NATIONAL QUALITY FORUM

Moderator: Benita Kornegay-Henry
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Kate Buchanan: Hello, this is NQF. Thank you for joining the call. We will begin in just another minute or two. Thank you so much.

Woman: Hello.

Kate Buchanan: Hi, yes, this is NQF. We will begin in just another minute. Thank you.

Hi, all, this is Kate Buchanan with NQF. Thank you so much for joining the call. Before I turn it over to my colleague, I do want to ask everyone to mute themselves if they are not currently speaking. To mute your line is star 6, to unmute is star 7. Once again, to mute your line is star 6 and unmute is star 7. I will now turn it over to my colleague, Sam.

Samuel Stolpe: Hello and welcome, everyone. This is Sam Stolpe. I'm a senior director here at National Quality Forum, and you have joined the Measure Application Partnership Clinician Workgroup Orientation Web Meeting.

This is our first meeting of the 2019-2020 review cycle, and I'm delighted to welcome each of you, both our returning members of the committee, as well

as the new faces verbatimly (sic) speaking that are around the table. Thank you for your willingness to engage with NQF for this important portion of our work.

Let's go ahead and jump into our slides, but before I do, I wanted to also welcome our co-chairs, Bruce and Rob. I wanted to double-check, are you gentlemen on the line?

Bruce Bagley: Sam, Bruce is here.

Samuel Stolpe: Very good. Did we have Rob join as well, or perhaps Dr. Fields will be joining us in momentarily. Dr. Bagley, we want to thank you once again and I'll turn it over to you to review our agenda.

Bruce Bagley: Well, thank you, Sam. Yes, and just a reminder, any of you who are not speaking, please put your phone on mute. There were some amount of echo before and it makes it very difficult to tell what's going on.

Well, first of all, I'm Bruce Bagley and I've been the co-chair for the last couple of years of the clinician workgroup and I'd like to welcome all of you, both the clinician workgroup members and staff, and to thank you in advance for your willingness to engage and contribute to this important work.

We know that many of you on the phone have been through this process before and today will be for our review and update for you. But for those of you who are new to the process, it may seem a little bit overwhelming. So today is designed to kind of get us all in the same page with the same vocabulary and the same understanding of the process.

So I think it will go along well and certainly if you have any questions, I want you to speak up, either raise your hand on the webinar or just break in and we'll get the questions answered.

So welcome to all, looking forward to our meeting face-to-face in December. Sam?

Samuel Stolpe: Thanks very much. Participants, a brief glance through our agenda, you'll note that after we finish our welcome, we'll be handing it over to our colleagues at CMS to offer a few opening remarks.

Then we're going to really jump into what Bruce just alluded to which is an orientation to MAP's pre-rulemaking approach. We'll overview the programs that are under consideration which we have three this cycle, one more in addition to the two that we usually cover. So we're really excited to have the Medicare Part C and D Star Ratings as part of our purview during this cycle.

Then, well, trying not to steal too much of CMS' thunder in the overview, our colleagues will give a detailed presentation of each one of the quality programs that we'll be examining during this cycle. That's really the summation of our - what we're looking to orient the group to. Then we'll open it up for public comments and next steps.

Just to note of who our team consists of, I mentioned myself, Samuel Stolpe, senior director here. We also have Kate Buchanan whom you've heard just a moment ago, as a senior project manager, and also Jordan Hirsch who's sitting with us here, as the project analyst.

Jordan is going to be doing a roll call here and I'll hand it over to him.

Jordan Hirsch: Thank you, Sam. Good afternoon, everyone. I will be reading through the organization member name as you see on the screen and if you are the representative, please state that you're here and provide a brief introduction.

Now, I'll start again with our co-chairs, Bruce Bagley who we know is on the line and has Dr. Fields joined? Okay, into the workgroup organization, The Alliance?

Ryan Peterson: Yes, this is Ryan Peterson representing The Alliance. I'm a developer and analyst here, and I'm manager of our Analytics. We are a cooperative of self-funded employers in the Midwest.

Jordan Hirsch: Thank you. The American Academy of Family Physicians?

Sandra Pogones: Yes, hi, this is Sandy Pogones representing The American Academy of Family Physicians. I am sitting in for Dr. Amy Mullins.

Jordan Hirsch: Thank you. The American Academy of Pediatrics? All right, the American Association of Nurse Practitioners?

