NATIONAL QUALITY FORUM

Moderator: Poonam Bal
October 17, 2016
3:00 p.m. ET

Operator: This is Conference #98649785.

Operator: Welcome, everyone. The Webcast is about to begin. Please note today's call is being recorded. Please stand by.

Poonam Bal: All right. Welcome everyone to the Measure Applications Partners Clinician Workgroup Web meeting. Welcome back to everyone that's rejoining the workgroup and welcome to all our new members. So we wanted to start out with just going over the agenda real quick. As we're going to do introductions and reviews and meeting objectives, we'll go quickly over MAP pre-rulemaking approach. We'll review the current clinician programs, we'll open up for public comment, and then we'll give you a little detail about to expect for the next -- rest of the year.

So starting out, we'll start with introductions of the clinician team. So this is Poonam Bal speaking to you right now. And we have a new senior director on the project, John Bernot. Many of you may have worked with Reva Winkler. She was the director for the past two years on MAP Clinician. Unfortunately, she passed away last month so we are going to greatly miss her and hope that she's looking down at us and is pleased with the work we've done so far.

But we want to thank John for joining the team. So with that, I'll give it to him to do roll call for our clinician workgroup.

John Bernot: Hello, everyone. Thanks for having me here but what I'll do is I'll just go down the list and just give us a yes if you're here. We'll start with the chairs. Bruce Bagley?

Bruce Bagley: I'm on. Thank you.

John Bernot: Amy Moyer?

Amy Moyer: I'm here. Thank you.

John Bernot: Scott Friedman? No Scott. All right. And...

(Multiple Speakers)

Scott Friedman: Here. Here.

John Bernot: Oh, here. Oh, great. Thank you, Scott. If I mispronounce anyone's name, please, just correct me and we will -- we'll get it right from there. Is it Terry Adirim? All right. Diane Padden? Paul Casale?

Paul Casale: Yes, I'm here.

John Bernot: Great. David Seidenwurm?

David Seidenwurm: Here.

John Bernot: All right. Stephen Friedhoff. All right. (Jennifer Lawsky)?

(Jennifer Lawsky): Good afternoon. I'm here.

John Bernot: Scott Furney. All right. Robert Krughoff.

Robert Krughoff: I'm here.

John Bernot: All right. (Norman Kahn).

(Norman Kahn): Yes, I'm here.

John Bernot: Great. Thank you. Beth Averbeck.

Beth Averbeck: Here.

John Bernot: James Pacala. All right. Stephanie Glier.

Stephanie Glier: It's Glier. I'm here. Thanks.

John Bernot: Glier. Thank you. Appreciate it. Marci Nielsen. Winfred Wu.

Winfred Wu: Here.

John Bernot: (Addie Wall).

(Addie Wall): Here.

John Bernot: Dale Shaller.

Dale Shaller: Here.

John Bernot: Michael Hasset.

Michael Hasset: Here.

John Bernot: Eric Whitacre.

Eric Whitacre: Here.

John Bernot: And Leslie Zun. OK. Peter Briss.

Peter Briss: Here.

John Bernot: Pierre Yong. All right. (Gary Malimou).

(Gary Malimou): Here.

John Bernot: All right. And last but not least, Clarke Ross.

Clarke Ross: Hello. Yes, I'm here.

John Bernot: All right. OK. And thank you everybody for going through that. Just -- we just want to see who's here on the call today and we'll all have a chance -- I look forward to meeting everyone whenever we have our in-person meeting but at least we'll know who's on the call today in case someone doesn't have access to the screen to see the list.

So at this point, I'm going to turn it over to Poonam. She's going to go over the structure of the meeting and then -- and what to expect from this call. And then going forward.

Poonam Bal: So our meeting objective is really to give you an idea of what to expect for 2016-2017 pre-rulemaking. To also update you on the Clinician Workgroup program, you know, it's always informative for people have -- that have been on and those that are new to learn about what's new with these programs. And then we'll provide some input on the potential measure gaps and we'll talk about that.

