NATIONAL QUALITY FORUM

Moderator: MAP Clinician Workgroup
October 8, 2015
11:00 a.m. ET

Operator: This is conference #93792400.

Operator: Welcome to the conference. Please note today's call is being recorded. Please stand by.

(Shawn): Good day, everyone. Welcome to the Measure Applications Partnership Clinician Workgroup Web Meeting. Please note that today's call is being recorded, and all public lines will be muted during this broadcast.

Workgroup members, please note your lines will be open for the duration of today's call, so please be sure to use your mute button when you're not speaking or presenting.

Please keep your computer speakers turned off if you've joined us by phone, and please do not place the call on hold. If you need assistance at any time today, please press star zero and an operator will assist you.

For technical support with the Web portion of today's meeting, please send an e-mail to (NQF@compartners.com). That e-mail address is currently displayed in the chat box area and will remain there throughout our time together today.

Today's meeting will include specific question and comment periods, however, you can submit your questions at any time by using the chat box. To do so, simply type your questions in the chat box on the lower left corner

of your screen. Please be sure to click the send button located next to the box to send your questions in.

During the designated public comment period, you will also have the opportunity to ask live questions over the phone by pressing star one. These instructions will be repeated later in the program.

I'd also like to draw your attention to the links area to the side of the slide window. You'll find the agenda and presentation materials loaded there for you to download at any time. Simply click on the link and it will open in a separate Web browser window and will not disrupt your viewing of the meeting.

And now it is my pleasure to welcome Reva Winkler, Senior Director. Reva, let's get started.

Reva Winkler: Thank you very much, (Shawn), and I add my welcome to everyone to today's Web meeting. We are beginning a busy couple of months in the (Premium) Rule-making work for the Measures Application Partnership.

Today I'd like to just briefly go over our agenda, which is initially, we're going to do some introductions. We do have a few new people joining the Clinician Workgroup and I want an opportunity to get to know everyone.

We'll be reviewing the pre-rulemaking approach and activities that we will be undertaking over the next few weeks. We will then specifically review the three clinician programs that the Clinician Workgroup will be looking at new measures. There will be an opportunity for public comment, and then we'll outline the next steps after this meeting.

So with that, it's my pleasure to turn the meeting over to our co-chairs, Dr. Bruce Bagley and Dr. Eric Whitacre.

Bruce Bagley: Well good morning, everyone. This is Bruce Bagley, and I just wanted to introduce myself. I have worked with the MAP process in the past during the first three years of the MAP Clinician Workgroup existence. So I have some experience, but haven't been on the committee for the last couple of years.

I understand the important work that we're going to be doing, and as Reva has pointed out, the time crunch that we're going to be under when the work finally starts.

So what we want to do today is get as much introduction to the work and how the work is going to be accomplished so that when we actually get things underway, everybody can hit the ground running. So I think with that, I'll pass it off to Eric.

Eric Whitacre: Oh, thank you, Bruce. This is Eric Whitacre. I'm Co-chair of the MAP Clinicians Workgroup. I've been on the committee for the past, well this is my third year. The first two years I functioned as a surgical content expert.

Just by way of background, I'm a full-time practicing surgeon in Tucson, and I'm on several quality committees with the American College of Surgeons. I would just like to echo everyone's comments first to thank people for participating in the call. We know how busy you all are, but this is really very important.

And having said that, I'd just like to move ahead so we can take advantage of our time.

Bruce Bagley: So what we're going to do is go down through the roll call and we'll ask each of you to introduce yourselves and maybe just give a few words about your day job and also your experience with the MAP Clinician Workgroup.

Severa Chavez: Let me start with Amy Moyer. Amy, are you on the line? Scott Friedman?

Scott Friedman: Bonsoir. My name's Scott Friedman. I'm currently in Paris, France, but typically I'm in Lakeland Florida and I'm a full-time ophthalmologist representing the American Academy of Ophthalmology and I am new to this committee.

Severa Chavez: Thank you, Dr. Friedman. This is just a gentle reminder to everyone please, if you're on the phone too, turn off or mute volume button on your computer, thank you. Next, Terry Adirim.

Terry Adirim. Yes, hi, I'm Terry Adirim, I believe this is my third round on, or maybe it's the second round on the Clinician Workgroup. I am representing the American Academy of Pediatrics and my day job is as an attending pediatric emergency medicine physician. I'm a professor of pediatrics and emergency medicine at Drexel University College of Medicine.

Severa Chavez: Diane Padden? Paul Casale? David Seidenwurm?

David Seidenwurm: Hi, I'm David Seidenwurm here. I'm representing the American College of Radiology and my day job is, I'm a neuroradiologist at Center Medical Group in Sacramento, and I do regional and enterprise quality tasks. And I've been part of the MAP Clinician panel since the beginning, so I don't remember how many years it's been, but it's been a good group to work with.

Severa Chavez: Thank you, Dr. Seidenwurm. Angel Oddo? Janis Orlowski? Scott Furney? Rachel Grob? Robert Krughoff? Cynthia Pellegrini?

Cynthia Pellegrini: Good morning. Can you hear me?

Severa Chavez: Yes.

Cynthia Pellegrini: Hi, this is Cindy Pellegrini, I'm Senior Vice President for Public Policy and Government Affairs for March of Dimes. I think this is my third round on the Clinician Workgroup and the MAP, and from the March of Dimes perspective, we're pleased to be able to bring research and some provider, and certainly consumer perspective to this process.

Robert Krughoff: This is Robert Krughoff. Were you able to hear me before? I just got some word that maybe I didn't come through. Can you hear me now?

Severa Chavez: We can hear you now.

Robert Krughoff: OK, sorry.

Severa Chavez: Could you just do your introduction? We weren't able to hear you earlier.