Diane Padden: Hi, this is Diane Padden, I'm the representative. I'm the vice president of Professional Practice and Partnerships. However, I will not be in attendance and our past president Joyce Knestrick will be representing on the day of the meeting.

Jordan Hirsch: Thank you very much. The American College of Cardiology? The American College of Radiology? The American Occupational Therapy Association?

Trudy Mallinson: Hi, this is Trudy Mallinson. I'm representing the American Occupational Therapy Association.

Jordan Hirsch: Thank you. America's Physician Groups? Anthem?

Kevin Bowman: Hi, this is Kevin Bowman.

Jordan Hirsch: Thank you. Atrium Health?

Scott Furney: Hi, this is Scott Furney. I'm an internist at Carolinas Medical Center. So we're a large not-for-profit healthcare system in the Southeast. I'm basically here helping my new quality co-chair transition on this year. Dr. Traci Vaden will be taking my place from now on with the committee.

Jordan Hirsch: Thank you very much. Consumers' Checkbook and the Center for the Study of Services?

Robert Krughoff: Yes, this is Robert Krughoff with Consumers' Checkbook and the Center for the Study of Services.

Jordan Hirsch: Thank you. The Council of Medical Specialty Societies? Genentech?

Donald Nichols: Hi, this is Donald Nichols, I'm a principal in the Health Systems and Policy Research team at Genentech which is a biotech company.

Jordan Hirsch: Thank you very much. HealthPartners, Inc.?

Kim Ritten: Hi, this is Kim Ritten. I'm sitting in for Sue Knudson today. She's the senior VP of Healthcare Engagement and Informatics at HealthPartners. HealthPartners is a consumer-governed, non-profit healthcare delivery and financing in the upside west.

Jordan Hirsch: Thank you. Kaiser Permanente? Louise Batz Patient Safety Foundation?

Carol Wratten: This is Dr. Carol Wratten. I'm the clinical director for the Louise Batz Patient Safety Foundation.

Jordan Hirsch: Thank you. Magellan Health, Inc.? Pacific Business Group on Health? Patient-Centered Primary Care Collaborative? Patient Safety Action Network? St. Louis Area Business Health Coalition? And if anyone who has joined since I read your name, please announce yourself if you're here.

Fareen Pourhamidi: Hi, good afternoon. This is Fareen Pourhamidi. I am representing Cardiology on behalf of Dr. Teeters.

Jordan Hirsch: Thank you very much. Moving on to the individual subject matter experts, Nishant Anand? William Fleischman? Stephanie Fry?

Stephanie Fry: Hi, good afternoon. It's Stephanie Fry.

Jordan Hirsch: Thank you very much. And finally onto our federal give liaisons, Centers for Disease Control and Prevention? Centers for Medicare and Medicaid Services?

Susan Arday: Hi, this is Susan Arday at the Centers for Medicare and Medicaid Services.

Jordan Hirsch: Thank you very much. Health Resources and Services Administration?

(Ghurma): Hi, this is (Ghurma) from HRSA.

Jordan Hirsch: Thank you very much. I'd like to now turn it over to our CMS colleague for opening remarks.

Maria Durham: Hi there, this is Maria Durham. Just really first off, I wanted to really thank the MAP clinician workgroup for your time and your participation. You know, this is always a workgroup that has some of the larger workloads of all of the workgroups that I feel like it's such an important area and it really drives quality and really at the forefront of all of the important work. So first and foremost, I really appreciate your time and your participation.

As Sam said a little bit earlier, I really want to introduce the inclusion of the Part C and Part D Program into the pre-rulemaking process. This is new for us this year and the MAP clinician workgroup, you know, will really be able to provide our Part C and Part D colleagues with feedback and recommendations for the first time, and I know that that team is really looking forward to receiving that feedback on the measures that they're considering for us in their program so thank you for that.

And I also -- and I think Sam touched on this as well, you know -- want to mention the rural health workgroups review of the measures as part of the MAP process because again I really feel like this unique perspective really gives the MAP clinician workgroup feedback from a rural lens, and that's also one of our primary goals at CMS as well.

So I really continue to appreciate all of your thoughtful review that you've had in the past on our various MUC list and really look forward to the upcoming in-person meeting and the rich conversation that is surrounding all of the measures under consideration. So again thank you very much for attending.

Samuel Stolpe: Thanks very much, Maria. This is Sam once again. Now, we're going to give an overview of the MAP pre-rulemaking approach. So with the next couple of slides, what I'd like to do is just give a high level overview of the work that

we're going to accomplish over the next several months, the timeframes into which those will occur, and just a couple of details about the nature of the work.