So with that, I'll give it back to John to talk about gaps.

John Bernot: All right. And one of the things we're going to do is just take a very slight detour for just two or three minutes and the reason for this is to talk about some of the measure gaps. This came up at the MAP's Coordinating Committee and so I thought it was worth bringing up. The important thing is it -- we're not trying to make any changes and they're not trying to change the direction of this group and make them more concerned about gaps than they were in the past. But instead, we're really trying to add some structure around it so that as each different committee reports gaps back, we, as an

organization, can really find a way to categorize these and have them at the same level of granularity.

So this is the current process. Again, nothing's changing. It's listed up there but the important things as we talk about gaps -- and I wanted to put it early so that it -- in terms of the -- a backdrop, as you're thinking about things today at the meeting, in between now, and even at our in-person meeting that we're thinking about it the same way. And, again, what that currently is just considering the individual program goals and objectives for the gaps is really what we're trying to do. So not the entire universe -- oh, was that a question? Sorry. Oh, sorry. But...

Poonam Bal: If you are on the line, please make sure you mute yourselves while we -- thank you.

John Bernot: All right. Thank you very much. But -- so what it is we're trying to say is when you're determining a gap, we're really trying to make sure we are looking at the program itself. And, again, not the universe of measures. There may be very well things that are gaps in measurement but it doesn't fit for our program that the Clinician Workgroup is talking about. And we'll do that -- we are going to review this -- the identified areas, the priority areas from CMS. And then the group, together, will consider if there's any current gap areas that need to have refinement. Again, none of this has changed. We're just trying to add some structure to it.

Also, consider -- the CMS identified measure gaps and when we recommend these refinements, they really should be something that the majority of the group is in support of as identifying this as a gap. All right. And here's where things -- we've tried to add some structure and granularity to it. And we put together just a gap definition and the short of it is, it's the lack of measurement in a particular area that has a quality problem and then also is likely to benefit from a measure in that area. And we're trying to think if we can go through these questions, we'll end up probably with something that's similar and the issue we've had is our gaps could come in from -- the example we've used is

end of life care where we may have a gap but it's not something that's actionable.

So we're trying to figure out, what is the quality problem here and how does this measure that we identify fill this gap? Who's the entity, what's the population? What aspect of care? And what type of measures? So in the back of your mind as you're thinking, "Hey, I think this is something that's a gap," that level of granularity will help us compare across the different workgroups.

OK. And now -- sorry for the detour on that but hopefully that will be a backdrop until we talk about over the upcoming weeks and months. And I'll it back over to Poonam now and she'll go over the timeline at this point in the pre-rulemaking approach.

Poonam Bal: So the MAP pre-rulemaking approach. So this is kind of -- gives you an introduction of how recommendations will be made. The MAP Coordinating Committee exam specific issues during December 21st -- sorry, 27th meeting. So a lot of that feedback we have taken, we've included some of the gap information here. We'll be having another meeting next month that's for all MAP members. I will go into more detail about what was the effects of their discussion and how will that effect the way that you look at measures in this cycle of pre-rulemaking.

Today -- during today's meeting, we'll help you get you familiar with the finalized program measure sets, identify gaps in the current measure sets, and we'll go into that -- we've already started mentioning, you know, kind of the (steps needed) for that.

After that, the MAP workgroup will evaluate measures under consideration their December in-person meeting. That is December 12th and 13th, it's a Monday, Tuesday. If you have not, you'll be receiving information very soon about hotels and airfare so be on the lookout from that. It'll be coming from a Meetings Department, not from the MAP Clinician inbox. And during that, we'll go over all the measures that have come in through the MUC or the

measures under consideration. And then once the workgroup has made their initial recommendations on those measures, they'll go to the Coordinating Committee on January 24th and 25th during their in-person and that's when they will be considered final.