Robert Krughoff: I'm with Consumers CHECKBOOK/Center for the Study of Services, we're a non-profit consumer organization that publishes print and online evaluations of many types of service providers, including healthcare service providers.

Severa Chavez: Thank you. Beth Averbeck?

Beth Averbeck: Good morning, this is Beth Averbeck. I am representing Minnesota Community Measurement which is an organization here in Minnesota that is a measure developer and also publicly reports measures and quality experience and cost, and I've been on the Clinician Workgroup since the beginning, and also pleased to be participating.

My other responsibilities, I responsibilities for primary care for Health Partners Medical Group here in the Twin Cities in Minnesota, and then I have a clinical practice in geriatrics.

Severa Chavez: Thank you. Scott Furney?

Scott Furney: Thanks. I'm sorry you couldn't hear me, so I had to dial in through the – through the phone system. I'm a practicing internist, Chair of the Department of Medicine in Carolinas Healthcare System, and Senior Medical Director for our Patient Safety and Quality Committee for our medical group. This is my first experience with the MAP Clinician's Group.

Severa Chavez: Thank you, Dr. Furney. Welcome. Bruce Sherman? James Pacala?

James Pacala: This is Jim Pacala. I am representing the National Center for Interprofessional Practice and Education at the University of Minnesota. In my day job I am a – the Associate Head of the Department of Family Medicine and Community Mental Health at the University of Minnesota Medical School. I'm a family physician and geriatrician. This is my second year on the MAP.

Severa Chavez: Thank you. Stephanie Glier? Marci Nielsen? Winfred Wu?

Winfred Wu: Hi, this is Winfred Wu, I'm representing the Primary Care Information Project at the New York City Department of Health and Mental Hygiene.

We're the nationally-designated regional extension center for New York City, working with predominantly small practice providers, focused on EHR adoption and quality improvement activities. My day job kind of focuses around population health, clinical informatics and healthcare analytics.

Severa Chavez: Thank you. Barb Landreth?

Barb Landreth: Hi. I'm Barb Landreth. I am a Clinical Information Analyst for the St. Louis Area Business Health Coalition. My day job is finally completing a nurse practitioner degree, family nurse practitioner, which I finish in December. And I live in Tulsa, Oklahoma. This is my first time on the MAP.

Severa Chavez: Thank you. Welcome. Luther Clark? Constant Dahlin? And now to our federal government partners, Peter Briss?

Peter Briss: Good morning, I'm Peter Briss. I'm the Medical Director in the Chronic Disease Center at CDC.

Severa Chavez: Kate Goodrich? Girma Alemu?

Girma Alemu: Hi. This is Girma Alemu, representing the Health Resources and Services Administration (HRSA), and I am a returning member to the workgroup.

Severa Chavez: Thank you, Girma. Other dual worker liaison, Mady Chalk?

Mady Chalk: I'm the Dual Eligible Committee for several years, and am the liaison from that committee to the Clinician Workgroup. My day job is Director of the Policy Center at the Treatment Research Institute.

Severa Chavez: Thank you. And we see Marci Nelson on the Web. Marci, are you on the phone now? OK.

Marci Nelson: I am trying to get on with the operator, and I am listening to you on the Web.

Severa Chavez: We can – we can hear you now. Marci?

Male: We can hear you now, but you might want to turn your computer speakers off.

Severa Chavez: OK. Did anyone just join us that I missed earlier? OK, I think…

(Crosstalk)

Severa Chavez: Janis Orlowski? Would you like to do your introduction?

Janis Orlowski: Sure. I am the Chief Healthcare Officer at the Association of the American Medical College.

Severa Chavez: Thank you. So I guess now the NQF Clinician Team's going to introduce themselves. I can start it. I'm Severa Chavez and I'm the Project Analyst for the Clinician Workgroup.

Andrew Lyzenga: This is Andrew Lyzenga, I'm a Senior Project Manager at NQF. I've been here since about 2009, have been involved mostly in our endorsement work, largely centered around patient safety, a little bit of work on surgery and readmissions. This is my first time dipping my toes into the MAP work, so I'm excited to be involved.

Poonam Bal: My name is Poonam Bal, and I'm the Project Manager on this project. I have worked on MAP work previously for the past two years, but I was on the hospital team, and this is my first year on the Clinician Team.

Reva Winkler: And I'm Reva Winkler, I'm the Senior Director at NQF, and this is my second year working with the MAP Clinician team, and I welcome all of the new members. So with that, go back to our Co-Chairs to talk about our meeting objectives.

Eric Whitacre: Oh, this is Eric Whitacre. The objectives for today's meeting are to review the pre-rulemaking approach of the MAP, and then to delve into the actual programs that the Clinician Workgroup will be commenting on, and we'll go over those in more detail later. Finally, it's to provide some input on potential measure gaps that we see among the spectrum of measures for the various workgroups.

Poonam Bal: All right. Thank you so much for that, Eric. This is Poonam Bal, and I'll be taking over the MAP pre-rulemaking approach. So for those of you who have

not been with us before, or even if you have been, we've had a couple of changes since last year.

If you were with us last year, you'll realize that we went through a big, a good chunk of change last year and we're trying to continue that, and continue to improve the process for you.

So one of the changes that came about this year, was that we actually had the MAP Coordinating Committee meet before all the workgroups met to provide some (inaudible) guidelines on – guidance on issues that we felt we didn't have enough detail on.

And so we'll actually be going into more detail, into that on another – the all-member call that will be in November, and we'll remind you of that. So I won't go into too much detail there.

But as you know today we're having our workgroup call. Today's goal is to really familiarize you with the finalized program measures that – for each program and to identify any gaps that we're looking for when the MUC list comes out and when we're reviewing that. The MAP, this workgroup will meet in December.