So a pre-rulemaking approach really began now on October with both the workgroups and the coordinating committee's work via web. We will be reviewing these pre-rulemaking approaches, taking a look at how we evaluate the measures, and familiarize ourselves with each of the programs, their nature, disposition, incentive structures and measure set before we dive into our work that really begins in earnest for this group in December.

Now, during the November timeframe, the group that Maria mentioned, the rural health workgroup will convene via web after the release of the measures under consideration list, the MUC list. We'll have PA, so preliminary analyses that are conducted by staff as a starting point for discussions, and we'll get those to the rural health workgroup in advance of their coming together via web beginning November 18th.

Now, the rural perspective as it's offered doesn't confer a recommendation per se, but does give the workgroup a look into some of the implications of those measures being implemented inside of rural settings.

In December, beginning on the 3rd running through the 5th with our meeting occurring on the 5th of December, the MAP specific workgroups will come together in person at NQF headquarters which I'll just remind you has moved a grand total of two blocks away from our old headquarters, but slightly different location and in my humble opinion, much more handsome so I think you'll like what we've done with the place.

So we'll meeting in December and then we'll convene our coordinating committee in January.

So just looking at this timeline from a different perspective here, so in October, the coordinating committee will be convening to discuss the strategic guidance for the workgroups during pre-rulemaking workgroups web meetings to review the program measure sets.

By statute, CMS is required to release the MUC list by December 1. Our colleagues have assured that this will occur well in advance of that. So because we anticipate that occurring beforehand, we scheduled rural initial meeting to begin on November 18th. Now, you'll notice what that implies is an accelerated timeline. So, for those of you who were returning, you'll likely note that this schedule is about a week in advance of when we convened last time.

So in November through December, we'll have that initial public commenting on rural health workgroup meetings; December, the in-person meetings. Once we finalize the reports for those recommendations, there will be a public comment on those workgroup deliberations. MAP coordinating committee will review the recommendations of this workgroup as well as MAP hospital and MAP PAC/LTC.

In January, at the end of January, the pre-rulemaking deliverables will be released, namely, the final report issued by MAP coordinating committee where the recommendations on all individual measures under consideration will be released.

Finally, there are two more sets of deliverables for guidance on hospital and PAC/LTC programs that will be released February 15th and then guidance for clinician and special programs by March 15th.

So, today's brief, what we want to talk about is the goals for this meeting. We want to look at the structure of the three programs that we're discussing. We'll review the critical objectives for each of those programs and talk about measurement gap areas.

So let's go ahead and jump right into that. We have the three programs considered by the clinician workgroup for your consideration today that I'll be offering a high level overview of, and then we'll be turning it over to our CMS colleagues for a deeper dive.

So the first of this is the Merit-Based Incentive Payment System, MIPS; the Medicare Shared Savings Program or SSP; and then the Medicaid Part C and D Star Ratings.

Looks at MIPS, this is part of what has been termed the Quality Payment Program. It's one of two structures that clinicians fall under in the quality and performance-based programs implemented and it's part of the rollout of the MACRA Bill of 2015.

The other structure is, of course, the alternative payment model which is not something that falls under our purview per se, but it reflects MIPS-like measures inside of it, so even the work that we do here can also be reflected there to some extent.

Now, what I'd like us to also note is that this is in fact the pay-for-performance program. There are four connected performance categories

which you'll see listed here, namely; quality, which is where we'll do a lot of weighing in as a workgroup; then promoting interoperability; improvement activities; and cost also factor into a final score that these individual clinicians and groups have as a basis for their adjustments of MIPS payments.

The program goals are to improve quality of patient care and outcomes, to reward clinicians for innovative patient care, and to drive fundamental improvement towards value in healthcare.

In 2019, there were 258 total measures included inside of MIPS. We've broken them down on this slide by the healthcare priority that they fall under which you'll notice a large bulk of measure is falling under the effective treatment - excuse me, effective prevention and treatment priority.

One of the more interesting things that pops up here is the best practices of healthy living, that area doesn't actually have any measures inside of MIPS so it's something certainly our CMS colleagues are thinking about.

We wanted to highlight the CMS' high priority for future measure consideration. Here we have five areas and I won't read details in the slide, but they're here for your reference. So those five areas of high priority are around person and caregiver-centered experience and outcomes, communication and care coordination, efficiency and cost reduction, patient safety, and appropriate use.

