure. It's two different messages for the majority, if not, all of the participants in most of our ACOs. And …

Jennifer Gasperini: Yes, this is Jennifer with NAACOS.

Bruce Bagley: This is Bruce.

Jennifer Gasperini: I'll just piggyback …

Bruce Bagley: Yes, this is Bruce. Thanks for …

(Inaudible)

Bruce Bagley: Thanks for bringing this up. I think in the interest of making sure we have enough time for the rural work report from NQF, I think we need to move on. It sounds like we need to get this officially straightened out and we'll get an answer for you, OK?

Robert Fields: Sure thing.

Bruce Bagley: Thank you for bringing that up. So, is Dr. Ira Moscovice on the phone?

Ira Moscovice: Yes, I just came on a couple of minutes ago.

Bruce Bagley: Oh, good. Well, you're right on time. So, do you want to kick us off on the NQF rural work?

Ira Moscovice: Yes. Is Suzanne on the call?

Suzanne Theberge: Yes, hello, I'm on the call. Can you hear me?

Ira Moscovice: Yes. So I think Suzanne can start.

Bruce Bagley: Yes, welcome to you both.

Ira Moscovice: I'll try chime in, OK?

Bruce Bagley: OK, great.

Suzanne Theberge: Great. Thank you, everyone. This is Susan Theberge, I'm the senior project manager on the MAP Rural Health Workgroup project team. And I'm just going to, next slide, talk briefly about the past work that NQF has done in rural health and then turn it over to Ira to talk about the results of our recent work, and then I will briefly talk about what we're working on now.

So, in – next slide, in 2015, NQF did our first round of rural work and really looked at quality measurement in rural areas and what we need to be doing to make that work better. And that project identified quite a few key issues affecting the ability to measure quality in rural areas which included geographic isolation, small practice sizes and limited staff time and availability to do (inaudible), and measurement, heterogeneity of patient populations and low-case volume impacting the ability to collect data from measures.

So in that 2015 project the – that group came up with the overarching recommendation displayed here on your slides to make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers, but to allow a phased approach for full participation across program types and also to explicitly address low-case volume. And then were some supporting recommendations including using a core set of measures,

using guiding principles to select appropriate relevant measures, and finally, creating a MAP workgroup to advise CMS on rural-relevant measures.

Next slide.

So, the second round of work occurred in 2017 and 2018 last fall, just about a year ago. We put together a new workgroup, the MAP Rural Health Workgroup. And, that group includes 18 organizational members, seven subject matter experts and three federal liaisons. And they were tasked with identifying a core set of the best available rural-relevant measures with – looking at and identifying some of the gaps in measurement appropriate for rural areas and then finally to look at the topic of access to care and make some recommendations on measuring and improving access to care for the rural population.

So, I'm going to turn it over to Ira, the workgroup co-chair, to talk briefly about what that group recommended. Ira?

Ira Moscovice: OK. Thanks, Suzanne. If we go to the next slide, we talk a little bit here about the rural health core set. And basically, we came up with 20 measures in the core set, almost evenly split between the hospital setting and the ambulatory setting. We also, of interest, identified seven additional measures for the ambulatory setting, but note that they're currently endorsed by NQF not for the individual clinician level but rather for the health plan or integrated delivery system level of analysis. So some would work – needs to be done to translate those over and get them endorsed for the ambulatory setting, but we thought they were important to note.

There's a large number of potential measures to consider. The workgroup came up with three criteria, they had to be – the measures we were looking at how to be NQF endorsed, they had to be cross cutting so we didn't focus on specific – in general, we didn't focus on specific diagnosis and that relates to low-case volume issue. But as you'll see, we have one or two measures that are an important areas that are fairly prevalent in rural environments.

We also want to include process and outcome measures and (make) some issues that are self-reported by patients. And we – one goal was to make sure that the majority of the measures are – were used or already being used in federal quality programs so we wouldn't be reinventing the wheel.

I just want to go in the next slide.

And the next few slides, I'm going to show the specific measures, you know, due to time constraints, we're not going to go with each and every one, but on the hospital side, there were nine measures and a couple were related to infection rates and either CAUTI or CDI, HCAHPS is there for the patient reporting. Falls with injury are really important issue, particularly in smaller hospitals, the emergency transfer communication measure is care coordination measure, VTE prophylaxis was viewed as really important.

Of note, we included the caesarian birth measure noting that we're seeing more and more smaller rural hospitals not providing O.B. services any longer, but for the ones that do, we felt it was really important to include that measure. And then finally, for comparison purposes, we've put down – we included the hospital-wide all-cause unplanned readmission measures so we can make comparisons between rural hospitals and other hospitals.