We'll have a two-day in-person meeting, and during that time, we'll be making basically, we'll be reviewing the MUC list and providing recommendations to the Coordinating Committee on how these measures, if we should support them, conditionally support them, or if we don't feel like they should move forward.

And then following that, the Coordinating Committee will meet again, and they will be focusing on some of the key issues that were identified by the MAP Workgroups, including this workgroup and seeing if anything needs to be really resolved, and that will be in January.

So if you move forward to our timeline, I have gone over most of this, but this goes into some detail about things that I did not mention. The MUC group, which is the Measures Under Consideration list is generally released by (HS) by – on or before December 1st. And as soon as we get that information, we'll

provide it to the workgroups and get you as much information as we can in that time frame.

Once we get that list, we'll go through an initial public commenting phase. The time frame for that will depend on when we get the MUC list and again, more details will be provided to you as we get closer. As I mentioned, we'll have our in-person meeting in December and the other workgroup, the other – the Hospital Workgroup and the PAC/LTC Workgroup will also meet during that time.

In December and January, we'll go through another public commenting, this time on the workgroup deliberations, and during that time, the Dual Workgroup will also meet to go over and provide additional recommendations. In late January, the Coordinating Committee will take all of that comments, and the workgroup deliberations into consideration, and finalize the MAP input.

February 1st, we will basically develop a spreadsheet containing all the recommendations and produce that to CMS, and then we'll also, in February 15th, the PAC and Hospital programs will send in their written reports and Clinician and Specific Programs will send theirs in March 15th. Next slide, please.

So this year, Clinician will be reviewing three main programs. We have a new program that we will go over in a bit, which is a merit-based incentive payment system, or MIP for short. We will also be reviewing measures for the Medicare Shared Savings Program.

This year all the – all the – or the MSSP, as it is also known, those measures will be reviewed by Clinician only. And then we'll also be going through Physician Compare. Again, this is dependent on what measures come through the MUC list, but these are the programs that fall underneath our purview.

OK, so for the approach for today's meeting, we'll review the structure of each program, and the measures that have been finalized for that program. This year we have introduced frameworks to help you with your work, so you can more clearly understand what's currently in the programs and what would be a

beneficial add. We'll also be – we'll be asking the workgroups to use these frameworks to really identify that list of measure gaps and provide input on potential refinements to the list.

So with that said, I'll give it to Reva to go over MIP.

Reva Winkler: Thank you, Poonam. I just would like to stop a minute to see if there are any questions or comments from any of the workgroup members before we start talking about the individual programs?

Is there a brief – if I could make a brief comment.

Reva Winkler: Sure.

Eric Whitacre: This is especially for the new members. There's enough information already. I know when I started on the committee, my head was spinning.

I had no idea what people were talking about. So just to provide a little bit of perspective, one, it is a breakneck timeline, but fortunately, when the MUC list, or the Measures Under Consideration list is received, the NQF staff fortunately are very good at preparing basically a workable summary.

And we'll go over it at different teleconferences, a different meeting, the exact mechanics of how this is done using a consent calendar and how the specifics of the voting and so forth on quorums will take place at the actual meeting.

So I think the purpose now is really just to sort of get this overarching view, so that when the time comes, we can all sort of hit the ground running and we understand the larger context. Because we'll be spending a fair amount of time looking at individual groups of measures and today's overview is really to provide the big context for that. It becomes clear as you roll up your sleeves and get into it.

Reva Winkler: Thank you very much, Eric. So we're going to begin with the largest clinician program, and for the Clinician Workgroup, this will represent a significant change from the programs we've looked at before. There is a new program that will consolidate many of the existing clinician-level programs.

The Medicare Access and Chip Reauthorization Act of 2015, otherwise known as MACRA, was – came into being in early 2015. And what that program – what that legislation does is it sunsets the PQRS study-based purchasing modifier and the EHR incentive program in 2018.

And it replaces, essentially, those programs with a new program called the Merit-Based Incentive Payments Program, or MIPS, which will begin in 2019. And it was intended to consolidate the existing Clinician Quality Incentive programs. Just briefly, some of the details of the MIPS program is that there will be positive and negative payment adjustments based on four categories of performance, Quality, Resource Use, Clinical Practice Improvement Activities, and the Meaningful Use of the HR Technology.

And so you can see how the characteristics of the preexisting individual programs are being consolidated into a single program. The measures that they will use for the quality portion will be the measures that are currently existing in programs in PQRS, Value-Based Modifier, and the HR Incentive Program, certainly in the initial years. So it seems a little confusing, perhaps, if we're asked – if we wonder you know MIPS won't start until 2019, but this is only 2015, so if we go to the next slide, I just tried to lay out a little bit of the timeline of how this works.

Last year, your pre-rulemaking input in 2014-2015, we're now seeing reflected in the 2016 proposed Physician Fee Schedule Rule. Data collection on those measures that are finalized on that rule will begin in 2016. But there is typically a two-year delay before those measures are actually used for public reporting or payment adjustment, so it's that several year lag as we go through this implementation.

So for this year, your work in 2015-2016 will impact the 2017 Physician Fee Schedule Rule for data collection in 2017, and by the time it's ready to be used, MIPS will have come on board.

So this is why we're a couple years ahead of the anticipated start of MIPS, but the measures under consideration that we will see this year will be the first ones that will actually go into the formal MIPS program.

So on the next slide, we want to talk a little bit about the measures that are already in the Clinical Program. The Clinician Program has, I'm sure many of you – most of you are aware, is a large-volume program, and the number of measures for 2015 number somewhat more than 250. The proposed rule has proposed an additional 45 measures as well as proposing to remove another dozen.

And so we're still talking about a measure set of around 300 measures. Once we have the final rule and know which of those proposed additions and removals, we'll be able to finalize the clinician measure set.