At this point, I'll hand it over to Bruce - actually let me check first if Dr. Fields is able to join. Dr. Fields, are you on the line?

Robert Fields: Yes, I'm sorry, my last meeting went way over so I am now on the line. Thank you.

Samuel Stolpe: Totally understand the nature of a practicing physician. So welcome and actually I'd like to - before you jump in to guide the discussion, since you are our acting co-chair for the year, I will mention that Dr. Fields will be stepping in for Amy Moyer who led the workgroup last year.

Of course, this workgroup's loss ended up being NQF's gain. She is now on staff with NQF and so can no longer continue in her role as co-chair. However, she is leading MAP's PAC/LTC group so we'll get to see Amy in action as part of our work on MAP but now from a staffing perspective.

So welcome to Dr. Fields and if you'd want to offer some words of welcome and then lead the workgroup in the discussion here, I'll hand it over to you.

Robert Fields: I don't want to impede progress, but then just thanking everybody for their time and efforts in trying to provide guidance. I think it's massively - the work has been massively impactful in terms of how we measure ourselves and has the implications to all sorts of operations. There are big systems and small systems and the like so I'm very appreciative of the thoughtfulness we'll put in discussion.

Samuel Stolpe: Very good. So at this point, Rob, we're just going to invite the workgroup to have any questions that they might have related to MIPS program, or the question for discussion here is, does the workgroup have suggestions for refinement or additions to these high-priority domains as articulated by CMS on the previous slide?

Any comments from the workgroup? I don't hear any immediate comments. All right, we're hearing none at this time. Thanks very much. We'll go ahead and move on with the - for the next care setting here.

So we're next going to do an overview of the Medicare Shared Savings Program. This is also a Quality Payment Program. Now, the incentive structure is pay-for-performance.

Now, this, of course, occurs for Accountable Care Organization which as everyone on the call is likely aware of the voluntary program that brings together groups of providers to take on the care for a fixed duration for Medicare fee-for-service beneficiaries.

The goal of the program is to promote accountability for a patient population, to coordinate services for those beneficiaries, and encourage the investment in high quality and efficient services.

Now, as you know when we defer shared savings program ACO to share in savings, they need to do two things. First is to demonstrate savings. They actually have to show that. And the second would be to perform on a set of quality measures which are articulated here on this next slide. These are the domains that they fall under are depicted here.

So you'll note there are 23 quality measures inside of SSP for 2019. Inside of the proposed rule, that number doesn't actually change. There's only some slight modification. The treatment - sorry, the healthcare priority domains are listed here, and I just wanted to hand it back over to Rob to facilitate the discussion around our suggestions for change.

Robert Fields: So any suggestions from the group here? I'm assuming we've got several ACOs represented here or systems that are working in the space.

I think, you know, there have been several changes and suggestions I think from different stakeholders over the last years on specific measures. But I haven't heard too much feedback from colleagues on the general domain. It doesn't sound like - I mean, the workgroup doesn't have any other suggestions on that side - on that front.

((Crosstalk))

Samuel Stolpe: This is Sam. I have to apologize I actually skipped over a slide here so I'll just dial it back over that.

There is one thing I wanted to point out is that the influenza measure is slated over the rule to be addressed by what ACO-47, the Adult Immunization Status measure which is an NCQA HEDIS 2019 metric. So that measure includes influenza, but also adds on I believe pneumococcal and herpes zoster as well so I don't know, perhaps Tdap. That measure is currently being reviewed by our CDP standing committee in population health this cycle.

Another thing to note is that the one measure that has been inside the pay-for-performance structure is the ability to pay for reporting and that is the ambulatory sensitive condition care composite measures that AHRQ has put together. Okay, let's go ahead …

Woman: This is …

Samuel Stolpe: Go ahead.

Woman: I just had a question. This slide was not in the deck that was emailed, right? It looks like this is an additional on.

Kate Buchanan: Yes, this is Kate. I apologize, this must be - have been an error, so we will make sure that the slide decks that were sent out reflect this.

Woman: Okay, great. Yes, I know this is a very large proposal so - in terms of the alignment with QPP that could have some unintended consequences so I just wanted to make sure that everybody caught that because I don't think we would be able to respond back.

Samuel Stolpe: Thanks very much for the comment. Okay, so with that …

Robert Fields: This is Rob. The question that you had on the next slide was not - was more about the general domains. There may be comments on those two specific measures. I know that I have some comments from that, so I don't know if we're really thinking about the domains, right?