So this is a much broader timeline. As you can see, we're already in the October-November timeframe. So we generally expect to receive the list of measures under consideration by December 1st. Sometimes we do get it sooner than that. However, December 1st is the drop-dead deadline so it will not get in any later than that.

We will do a initial public commenting period. This will really depend on when we receive the MUC list. If we get it earlier, we'll do it in November. If we get it later, we'll do it in early December. After that, we'll have the December in-person meeting which I mentioned Clinician will be one of the first to go. And after that, we'll have another public comment period late December, early January on the recommendations by not just this workgroup but the other two workgroups that are reviewing measures, hospital and PAC/LTC.

Those recommendations and comments will be shared with the Coordinating Committee in late January. They'll finalize the MAP input and then we will have a spreadsheet of final deliverables sent out February 1st. And then the Clinician written portion of our deliverable will go out before March 15th. So that's the kind of timeline of what we're going to do. So for the Clinician Workgroup, we generally review measures for three programs, the Medicare Shared Savings Program or MSSP, the Merit-based Incentive Payment System or known as MIPS, and Physician Compare. And we'll go into a little more detail about that.

For this -- last year, we did do a great deal of work for Physician Compare where we looked at the measures that were currently in the PQRS program and seeing if those should recommended to be included on the Web site or in the spreadsheet. We do not anticipate doing that this year since it's now -- and we'll provide more detail about this in the in-person. But whatever will be

considered in the MIPS will also be included in Physician Compare. So we will not be taking as large of an active role on that this year but we obviously still have input as we review measures for MSSP and MIPS.

So for -- again, the goal of today's meeting is to really review the structure of each program and the measures that have been finalized for that program. You -- along with the agenda, we sent out an Excel spreadsheet that had the MSSP framework and the MIPS framework. We'll go over that in a little bit about exactly how to use that document for your review. I think I've already said all this so I'll move on.

And so with that, I will give it to John to go over MSSP.

John Bernot: All right. Thanks, Poonam. So just (indiscernible) we have a lot of data coming to you. It's really a data dump today. And I have since learned that a lot of this is just things that we can avoid doing in person, not wasting our in-person time. So we will be giving -- pushing forward a lot of information. I know there are some new members of this workgroup and if there's any questions about anything, whether it'd be just clarification or content, please let me know. The intent here is to give a very high level overview of these programs, not really getting way down into the details.

However, we will have representatives. The government leads on these programs available at the in-person meeting. And certainly on the MIPS side of things, we will likely have a small presentation that goes over some of the details from the lead, too. OK? For the -- for the MSSP, we'll take this one first. It's the -- one of the smaller number of measures and also it is one that has not changed that much over the last year. So this is a program came -- it was authorized by the Affordable Care Act and this is the one that is in participation by the ACOs, the Accountable Care Organization.

There's incentives created for these providers to work together and coordinate the care with high quality for the patient population. The program does have the ACO submit the application to the shared savings program and then do a three-year agreement with CMS. And I won't read all of the information on

the slide. I think this is something you probably are familiar but I want to take time at the bottom of the slide just to say the types of measures that are specified are the clinical process and outcomes, patient where practicable -- and where practicable, caregiver experience of care, and the utilization, and those are what we're looking for at the types of measures in this program.

So each year, CMS has their -- the needs and priorities. And for this program, we'll highlight them here. The outcome measures are a priority, especially ones that address the high class, high volume Medicare patient outcome measures.

Again, we're going to see a theme here targeting the needs and gaps for the -- and for the Medicare fee-for-service patients and their caregivers. The gaps is going to be a big thing we're seeing throughout all the programs. And what we're looking for -- what -- I should say what CMS is looking for is measures that align with other initiatives.

So it's not reinventing the wheel specifically with MIPS as this group will look at both of these programs. We're looking measures that support individual -- improve individual and population health and, again, on the alignment side, recommendations from the core quality measures collaborative.

So, again, I mentioned this is the smaller of the program in terms of number of measures and you can see here that we're under -- 10 or under for all four of the domains that were specified by the ACA in these categories.