What we've provided for you and Severna's going to demonstrate it in just a moment, is a sortable spreadsheet of the measures that are currently in the Clinician Program. And it is a spreadsheet that's sorted – sortable, by measure type, by NQF priority area. And we used as our starting point a spreadsheet that CMS had posted on their Web site. But what we've done to make it a little bit easier to get your arms around 300 measures is we've added a column where we've assigned a topic area.

As I think most of you may be familiar with the past clinician work, we've typically divided these large lists of measures under consideration into topic areas just for ease of management and logistics. And so we're doing a similar thing with the overall list of measures, so it's easier for you to get your arms around.

And the topic areas aren't meant to be functional. Some of them are more cross-cutting such as Care Coordination, Prevention, or Patient Safety. Some of them are very disease-specific, such as Diabetes or Cardiovascular Disease, and some of them are very specialty-specific, such as Eye Care or Dermatology.

So when we look at the spreadsheet, you will be able to sort by those topic areas, and so hopefully when you are looking at the Measures Under Consideration list, and see what topic area it addresses, you can then refer back to this spreadsheet to see what measures are already in this topic area and can begin to assess how this measure might add to the existing program.

So with that introduction, I'm going to turn it over to Severa, and she is going to bring the spreadsheet up on the Web platform to introduce it to you so you can see how it works. I think we have just a…

Severa Chavez: Yes, we are – position it.

Eric Whitaker: That's it. Drag it up.

Severa Chavez: Unfortunately, we're having a little difficulty with the screen sharing at this time. We do have it linked to the right of the screen, and we'll try to get it up for you in a little bit. Do we want to move on and once we can get this to work, we'll shift back, Reva?

Reva Winkler: That sounds fine. So if we could then bring up the next slide, guys. OK. We done just a very high-level look at the measures in the program for 2015 to get a sense of how the measures lay out.

One of the major focus of the Clinician Workgroup has been an interest in moving towards more high-value measures, specifically outcome measures, patient-reported outcome measures, efficiency measures, patient experience measures.

And so we've done just a quick pie chart for you to look at the distribution of the types of measures. And you can see that in the current measure set for PQRS that the vast majority of them are still process measures, though outcome measures are representing a larger portion, I think, every year.

We're still relatively low on patient experience and efficiency measures, and so I think this has been an ongoing theme of the discussions of the clinician workgroup, with hopes that each new (muck) list each year will bring more high-value measures under consideration.

Next slide.

Unidentified Participant: Could you clarify something – when you were talking about – on that – that's actually the number of measures, right? Some of these you know like patient experience, expect to have very many measures …

Reva Winkler: Right.

Unidentified Participant: It'd be nice to have some of them used …

Reva Winkler: Yes. Well …

Unidentified Participant: Whereas, of course, there's potential for x number of process measures, but that doesn't mean they're all being used for everybody, or whatever, right?

Reva Winkler: Well, as the clinicians programs work, the measures are available for use. And there are so many different variations of use, by large groups, by small groups, as well as by individuals and there are some requirements for the large groups to be utilizing the patient experience measures, perhaps more so than required for individual providers, but nonetheless I think there's still a desire for more measures that could be used by providers to report.

Unidentified Participant: OK.

Reva Winkler: OK. Next slide please.

The other characteristic that – a focus for the clinician programs is the distribution across the national quality strategy domain. Currently for PQRS, the requirement is that the measures selected by providers to report address at least three of the domains. And you can see that there is some distribution though the largest group still is the effective clinical services domain of the national quality strategy.

So again, not as much in the communication and care coordination, not that many measures, also not that many measures in efficiency and cost reduction, or person and caregiver-centered experience and outcomes.

So again, I think the clinician workgroup has discussed this previously, about the desire for more of these types of measures and we hope to see them on this year's measures under consideration list.

Next slide, please.

Severa Chavez: Do you want to try one more time the screen share at this point?

Reva Winkler: Sure.

Severa Chavez: Can you see the spreadsheet?

Reva Winkler: No, all I see is the …

Unidentified Participant: The desktop.

Reva Winkler: Yes, we just need the desktop.

Unidentified Participant: I don't think – for whatever reason we're having some technical difficulties, but you can refer to your link page.

Severa Chavez: Thank you.

Reva Winkler: OK. Go back to the slides then, Severa, thanks.

All right. This year, CMS published a document that outlined the priorities and needs for measures for all of their federal programs. It's a 40 page document and it is available to you on your reference – in the general references section on Sharepoint and feel free to access it.

CMS identified their priority and needs for each of the three clinician programs and we'll share these with you. For MIP, they specifically are looking for outcome measures, measures that are relevant for specialty providers and I think these really have been the common theme for the clinician workgroup over the last several years and align with the guiding principles that the clinician workgroup created several years ago.

High priority domains within the NQS I think are the ones we saw just a moment ago that really don't have as many measures as some of the other domains around person and caregiver-centered experience and outcomes, communication care coordination, resource use, and appropriate use. So I think this is sort of the ongoing conversation, needing to see these high value measures become available for use in these programs.

In addition, CMS is interested in measures that address not only clinical care but safety care coordination, caregiver experience, and population health and prevention. CMS expresses a preference for ECQM, the electronic clinical quality measures, or e-measures, that are appropriately specified for use in EHRs, as you saw in the meaningful use program. They really are trying to avoid duplication of measures in the set, and I think if you look at the measures that are proposed to be removed from the current list, some of the rational is the fact that they are duplicates.

Also, CMS is particularly focused on measures for which there is still an opportunity for improvement, and they wish to avoid measures that are topped out, and so you will see also in the proposed measures to be removed from the current program that they are topped out with little opportunity for further improvement.

And so these are the priorities and needs that CMS has identified for the MIPS program and so we do want to keep these in mind and we will be using them as part of the preliminary evaluation that staff will do to point out to you which measures seem to particularly address the priorities and needs that CMS has identified.