If we go to the next slide, it shows the measures, the core set for the ambulatory care setting. Once again, we have self-reported measures in terms of the CAHPS clinician and group surveys, but a lot of focus on preventive care and screening measures, tobacco use, influenza immunization screening for clinical depression and follow up.

The area of mental health was discussed a lot by the committee and there'll be another measure that I'll show you soon related to that also. We did look at the diabetes, there was a lot of interest in making sure that diabetes care was appropriate, particularly since the prevalence of obesity in rural environments.

And so, the measure there for the poor control of A1C was included, had a measure on medication reconciliation. Of interest, we put in the advance care

planning measure which people felt a lot of discussion on that, but the majority of the group felt that was important to include that.

If we go to the next slide after that, the final measures in the ambulatory care setting. Once again, some preventive care measures with respect to BMI screening, follow up and also unhealthy alcohol use. And then once again, on the mental health measure set, we also included depression remission at six months. And finally, an optimal diabetes care measures.

So those are the 11 measures on the ambulatory care slide. And then here are the seven measures that we think are relevant to the ambulatory care setting. But right now, NQF endorsed that the health plan (will) integrate delivery system and I think the committee really felt strongly about including some cancer screening measures, and so that's why those are there.

And I think the important point of these other measures is that we had a vibrant discussion in the committee that we recognize that the ambulatory primary care doctor can't necessarily have complete control over some of these measures. But that they certainly have an impact on them and we feel the accountability should be shared both at the individual clinician level and also at the broader either health plan or integrated delivery system level.

So those are the measures, if we go to the next slide. One of the other activities that the group worked on or what are some measurement gaps in terms of rural health quality and outcomes. And the five areas that we address or initially discuss related to access to care which is hard to de-link from quality. The whole notion of transitions in care coordination, the cost issue which NQF has discussed in other deliberations of the MAP, substance use measure, particularly those focused on alcohol and opioids and outcome measures.

And we decided to go to the access to care – consider the access to care issue because it's so central, if you don't have access to care, it's going to be hard to have high-quality care.

And so if we go to the next slide, what we see is that we want to make sure that we're considering the rural context to this, and that we wanted to at least take initial shot at some strategies for addressing the challenges in terms of access to care measurement and issues.

And some of the key aspects of our discussion of the workgroup related to, as I said, difficulty of de-linking access from quality. I mentioned both the clinician level and higher level accountability, which is really important. And we talked about the rural environment, the whole issue of distance to care and transportation issues are really vital issues that have not received nearly enough attention in terms of measurement research, et cetera.

And then finally, telehealth certainly has been proposed to address several of the barriers to access, but there are still limitations to its use whether it relates to payment, whether it relates to acceptance by the rural population, et cetera, so there are some limitations to using telehealth that still exist.

And so if we go to the next slide, it describes the three domains that we basically broke the access to care issue up in the rural context. The first was availability and just give examples whether it's specialty care, or just the ability to get an appointment and the timeliness of being able to get care. And there are a variety of strategies that could be used to try to address that, broader workforce policy, greater use of team-based care, telehealth as we said, partnering with supporting services perhaps outside the healthcare arena.

Second domain was accessibility and that related to transportation issue we discussed. But also relates to health information, access to health information, to health literacy, other interpreters available, et cetera. And kinds of strategies here related to tele-access to interpreters of those we needed, partnerships within the community, as I said, particularly whether it could be with social service schools and other kinds of organizations, the use of remote technology and enhanced clinician-patient communication.

And finally, the third domain relates to the affordability side and, you know, we highlight here the increasing amount of out-of-pocket cost for many people. And what we've seen from surveys done by Robert Wood Johnson

Foundation and others, those out-of-pocket costs often lead to a delay in care due to how much the cost. And the strategies here were, you know, obviously, can we figure out strategies for dealing with expanding insurance coverage or protect in the safety net, making sure we're going to be dealing with these issues that we appropriately risk adjust, obviously the social determinants of health and the whole distance transportation issue comes into play in rural environments.

And then on the final slide, before I turn it back to Suzanne, the group, you know, is hoping to recommend to the CMS to continue the work which they have done. We view this core set, these 20 measures as a starter set, it's a dynamic environment. And the core set needs some refinement overtime. They're not ready for primetime right now just to go into a particular environment then just to drop them down, they need some further work to be able to be implemented.

New measures are continually being developed, particularly in the care coordination area. It's really important we feel from a rural perspective that new measures develop there. Measures can be modified and we really want to look at, are there any unintended consequences of the kinds of measures we're proposing to be collected.