And Poonam will -- I'll turn it over to her. She'll walk through the spreadsheet and how that's -- can be used when you're looking through and trying to look up the measures and identify any areas for improvement in the program.

Poonam Bal: All right. Thank you. I'll get that on the screen really quickly. Give me one moment. All right. So you should be seeing on the screen an Excel sheet. This is the Excel sheet that we included in invite and in the e-mail that we sent

out. And so you'll see that for the MSSP program, we've done it by program quality domain so it'll be broken down by those things. We have added -- this will look different for people that have been on the workgroup previously. We did send out frameworks last year. We've refined those a little bit. They're -- you'll probably find a little more information about, you know, a group number, a measure title description, numerator, dominator exclusions and so on.

And so this should give you a better idea of what are the details behind these measures that are in the program and then also what program domain they go into. And I'll go into more detail about the MIPS framework after we speak about the program.

John Bernot: And again, if there's any questions about any of this, hopefully it's straightforward but by all means if anything comes up, please let us know. And what we're looking for and this would be an opportunity if there are thoughts from the workgroup at this point -- if the group has any suggestions already, people who have been on the group in the past for refinement to the high priority domain, we're welcome to take some time and talk about that. We'll have more than enough time on the call today, so if there are any comments or discussion, we can take that now.

Poonam Bal: Or even questions about the program or the pre-rulemaking process that we've spoken about so far.

Bruce Bagley: This is Bruce Bagley. If anybody, especially those of you who went through this process with us last year, have any suggestions that might make it more usable for you. I realize it's a lot of information and what the staff has done is to really put it into a format that makes it easy to navigate. So if anybody has suggestions, please let us know. Either now or by e-mail.

John Bernot: Thank you, Bruce. OK. Well, if there's no further questions, that's OK -- or discussion. We can take that at any point. So do -- please speak up if you think of anything or as he said, even after the meeting, we definitely want any feedback how we can make these processes as smooth as possible for the

workgroup. So the larger of the programs in terms of measures and probably in terms of complexity and certainly newness is the Merit-based Incentive Payment System which is known as MIPS. Do have an asterisk that it's subject to the update based on the final rule.

The final rule was out late last week so we are -- the information here though high level is based on the proposed rule. We didn't think we could do it justice to get everything done over the weekend and have it completely updated for this presentation. Again, most of this stuff is on the higher level so feel pretty comfortable about the information here. Again, for those who are new or those who just want a little refresher, so what is MIPS? It's this -- the Merit-based Incentive Payment System. And this came out of the MACRA. So the other -- the MSSP came from the ACA. This came from MACRA law in 2015.

And it is a -- the rule that sunset the PQRS, the value-based purchasing, the EHR incentive. And it sunset them but superseded. And I don't want to say necessarily took the place of one-to-one but incorporated the items from those programs. So that will sunset in 2018 and the MIPS program begins in the 2019 and, again, it consolidates all of those.

What this does it sets up a payment adjustment based on performance. And so the payment will -- can go based on their overall performance broken down into four categories. It's 30 percent of quality, 30 percent of resource use, i.e., efficiency, and then 15 percent about clinical practice improvement activities and 25 percent of the meaningful use certified EHR technology. So you can see that that is -- that's just pulling in the PRQRS, the value-based, and the EHR programs and adding some structure to them.

And additionally, it will use a lot of the existing measures. And that's -- so what you'll see here even though this is new program, the measures here are existing from the PQRS and the programs that have been reviewed in the past. So, again, what the high priority domains for measure consideration are on this program, the priorities that came out, outcome measures are something that was definitely on the list of priorities. The other ones are -- measures that

are relevant for specialty providers and that came out -- and it's something that -- not just measures for specialty providers but when we're thinking about the measures that are, again, can give clear indication of performance in that specialty.