Next slide.

Now last year this clinician workgroup spent some time identifying gaps in the measure list, and I think this is a good starting place to consider the gaps in the program and where we hope to see measures on this year's measures under consideration list. And that included things like palliative and end of life care, cancer outcomes, measures for multiple chronic conditions or complex conditions. Again, a focus on patient centered measures using patient reported data. I think this is an ongoing theme that we hear from a wide variety of stakeholders.

Measures around trauma care were raised as something that is becoming more and more prevalent around the trauma for elderly patients, particularly, and Medicare – again, geriatrics and frailty. So those topic areas were those that

you all identified last year in your conversation about where measures would be important to address, important topic areas for clinician measurement.

Additionally, types of measures that would be particularly important would be measures of diagnostic accuracy, measures again with specialties with few measures needing to enable them to participate in these programs, and then EHR measures, particularly those that promote interoperability.

And so, with that, this is an introduction to the MIPS program, what CMS is looking for, some of the thinking of the workgroup last year, so I think at this point we'd be – welcome any comments or questions that will help you prepare yourself for looking at the measures under consideration for this program when we meet in December.

Bruce Bagley: Hi Reva, this is Bruce. I just – I might like to mention you have the measures of diagnostic accuracy, I think at some point we should be looking, if possible, at measures of diagnostic and therapeutic efficiency. So if you could add that or modify your list to include that I'd appreciate that.

Reva Winkler: Happy to do that.

Bruce Bagley: I mean, it's aspirational, I realize, but I think that's where we need to go.

Janice Orlowski: This is Janice Orlowski. I have a question – is it the intention that these measures would eventually point down to a single provider?

Reva Winkler: I think that these measures are used by providers in different sized groups – sometimes they're large groups, sometimes they're medium to small groups, and sometimes individuals – so I think all sort of levels might be used.

Bruce Bagley: Janice, this is Bruce Bagley. Just to expand on that, I think that oftentimes there's not enough numbers for individual providers so we worry about this statistical significance of small numbers, but at the same time if you're trying to manage a group of providers, having any information is better than having no information.

In other words, even though you might not want to use small numbers for payment and judgment, you certainly can use small numbers to help supplement what you know about clinicians within the group you're trying to manage.

Janice Orlowski: The only reason why I asked that is – one, is to get to the issue of groups and whether – you know do we envision that the payments – either a positive or negative payment – will be directed against a specific physician and PI number, or is there the opportunity to cluster?

So that's one question, but the second is an issue that I'd like to raise of – no more of a theoretical issue, and that is, is that we, right now, are really working hard in medical school, curriculums and residencies on inter-professional and team performance, and so as we continue to take a look at care management and inter-professional teams working collaboratively together, in some ways this identification of a particular physician is contrary to where the field is going, in a number of these programs, so it's more of a theoretical issue, but one that I think we have to address.

Reva Winkler: I certainly can say that the current PQRS program is – uses both participation by large groups, small groups, and individuals. As we move into MIPS, I think I'm not as certain of that. If there's somebody from CMS who would like to respond to that, I'd be happy to inform the group, if not, perhaps we can hold that and ask Kate to respond to that when we meet in person.

Eric: This is Eric. I think a great example of that would be trauma care – certainly that's a team sport at its best, everything has to work together. We identify that as a clinician workgroup as a potential deficiency and where that fits into the CMS priority needs would have to be looked at. It's an important point.

Janice Orlowski: Thank you.

Unidentified Participant: I'd like to – trying to be sensitive to the various uses of these measures – some of them, of course, are for payment, but we also, I assume – the physician (compare) is still going to survive, which is (inaudible) directed toward individual consumers – individual consumers still really want to know about individual doctors, and I just think we have to straddle both of these

things, and I think when it comes to patient experience, there's a whole lot of evidence that most of the variation takes place at the individual doctor level.

There's no – there are not sample size issues – I mean, you may not have enough sample size to do outcome measures or whatever, but there's plenty of sample size for most physicians to do patient experience information.

And even for some clinical outcome – for many clinical outcome measures, there is quite a bit of – a lot of variation from physician to physician and consumers, quite legitimately, want to know about that. And I don't – I've never quite followed the concept that having that information out there at the individual physician level diminished the potential to work for – to develop team performance.

You can (tell) both about the individual and about the team and, of course, what you know about the individual may – seems to me – may be constructive in helping the team move forward. So I don't – I'm not comfortable with this sort of split in saying that we might go off only to look at practices in groups.

Hello?

Reva Winkler: Any other thoughts from anybody else?

Bruce, Eric, you think we should move on?

Bruce Bagley: Sure, as long as there are no other comments.

Unidentified Participant: I just want to add one comment – I think that the domains are right on, I just – in terms of what are potential gaps, I think one interest we have here, looking at around diabetes, specifically, around supplemental education and underutilization that we've been observing, both locally here and based on analyses done national as well, so kind of if we can concretely think about how that gets into future opportunities for measurement is something I just want to raise up to the group.

Reva Winkler: OK. Um, thank you. We're going to move on to talk about the next program that the clinician workgroup will consider measures for. Andrew, I think, is going to walk us through this.

Andrew: Yep, thanks Reva. So the second program we're talking about today is Medicare Shared Savings Program, or MSSP. This was authorized by the Affordable Care Act in 2009 and then established in 2012.

The program aims to facilitate coordination and cooperation among providers of Medicare (inaudible) service patients. It's intended to encourage investment in infrastructure and redesign care processors to support those goals, and the participants are Accountable Care Organizations, or ACOs. These ACOs can earn shared savings by meeting program requirements and quality standards like the one's that we're taking a look at today.