Samuel Stolpe: Yes, it was about the high priority domains specifically, it was the discussion question.

Robert Fields: Yes, Okay.

Kate Buchanan: And we did receive one chat comment from a workgroup member, why are there no patient safety or - patient safety or affordability measures? So that was the comment that was received.

Samuel Stolpe: Okay, that was from Karen Roth?

Kate Buchanan: Yes.

Samuel Stolpe: So we can - we can feed it to our CMS colleagues if they would like to address the question, why are there currently no patient safety or affordability

measures contained inside of the 23 measures within SSP set? Is there a rationale for that or a proposal to address those gaps at this point?

Fiona Larbi: Hi, this is Fiona from the Shared Savings Program. We do actually have a patient safety measure in the measure sets, so I'm not sure why that's not represented in that table that you have. And you know, any suggestions that you wish to provide about measures for affordability, we'll definitely take them into consideration.

Samuel Stolpe: Very good, thank you very much. Any other discussion points or questions from the group?

Man: Yes, just a question, the second one, making care safer, is this different from patient safety? On Slide 18, we have here making care safer. Is that different from patient safety or that implies the same issue.

Samuel Stolpe: Thanks very much for the question. My assumption would be that they are essentially the same domain. They were talking about the same priority. The patient safety and the making care safer is going to be making care for the patient safer so I think that they are actually the same.

So I guess the question that was articulated by Karen Roth, perhaps she meant why were there no best practices of healthy living and no making care affordable measures. So we do have the single measure of safety noted in this table, maybe we meant the best practices and healthy living.

Woman: And this is just a comment, but I know making care affordable is certainly measured in the ACO program. You know, there are other ways that ACOs are measured on their costs.

Samuel Stolpe: Right, I'm going to say the same thing. It's sort of the whole point of the program. All right, well, thanks very much. If there are no other questions at this point on SSP, we can go ahead and move on to our - the new program that we'll be considering which is the Part C and D Star Rating System.

So this is an interesting hybrid of both public reporting and quality payment where Medicare Advantage Plans, Medicare Part C has both elements present, but their Medicare plans under the Part C domain are eligible for quality bonus payments, a 5% increase if they achieve 4 stars or higher for their summary rating.

Both Medicare Part C and Medicare Part D have a public reporting component. So if you were to go on to Medicare's Plan Finder Web site, you'll be able to type in general the list of plans that you can enroll. Next to name of those plans will be a rating from 1 to 5 stars and of course, CMS puts a special emphasis on those that are able to achieve 5 stars and certain incentive sections are in place for higher performing Part D plan that's the primary driver for this public reporting.

Now, the program goal is to provide information about plan quality for beneficiaries if they're making plan choices; and in particular for Part C to incentivize high-performing plans to continue to achieve high quality and performance.

There are two high-priority areas that CMS has emphasized for future measure considerations inside of Medicare Part C and D. The first is to promote effective communication and coordination of care, and the next is promote effective prevention and treatment of chronic disease.

For 2020, inside of the April 1st Rate Announcement and Call Letter, CMS released their final policy and they have specific updates for Medicare Advantage and Part D programs. This Advance Notice was posted in two parts, the first occurring in late 2018, second at the end of January.

Now, CMS accepted comments through March 1st and we summarized some of the changes and those are linked inside of the slide deck.

In summary of the 2020 Part C and D changes, there will be the addition of two measures; transitions of care measure for Part C and then follow-up after emergency department visit for patients with multiple chronic conditions.

Now, consistent with its policy for new measures, these measures first go into what's been termed the display page which is a publicly reported set of measures for each health plan, but do not go directly into the calculation for individual contracts' actual (formal treatment) of star rating.

Now, there's also been the temporary retirement of the controlling blood pressure measure to the display because of the changes in treatment guidelines, and the statin use in persons with diabetes measure will be single-weighted. Now, what that means is certain measures inside of the Part C and D Star Rating System are weighted heavier than others.

So some can be as much as five times weighted outcomes and intermediate outcomes for longer triple weighting; some measures are at 1.5 times their weight and others at 1.

For 2021, the proposed changes are additions to the display page, so concurrent use of opioids and benzodiazepines, polypharmacy use of multiple

anticholinergic medication in older adults, polypharmacy use of multiple CNS, active medications in older adults are also meant to be added.

There's a retirement - temporary retirement of the plan all cause readmissions measure to the display because there's quite a few changes. And then they included a reminder that the patients' experience and complaints and access measures will receive a two times weighting beginning with the 2021 ratings.