Trying to stay away -- trying to address a gap and also stay away from a measure that doesn't have a lot of variation or is unlikely to show improvement in that specialty. And then the high priority domain, again, the person- or patient caregiver-centered experience that the (proms) measure that highlight communication, care coordination, appropriate use, and patient safety. So these are the areas that the MIPS program is considering to be high priority.

(Jennifer Lawsky): Can I ask a question on that slide?

John Bernot: Sure.

(Jennifer Lawsky): All right. This is (Jennifer Lawsky). So when you say -- if you can -- great. So when you say that these are high priority domains, defined by whom or what criteria?

John Bernot: Sure. So -- this also brings up a brief side. The wording is -- like there's domains and National Quality Strategy Domains. And then these wording came here from a publication from CMS that outlines their priorities for each program. So a document from CMS that came out in April of 2016 and that was identified on that document. So it came from CMS, not from the NQF.

(Jennifer Lawsky): OK. That's what I was looking to distinguish. So this is a CMS high priority domains not to be confused or potentially overlapping with NQF high priority?

John Bernot: Exactly. And I -- we actually even debated about changing the words but because it was the word used in that priority sheet, I didn't want to change them but exactly. So not to be confused with the National Quality Strategy

Domain. This was just the high priority areas that was CMS-listed. Any other questions or clarifications on that? OK. Thanks for your question.

And then also -- again, from the same document, the measure -- the measure requirement. So what are the -- what types of measure, where to look, where the areas of care but what specifically are they looking for in a measure. Preference given to anything, it would be an eMeasure, these electronic clinical quality measures. Preference to measures that are fully developed, fully tested, have data behind them. And I think that's a -- it's a big theme for CMS on this is really have things that are vetted going forward. Not duplicative in other measure sets. Another issue that's seen in the programs as well as just in -- all of the measure development is really being careful to make sure that we avoid measures that are similar or overlapping and that there's not something else out there that would already take the place of a measure here.

And lastly, and this is an area that I think is quite important is a measure that actually has an opportunity for improvement and by that, something that they would have to have some variation. If everybody's had the same, it's probably not a great measure. Or measures that are topped out at a very high percentage that no matter where we measure these, they're getting a very high percentage all the time. Those are the measures that not only should we look to avoid putting in but we should be looking to make sure that they're retired or removed going forward or at least giving recommendations again for some of these things.

But certainly as new measure development comes out, we want to make sure that we're not putting something in that looks like it's just going to end up being a topped out measure and have to be removed.

As I mentioned, the -- the current measures which we did breakdown by the NQS Measure Domain. So the six National Quality Strategy Domains and these are -- also, you can sort the spreadsheet by this and you'll see, again, a much larger number of measures overall and certainly some lopsidedness into where they are in the effective clinical care by far trumping the measures and

if -- I would assume by no coincidence, the person- and caregiver-centered experience outcomes is a priority and there's many fewer measures in that particular domain.

So the spreadsheet on here, again, Poonam will go over with this one but I just wanted to point out a couple caveats on this one that we still need to update this based on the -- the rule that came out late last week. That will be done shortly. And it's (sort-able) by a measure type that (queue estimate) we mentioned. But also a topic area. This is something that Reva Winkler started in the past and a topic area is just a way for us as a group to look at these measures.

And again, we'll take suggestions going forward if this is not an easy way to look at things but the topic area could be cross-cutting area, it could be condition-specific or it could even be specialty specific. So I want to let you know there's not one particular thing in that topic area though when you -- when you take a look at the spreadsheet, I do think you'll find it -- I hope you'll find it easy to use but we'll take suggestions going forward if there's -- if there's better way to display the data.

I'll turn it over to Poonam. She can go over the spreadsheet again.

Poonam Bal: OK. So, again, the same -- it's one spreadsheet but different tabs so if you go to the MIPS framework tab, you'll see, as John just mentioned, this is the different topic areas. You can filter by really any domain that you want including type and NQF endorsement and setting and so on. For -- because this is a much larger list, it probably will -- you know, in order to really review it, you'll need to narrow it down in that form. You'll notice that we have some measures in here that are in red and crossed out. They were slated to be removed in the proposed rule, so that's what that means.