There's a variety of ways in which these shared savings can be structured and distributed – one-sided shared savings, two-sided shared savings and losses, but we won't get into that too much today.

Beneficiaries are assigned to an ACO based on utilization of primary care services provided by ACO professionals. As I understand it, that's done retrospectively, although CMS does provide ACOs with a preliminary prospectively assigned population.

As the authorizing legislation, the ACA calls for the MSSP to include measures assessing clinical processes and outcomes, patient and caregiver experience of care, and utilization.

The set of measures in the shared savings program – there are 33 of them, so a good deal less than what we saw in MIPS, they're divided into four domains that were specified again in the Affordable Care Act. Those four domains are patient and caregiver experience, care coordination and patient safety, preventive health, and clinical care for at-risk populations.

Measure selection for the shared savings program emphasizes prevention, management of chronic diseases that have a high impact on Medicare beneficiaries, including heart disease, diabetes, and COPD.

There is one new measure proposed for 2016 around (inaudible) therapy for the prevention and treatment for cardiovascular disease – I should note that we did not include this one in our spreadsheet but we will add it and circulate an updated version of the spreadsheet to the committee after this call and call that one out in red text as you saw in the MIPS spreadsheet, or you will.

We don't have the same number of distinct topic areas as the MIPS program, or the sheer volume of measures as we saw in MIPS, so we didn't see as much utility in providing similar analytics as we just presented for the MIPS program, but just to give you some sense of the kinds – the overall kinds of measures that are in the program – we have a pretty even distribution of measures across those four domains you see at the top of this slide – eight in patient caregiver experience, 10 in care coordination patient safety, eight in preventive health, and seven in clinical care for at-risk populations. In terms of the data sources that these measures are based on, the large proportion of them are reported through CMS's Web-based interface through group practice organizations – 17 of them – so that's about half.

The remaining measures are fairly evenly split between claims based measures, of which there are seven, and survey based measures, of which there are eight. One is reported through the EHR incentive program, so presumably as an e-measure.

In terms of measure type, there are more process measures than any other kind of measure with thirteen, but a good number of outcome measures as well with eight. Two measures which we will probably call intermediate outcomes, eight patient experience measures, those are the CAPS measures, one structure, and then one composite measure around diabetes care.

I don't know, Severa, if you want to try to screen share the spreadsheet again, or probably we'll skip that for now.

Severa Chavez: We can try one more time. What's the harm?

Andrew: I think we're having the same trouble that we were before, so let's go ahead and skip to the next slide, I think. OK.

So CMS has identified several needs and priorities for measurement within the shared savings program, which serve as guidelines or parameters of a sort for their measure selection process.

What they'd like to see are outcome measures for conditions that are high cost and high volume for Medicare patients, measures targeted to needs and gaps in care for Medicare fee for service patients and their caregivers, measures that are aligned with measures in the PQRS and value-based modifier program, which is now MIPS, as you heard, and then measures that support improved individual health and population health.

Unidentified Participant: Excuse me, Andrew?

Andrew: Yes, go ahead.

Unidentified Participant: Can I ask a quick question?

Andrew: Sure, sure.

Unidentified Participant: It seems to me that the experts on high cost and high volume measures would be CMS. Are they going to provide us with information on which outcome measures they really need based on those criteria? I mean, I could guess what they might be, but they have the data. I'm asking you to read CMS's mind, maybe they just …

Andrew: Yes, I can't do that too much, I mean I think that is something we can provide input to the extent that we have you know this group has any insight into what are the, sort of, high cost and high resource measures, we could maybe ask CMS to also give us a bit of guidance and thoughts around that. Reva, do you have any thoughts on that?

Reva Winkler: Yes, I think that in some of the early work that MAP has done were around some of the high cost, high volume, high value Medicare conditions and so there is sort of the same list of 20 that floats around. So we can certainly use that as a reference as well as just discuss a bit with CMS to see if there's – if it is still the good list.

Unidentified Participant: Great, thanks.

Andrew: So as part of the – of last year's process, the MAP process, our clinicians workgroup did provide some feedback on the shared savings program at that time. The workgroup members suggested that measures in the MSSP should focus on composite measures for clinical conditions to provide a bit of a broader view of the quality of care for those conditions.

They would like to see measures that promote care coordination, more outcome measures, measures using patient reported data, and then measures assessing and focused on prevention and population health.

So with that I will again turn it over to our co-chair to see if the group has any thoughts on how we can refine the high priority domains or thoughts on gaps in this program for future measurement.

Bruce Bagley: Yes this is Bruce. It would be helpful to back up the one slide so we can see that in front of us.

Does anybody have any comments?

Eric: Well Bruce, this is Eric. My only comment would be that I love the list but it's all going to depend on the (muck) list. And whether or not there are measures on the list that will fit into these categories. But we should definitely keep these in mind.

Reva Winkler: This is Reva. These are the guidance that we will be using when we do the preliminary evaluations to help get things started for you for this year's (muck) list.

Barb Landress: This is Barb Landress. I can't remember from the spreadsheet that I looked at before this meeting, that was with this meeting – no – if there was a measure that dealt with pain management and opioid abuse. If not, I want to make sure that there's some way we can look at that issue within the guidelines of these five measures, or within the guidelines of these five criteria.

Unidentified Participant: Yes I don't believe there is a measure currently in the program focused on that issue, so that's something we'll make a note of.

Any other thoughts from our workgroup?

Well hearing none, I think we can move on.

Reva, do you want to talk about the physician compare program?

Reva Winkler: Yes, I would. Thank you. Physician compare is I think of great interest – this is the public reporting program – go to the next slide – and physician compare is the program that publically reports information currently on PQRS as well as the Medicare shared savings program for ACOs.

So we go to the next slide – this is a screenshot of what physician compare looks like for an individual physician. All of the physicians being reimbursed by Medicare can be looked up and will have a public facing webpage.