And in the future, the group really appreciate the opportunity and really would like to provide a real perspective. We're very interested on other topics going forward. So, it was a great workgroup and that's the summary of – a quick summary of what we did this time around. And I'll turn it back to Suzanne.

Suzanne Theberge: Great. Thank you, Ira. So just to talk about what we've done in the last couple of months since the report came out in August, the next slide, in September, we had a Capitol Hill briefing on the report and the recommendations of the workgroup, which is really exciting. It's very successful, we had about 85 people attending. And NQF promoted this project on our homepage so we had a big splash screen about it right on our main homepage.

And this project did pick up some media coverage, we had at least six publications and a Health Affairs Blog article. So, it's very exciting, people are really interested in the work, and we are. As Ira said, we're excited to continue.

So next slide, we'll just show you briefly some of what we're working on now. The first part of the next phase of work is sharing the recommendations of the workgroup with you and with the PAC/LTC group today on our – some webinars and with the hospital workgroup next month. We are going to be bringing the workgroup back together in a couple of weeks to get their feedback on clinician specific measures on the MUC list. And Ira will be attending the clinician meeting to provide rural input on the MUC list during that meeting.

And then the last piece of work that we're doing right now is that we convened a five-person technical statistical experts to talk about the low-case volume issue which came up in 2015, and then again a little bit in most recent round of work. So, these five statistical experts are developing recommendations on how to deal with this issue, and they've actually met twice already, once on October 31st and then, again, yesterday afternoon. So they're well along the way of developing the recommendations. We're going to finish that in a couple of weeks.

On November 30th at noon, they have another call set and then we'll be writing those up and interacting – putting out a draft report for comment on January 18th with final recommendations to come by the end of March. So we're really excited with the continuing work and hope that you all have found this interesting and informative.

So, we did put together a few discussion questions and we're interested to hear your reactions. I know we're almost at the top of the hour, so we have a very limited amount of time. But I'll turn it back over to the MAP team to see if you have any feedback you'd like to share.

Bruce Bagley: You know, in the interest of time, this is Bruce, maybe we should try to do this exercise at the face-to-face meeting. Ira, you're going to be there, Suzanne said.

Ira Moscovice: Yes, I'm going to be there. And I don't know if this is going to come up there or not, but I'd be glad to talk about it there, sure.

Bruce Bagley: Well, we could just get it on the agenda so that we don't lose track of it because, you know, I think this deserves some good thought and discussion around the table which might work better than on the phone. So …

Ira Moscovice: OK.

Bruce Bagley: … we are a little short on time and we do need to have opportunity for the public comment. So, I would suggest that to the staff that we just make sure we get a brief agenda item for the December meeting. And since Ira is going to be there, he can, you know, get that input from the committee.

Erin O'Rourke: Hi, Bruce, this is Erin, we can add that to the agenda for December.

Bruce Bagley: Great, thank you very much. Now, is there any – are the lines open for public comment? Can we check with the operator?

Operator: Yes. To make a public comment, please press star then the number one.

And at this time, there are no public comments.

Female: Hi, everyone, this is (Inaudible).

Bruce Bagley: Oh, go ahead.

Female: I just wanted to move into a little bit of the next steps. But if you want to say anything, Bruce, feel free.

Bruce Bagley: Oh, no, go ahead, I just – I think that we gave a little time for public comment. I didn't hear any. So, it's time to move on. Go ahead.

Female: Perfect. So, I just want to move in to a little bit of an overview of what happened. Hello?

So I just want to move in to a little bit of the next steps. I know that Erin went into a little bit of an overview of the rulemaking approach, so I just want to talk about a couple of the dates that are important to remember. So, the MUC list will be released on December 1st. And then there's going to be a public comment period followed by our workgroup meeting on December 12th, so we look forward to seeing everyone there.

And then we'll have another public comment period and then a final input from the coordinating committee around the end of January.

The slides sort of involved some of the resources that we have for you guys to take a look at. If you have any additional questions. Now, I'm going to turn it over to Bruce and Amy for any closing remark.

Female: I had a question, I just want to confirm our meeting is on the 14th, correct?

Miranda Kuwahara: Our meeting is on December 12th.

Bruce Bagley: Yes, Wednesday, December 12.

Female: OK, great. Thank you.

Bruce Bagley: Amy, did you have any comments?

Amy Moyer: I don't think I have any closing remarks in the interest of time. I think we may have already seen something from NQF about scheduling that meeting. And maybe if we haven't, I don't know if anyone should be concerned, but that was the only closing thought I had. Other than that, I'm looking forward to a robust discussion in December and working with everyone again.

Bruce Bagley: OK. I'd like to thank all our speakers today and we're looking forward to seeing you all in December. Thank you very much.

END