And then you also see, if you go all the way to the bottom, measures that are just in red. This is a long list, probably should have filtered. Here we go. So you'll also see we have measures here as well that are in red indicating that these are supposed to be added to the MIPS program. So that's the basic

breakdown of how to use it, you know, you can filter in any way that you see fit, measure number, ID, NQS ID, so on. All by measure title and that is how to use that framework.

Stephanie Glier: Poonam, this is Stephanie. I just wanted to clarify that. So when we're looking at the spreadsheet, the measures at the very bottom that are in red were proposed to be included in the MIPS program. In this year's proposed rule, many of them were finalized in the final rule but we're actually not going to be recommending up or down on these measures during this cycle. Is that correct?

Poonam Bal: That is correct. They are -- yes. So they were already in -- many of them we reviewed last year and so they are already in the works for being included in the program. Any other questions?

John Bernot: All right. There is just a -- one more side on the gaps. And this is just for those who were here in the past, these were gaps that were identified in MSSP and MIPS from previous -- mainly from last year I believe. So just to point that out and, again, they were at a higher level. We're trying to get that down a bit but the patient-centered measures, for sure, appropriate use and team-based care was something that the group had said overall, this is -- this is some area that we found as gaps last year. And, again, just for a historical perspective and hopefully it gives us something to go forward with.

So, again, I know the MIPS is a bigger program and not everyone has even had a chance to look at the spreadsheet likely because it is so large but, again, if there's any particular discussion or suggestions right off the bat or questions about anything we've talked about so far, we did want to take the opportunity to open up the phones for any discussion, questions, comments about the MIPS and maybe even future refinements for the high priority areas.

Bruce Bagley: Yes, this is Bruce again. Just to point out. Even though we don't have the detail on the final rule ready to present today, the chances of there being remarkable changes in the measure set are pretty slim. I think that most of the

changes will be around how the program is rolled out, the timeline, some of the requirements, but the measure sets are likely to be very similar.

Poonam Bal: And thank you, Bruce. And with that said, we will have a presentation during the in-person meeting from the MIPS liaison who will really go into detail about -- more about the program and what to expect so everyone can have a better understanding of the new path for this programs since it's relatively new, I'm sure many people have questions about it.

Beth Averbeck: So this is Beth Averbeck. I guess one question would be and just based on some previous series of experiences. People have questions before the in-person meeting on a measure has been NQF-endorsed, some clarifications, specifications, or exclusions. Is there a contact person that we could contact before the meeting to get those questions answered prior?

Poonam Bal: Yes. So you can definitely e-mail me at my personal e-mail, which is pbal@qualityforum or you can e-mail the main Clinician inbox which is just mapclinician@qualityforum.org. So either or it's better -- probably better to do the team inbox so we can keep it all together and we're always ready to answer any questions or clarify anything.

Beth Averbeck: OK. Great. Thank you.

John Bernot: Yes, and thanks, Beth. And I'll also be on the team inbox. It's -- and if between the two of us, we cannot get the answer, we will do the leg work to find the person in the NQF who can help out with that and get back to you so you're not searching around looking for that.

Beth Averbeck: OK. Great. And the team, could that e-mail be sent out again or is it in one of the e-mails we received already?

Poonam Bal: Yes, so the meeting invite for this came from that e-mail and then the e-mail that was sent out today with information also came from the e-mail.

Beth Averbeck: All right. Thank you.

John Bernot: You're welcome. Any other thoughts, comments?

Clarke Ross: Hi, John. This is Clarke Ross. I'm the new liaison from the workgroup on persons dually eligible for Medicare and Medicaid. And just to share a challenge on the duals workgroup approach and the filter that I'll be using at the in-person meeting. So much of our focus on people who are severely disabled and dually eligible for Medicare and Medicaid are on the non-medical community services supports and resources that they depend upon daily in order to function in the community and in their home. And trying to crosswalk that with more medical and clinical measures.