Right now for most individual physicians, we don't see any specific measure information, we do see information about their participation in PQRS or meaningful use, perhaps, but very soon, there will be a large amount of information available for small group physicians and individuals with specific measure information at the end of 2015.

We're going to see a large expansion of the information that is provided on physician compare in this public facing Web site for the individual physicians.

So keep the Web links handy and when we get a little farther towards the end of the year you might want to take a look and see how that's rolling out.

Next slide, please.

Barb Landress: Before you go on, is that only for MDs, or is that for all providers? Nurse practitioners, physicians' assistants.

Reva Winkler: You know I'd have to go back and check. I'm sorry. I can't answer that question myself. We can go take a look, thought.

Unidentified Participant: Reva, I believe it's for all eligible providers …

Reva Winkler: Yes, I think you're right.

Unidentified Participant: Yes.

Reva Winkler: Yes, which would – all eligible providers would include nurse practitioners, physicians' assistants, and other non-MD professionals.

The next screenshot …

All right the next screen shot that we're showing is another part of Physician Compare for the Medicare Share Savings Program for ACOs. On this Web site for the participating ACOs at this point, you will see actual major information. This is only a partial shot of the screen that shows major information for this representative ACO but you can see that there are measures around diabetes, and if you go down farther there will be measure results around coronary artery disease.

So Physician Compare is – will continue as the public reporting program for these clinician programs.

Next slide please.

Physician Compare has been undergoing a phased rollout. It began with the Web site in December of 2010 and progressively data on initially larger groups and then more of those groups in 2014. But in December of 2015 we will see more groups including very small groups as well as individual providers. The final phase is in the 2015 data that's currently being collected, will be eligible for public reporting in December of 2016.

So this is the phased rollout. And according to the macro legislation, the mixed data will be reported on Physician Compare. We can expect to see public reporting of this information going forward.

Next slide please.

Physician Compare currently uses several criteria for public reporting for the (PQRS) data. That is they will publicly report data if it's been used for at least a year and the measure successfully tests for reliability and validity. The public reporting that CMS tends to do is by two methods.

One is the clinician Web page. That was the one we just looked at. CMS intends to publish on that Web page measures that are particularly meaningful to consumers and beneficiaries. For measures that are more technical and less salient to consumers and beneficiaries, CMS will publicly report these, but by way of a downloadable spreadsheet, so that they are available but they won't necessarily be on that individual clinician page. For those stakeholders that are interested in more technical or specialized measure and measure results, the information will be available.

But CMS is asking us, asking MAP for feedback on which of the measures would suit the clinician public-facing Web page. As we look at the upcoming measures under consideration we will be initially doing an analysis and decision on whether the measure should be recommended for the (MIPS) program, and what your recommendation is.

Secondarily, if you do recommend the measure, we will also be asking for your recommendation on whether it's a measure that might be appropriate for the public-facing webpage versus the spreadsheet.

GO to the next slide please.

In our initial evaluation, prior to our December meeting, staff intends to use the Clinician Workgroup guiding principles for Physician Compare that you all created over the last couple of years and the bullets here outline those measures that the Clinician Workgroup has identified as being particularly important for public reporting in a way that is beneficial for consumers and beneficiaries, and clearly meaningful measures are important, outcome measures, patient experience, patient reported outcomes, care coordination, population health, appropriate care and composite measures.

That is the guidance that you have provided up to this point on the types of measures that you believe are important to consumers, beneficiaries,

purchasers and other stakeholders to be readily available through public reporting.

We will make a stab at providing a preliminary assessment, but again, we will be asking the Clinician Workgroup for a recommendation not only for – should the measure be in the program, should it be publicly reported on the public-facing Web site or the spreadsheet. It would really be helpful if you all could provide even additional guidance to help us refine this perhaps a little bit. If you have additional thoughts on the differentiation of measures for the public-facing Web site versus the downloadable spreadsheet.

Barb Landreth: This is Barb Landreth again. My experience has been if you're asking a senior to download a spreadsheet to do for their analysis that's probably beyond their technical capabilities.

Reva Winkler: Right.

Barb Landreth: So if I'm a senior, for instance I have osteoporosis and I'm trying to find a doctor to help me with my osteoporosis, I want to know more technical measures than simply patient experience and patient reported outcomes. I think that we've got to balance providing information to consumers that they can understand, with information that's actually meaningful. If our purpose is to provide data to help consumers select physicians that are doing a good job.

Reva Winkler: OK. Thoughts from anybody else?

Beth Averbeck: This is Beth Averbeck from SOT measurement. The one area I don't see maybe we're getting at it with appropriate uses around cost, from the standpoint of consumers, is one of the things that we have experience with, it's one of the areas that is most highly clicked on at least from our experiences has been anything related really to cost.

Reva Winkler: Thank you Beth. That was a topic area that was raised by several members of the coordinating committee also as important to focus on.

Beth Averbeck: OK. Thank you.

Reva Winkler: Any other thoughts from anyone?

Scott Furney: This is Scott Furney. Although I'm new to this group I would think that one of the priorities would be to come up with a core set of measures that we would use for each specialty, and the comments earlier about being overwhelmed with the volume of material is appropriate. What would be the venue by which we could discuss, say for a family physician, a combination of prevention measures, immunization, and disease management, would seem appropriate.

And then my other comment is, akin to there'll be different users who will use that site – health literacy being incredibly important, will we have the ability to guide the Physician Compare Web site to provide a low-literacy say a composite, and then a more detailed downloadable spreadsheet would make sense to me.

So is it primarily the measures we're responsible for or is it to guide the content, development and display?

Reva Winkler: In general I would say our primary responsibility here is the measures. However the discussion that goes on around the measures and how the measures are used, is very valuable. So I think that while we can't forget about the specific recommendations on the measures, some of these conversations are incredibly important. I think we will have an opportunity to address them.

All right, if there aren't any other comments or questions, perhaps we can move on.

At this time we'll see if there are any public comments. Operator would you please check for us?

Operator: At this time, if you have a comment please press star one on your telephone keypad. We'll pause for just a moment to compile the roster.

You have a comment from Corinne Rubin.

Corinne Rubin: Hi, this is Corinne Rubin from the American Medical Association. Thank you for allowing me the opportunity to comment and the summary of the task that the MAP has in hand this year was helpful. I would like to highlight that the intent of MACRA was stated to consolidate and streamline the programs, however the congressional intent was not just to take the existing measures and apply them to the (MIPS) program, but an opportunity to reevaluate the structure of the program.

So it's not quite clear to me how you can provide thoughtful and educated comment to the MAP and to CMS when the full (MIPS) program and methodology has not yet been designed or proposed. We're currently in RFI process with CMS, where they ask over a hundred and thirty-seven questions in regards to design of (MIPS).

And then another comment/suggestion that would be helpful for evaluation purposes, that when the (MU.K.LES) comes out and the MAP deliberates all that's really provided is – by topic and disease area is highlighted, but it would be helpful if we could break it down a little bit more to include exact categorization of the measure.

So for example with the Value Modifier program it has multiple facets and if you categorize on how it would be classified in the program. So for example with the Quality Bucket you have the (PQRS) measures and then another bucket for administrative claims base measures, and then you also have the cost category.

So it would be – you'd be able to provide some more educated comments if there was a clear breakdown of where the measure is being considered, and under what category. SO for (MIPS) it would be quality resource use, clinical practice improvement, meaningful use. Thank you.

Operator: There are no further comments at this time.

Reva Winkler: Thank you so much for your comment, and we'll definitely take that into consideration as we further – we go further into the process.

With that said, we're actually ahead of schedule today, so we'll probably let everybody out early today. Again, I just wanted to show the graphics of next steps that will be gone through in some detail, I won't mention too much. There's two events that I want to bring to your attention – next slide please.

We will be having the all-MAP Web meeting on November thirteenth, this will include this work group along with the hospital PAC duals, the coordinating committee. This will – while this is more about the programs and the measures currently in the programs, that meeting will really focus on more profit issues, so as earlier we'll being talking about how we're going to be validating measures, what staff does beforehand to help the work groups, what the responsibilities of the work groups are, how the proceedings during the meeting will be.

Many of these things have changed from last year, so even if you have been on Clinician for a while we really request that you attend this meeting because we have changed a good chunk of our processes even from last year.

After that we will have the in-person meeting on December ninth and tenth. You should be getting travel information shortly from the – that will not come from the Clinician e-mail or one of our individual e-mails, it will come from the meeting department, so please make sure that there's nothing in your spam and you are getting that travel information (inaudible)

Bruce Bagley: Yes, this is Bruce. Although we're going to cover it in detail in the November thirteenth Web meeting I want to try to put everybody on notice about the consent calendar process. Some of you have used it in the past, either on the MAP or other organizations, but the idea is when you have a large number of items that we would probably want to consider all of those items together unless somebody on the committee has a concern. The idea is that you have to be prepared to pull something off the consent calendar so it can be discussed. If you don't go through the measures before the meeting and know which you have concerns about you can't really – might not have an opportunity to pull it out for discussion.

I just wanted to get everybody in the right mindset about that. Does anybody have any questions about that?

Reva Winkler: Not directly related to that but in regards to November all-MAP meeting we had a comment come in through the chat from (Jerry Adam), and he (inaudible) asked if the November meeting would be recorded and posted, and yes. This meeting and the November meeting and all the other Web meetings that will be happening in person we will provide a recording and a transcript. That's available for use for anyone who can't attend either meeting.

Were there any other questions on that? Yes, go ahead.

Eric Whitacre: This is Eric. I just had a comment about the consent calendar. I think it worked very well at the last meeting and adhering to the rules of the process will be very important and really create efficiencies and let us focus the discussion.

Reva Winkler: Thank you so much for that. Were there any additional comments? And again we will go into more detail about this in the November meeting and we'll go over it again in the in-person meeting. So we want everyone to be as prepared as possible.

All right, then, just some additional logistics. The SharePoint site is up and updated. We really prefer that Workgroup members use the SharePoint site to get whatever content they would need. We have a new product for you.

It's the MAP member guidebook, so for you that have been involved in the (inaudible) process, we've had a guidebook for our standing committees for a couple of years now, and we've also developed one for the MAP Workgroups now. All the new information about consent calendars, voting, the process, everything involved we have put in those guidebooks, so we do really recommend that you look through those and get yourself familiarized with the process.

Again we advise you to go to SharePoint, get that guidebook, if you're having difficulty getting into SharePoint or for some reason you did not – you do not have access at this point please let us know, you can e-mail the team at

mapclinicianqualityforum.org. Along those lines, with the in-person meeting we do plan to host a dinner in between the – so on December ninth we will be hosting a dinner in between the two days and we wanted to give you a heads up in case you wanted to attend that.

More information along with the travel information will ask if you would like to attend that dinner as well.

With that said, were there any questions at this time about next steps?

That's what we have for staff. I just wanted to ask Bruce and Eric if they had any additional comments they wanted to make before we closed.

Bruce Bagley: No, just to thank everybody for your time this morning.

Eric Whitacre: I would echo that. Thank you all.

Male: Thanks everyone. And don't hesitate to reach out to NQF staff if you do have any follow-up questions or concerns or clarifications. We'd be happy to help you out.

Hope everybody has a good afternoon.

Male: Thank you.

Operator: This concludes our meeting today. You may now disconnect.

END