So that's just the -- my introduction to the filters that I'll be using in trying to think through the application of medical-clinical measures in a Clinician Workgroup to the community inclusion and retention focus of the duals workgroup.

Poonam Bal: Perfect. Thank you so much for that, Clarke. Actually, that's a great segue. We -- when we're doing the roll call, we didn't provide details about what the different roles were. So with the -- if the organizational seats, those are -- the owners are really the organizations and there's representatives from those organizations on the workgroup but they are able to send substitutes or have different representatives each year as they see fit and they're really coming as their organization into our work. And so that's the organizational seats that you'll -- and then you'll notice on the slides and we will post these after this meeting, there's asterisks next to the organizations that are new to the -- to the workgroup this year.

And then also, our service matter experts -- and so the organizational seats have voting and so does subject matter experts. These individuals are not representing any organization. They're representing themselves and the knowledge that they bring to the workgroup. And so they should be, you know, only should be speaking on behalf of themselves and not an organization. And then we also have federal government members. These are representatives from different agencies within the government. They do not

have a -- they do not vote during the in-person meeting on the measures but they, you know, do bring in viewpoints from federal government that we may not have otherwise.

And then, as Clarke just introduced himself, we have a representative duals workgroup, also non-voting but they do, again, have the opportunity bring their special point of view in that we may not have otherwise. So thank you for that, Clarke, you know, for bringing your point of view forward and for giving us the chance to explain that to the group.

John Bernot: Yes, and then, again, as the clinician committee, it is -- there is certainly -- physician-heavy but we absolutely -- we -- you know, what -- we need the perspective of folks like yourself, Clarke, and there's a lot of other members on the committee, physician or otherwise, who we hope bring a great background and perspective and we can put this altogether to conform our final recommendations. So thank you again.

Any other questions, thoughts? Again, we have -- we put these couple of questions -- the first question out, but it can be about anything or just questions about the process in general. If anybody has anything, feel free to speak up. OK. And that's fine. And then...

Male: Poonam, just a quick question. Do you have any information whether any topped out measure is included in the list? In the list which you sent us, is there any measure which is, you know, as you suggested before, you know, topped out?

Poonam Bal: So the measures that are considered topped out by CMS have been sanctioned to be removed. So the ones that are currently in the program would be our assumption that they're not considered topped out by CMS, but I will see if (Sofia)'s on the line because this is really based on the proposed rule. Are there any measures that remain that are not slated to be removed?

(Sofia): Hi. This is (Sofia). Hi, Poonam. So what we try to do prior -- as Poonam stated, was remove those measures that we definitely considered topped out.

You will notice that if -- as you go through the list, especially for the quality payment program, that we included a set of measures so -- and that is in particular the surgical set. You'll notice there are about 12 measures in that set. So that can be reviewed as a complete set. That would probably help you instead of you individually so -- but generally our process is that if the measure has any indication of not identifying a performance gap or what we consider topped out, we don't include it in the list. So everything should be removed that is topped out.

Poonam Bal: Thank you, (Sofia).

(Sofia): You're welcome.

Poonam Bal: Were there any additional questions? OK.

OK. So there was one question that came in during the -- through the note section. It was, MIPS measure requirement, is there a difference between requirement and preference and which is the (case)? So the question is about requirement and preference.

(Sofia), did you want to answer that? What -- is there a difference between requirement and preference for MIPS based on what was written in the rule?

(Sofia): I guess I need a little bit more clarification on the question.

Poonam Bal: The question came in from (Gretchen Wartman). Are you on the line, (Gretchen)?

(Gretchen Wartman): I am. Can you hear me?

(Sofia): Hi, (Gretchen).

Poonam Bal: Yes.

(Gretchen Wartman): Hi. How are you? There was simply a difference -- I think the slide's -- the language on the slide was requirement but the language that the presenter used was preference. And those are simply two different things to me. They're related but they're two different things and I was wondering which is actually the case.

(Sofia): In reference to -- because...

(Gretchen Wartman): In reference to one of the priorities for MIPS measures.

(Sofia): OK. So in reference to priorities, it is a preference. It's not required that it only be those priority areas. So I think that is a clarification. You're right, requirement is slightly different from preference but in reference to the priorities, it would be preference.

(Gretchen Wartman): Thank you.

(Sofia): You're welcome.

John Bernot: Thank you.

Poonam Bal: All right. So that was actually a public comment so we can just jump to the public commentary.

Operator, if you could open the lines, see if there's any public comments please.

Operator: Certainly. At this time, if you would like to make a public comment, please press star one on your telephone keypad.

And there's no public comments at this time.

Poonam Bal: OK. Perfect. And we did get a comment on the chat from (Deb Barr) just asking if the Excel will be made available to the public and yes, it will. We'll be posting it on our Web site so it will be available for everyone. (Inaudible)

wanted to update it based on the final rule before we posted. So once that update's made, we will have it on the Web site and available to the public.

So with that said, we can just close up with next steps. So this is just the same diagram. So from now until the in-person, we're really -- we'll basically be -- you should be receiving information about travel very shortly.

Again, that will come from our Meetings Department and not from the Clinician inbox so please keep a lookout for that. We will update the Excel based on the final rule. We will send that out to the committee and -- I'm sorry, the workgroup and then also post it on the Web site. We'll post these slides and a recording of this meeting also on the Web site for everyone to use. So in case you did miss a portion or have any additional questions, you can go after that. And then once the MUC is available in public, we can go ahead and we will send out documents. So in the past we have sent out discussion guides which details (staffs) analysis and information on those measures and how we'll be reviewing them.

The breakdown of how we review measures we'll really be during All MAP meeting next month so we really encourage everyone to attend. It will provide a great deal of information on what to look for on employee analysis, what to look for the discussion guide, and how to really review measures on the MUC list. So we encourage everyone to attend, if they can, that meeting. You should have it on your inbox. If you -- if you do not already, go ahead and e-mail us at MAP Clinician and we'll forward it to you. The exact date is November 16th.

So after that, we -- when we have the information, as we said, we'll open up for public comment, send out the documents to the workgroup, and then we'll have the in-person December 12th and 13th. And that's really the next steps for this project.

Are there any -- is there anything else -- any questions about next steps and what to expect moving forward?

John Bernot: You know, one thing just from our perspective, please -- we are certainly here to help. If there's any questions, it doesn't matter what it is about the process to -- you can get to the MAP Clinician e-mail, send it, and Poonam or I will work on it for you and -- so you don't feel like you have to wait until the next meeting to get questions answered if there's anything that we can walk you through.

And otherwise, Bruce or Amy, I don't want to put on the spot, but is there any other information you wanted to, as the co-chairs, to disseminate to the group?

Bruce Bagley: Well, this is Bruce. Just thanks everyone for their participation today.

As you will remember, those of you who have been on the committee, that the workload is pretty light until near the end and then it gets very heavy in a very short time. So it's probably best to familiarize yourself with some of the tools so that when you do have to really dig in and look at the measures one at a time that you're facile with the spreadsheet.

Poonam Bal: That's a great point, Bruce. Thank you.

Amy Moyer: This is Amy. I'm just looking forward to working with everyone and seeing what being a co-chair is like.

Poonam Bal: Thank you, Amy. We're glad to have you as a co-chair and we're looking forward to working with you this year.

Amy Moyer: Thank you.

John Bernot: Any further questions or comments? Looks like we might be able to get everyone an extra hour of their day back. But, thank you so much for attending and taking your time, we really appreciate it.

Bruce Bagley: Thank you both.

Male: Thank you.

Male: Thank you.

END