Current plans, there's current plan to retain the medication reconciliation post-discharge as a standalone measure as well.

And then I believe this is last summary slide of changes from the 2020 call letter. This will be in 2022 slated for the return of the controlling blood pressure to the star ratings with a single weight; a temporary retirement of plan all cause readmissions to display; temporary retirement of care for older adults' functional status assessment for 2022 and '23; and then removal of adult BMI assessment and both Part D appeals measures; then lastly, the adoption of a new MPF price accuracy measure and specifications.

Okay, so that's the summary of the changes that were really the quality metrics inside of the call letter and final rule. So at this point, I'll hand it over to Rob to lead the discussion, answer any questions that the workgroup might have about Part C and D.

Now, keep in mind that we do have our colleagues on the line who will be doing a deeper dive into each of these programs and will be able to answer questions at that time as well.

Robert Fields: Excellent. Any comments from the group? Anything come up in the class?

Bruce Bagley: So this is - yes, this is Bruce Bagley. Any insight into the reason for taking out the BMI measure, BMI assessment?

Elizabeth Goldstein: This is Liz Goldstein from CMS. It's topped out. It's very hot so that's why we're taking it out.

Bruce Bagley: Thank you.

Robert Fields: Any other questions from the group?

Kate Buchanan: Okay, with that, this is Kate Buchanan and I was going to take a few moments to discuss the workgroup deliberations last cycle.

So during the last interview of the MUC list, the clinician workgroup identified two overarching themes across the MUC that was emphasizing appropriate attribution and level of analysis for incorporated measures, as well as aligning cost measurements with quality improvement efforts.

And so when emphasizing appropriate attribution and level of analysis for incorporated measure, the workgroup knows that measures need to both assess high-priority topics and to demonstrate that they can evaluate performance aty the appropriate level of analysis to ensure the information provided is meaningful and actionable.

Measures must be actionable as well as valid and reliable at the level of analysis of the program, and that selection of appropriate quality measures for accountability programs can have enormous impact in the acceptance of the program and engagement of clinicians.

When looking at the aligning cost measures with quality improvement efforts, the workgroup said that cost measures implemented in MIPS should be included consideration of clinically coherent groups, specifically patient condition groups and care episode groups.

Measures of cost and quality must be aligned in order to truly understand the efficiency and value of care. And lastly, that align cost and quality measures while protecting against potential negative unintended consequences of cost measures such as stinting of care or the provision of lower quality of care.

As it's been discussed earlier, the MAP rural workgroup as a pilot program last year provided input on the clinician measure under consideration, and this year they will be providing feedback to the rural and all three setting-specific workgroups.

So this is just a brief overview of the rural health workgroup. It will be a more systematized review than it was previously because it will be across all the three setting-specific workgroups.

So the MAP rural health workgroup will provide timely input on measurement issues to other MAP workgroup and committees, and to provide rural perspectives on the selection of quality measures in MAP. It will help address priority rural health issues, including the challenge of low case volume.

So the workgroup will be looking at in their review of the MUC is the relative priority and utility of the measures in terms of access, cost, or quality issues encountered by rural residents; data collection or reporting challenges for rural providers; methodological problems of calculating performance measures for small rural communities; potential unintended consequences in specific

programs; and gap areas in measurement relevant to rural residents and providers for specific programs.

So as Sam had mentioned, the rural health workgroup will be meeting via three web meetings between November 18th and 20th of this year. That feedback will be provided in the measure discussion guide as returning members or member, but for new members, we will send out a discussion guide which includes measure specifications, the preliminary analysis, public comments received. And it will also include the rural health workgroup discussion of the measure under consideration.

This will reflect - the voting will not be as a recommendation. The voting will just be on an agreement that the rural workgroup has on the feedback they are providing, so just indicating that the feedback that they are providing to the setting-specific workgroup was pretty universal among the rural health workgroup.

There will be - similar to the previous rural eligible liaison workgroup, there will be a liaison attending through each of this setting-specific meetings. And the rural health workgroup liaison will really have an opportunity to provide richer detail and more nuances to the feedback that was provided in their November web meeting. So there will be a rural health liaison attending each of the workgroup meetings in December.

And I wasn't sure if there are any questions on the rural health workgroup and their role this year. Okay, well, hearing none, I am going to turn it over to our CMS colleagues and Susan Arday, it looks like you are first. If you just want to say next, I can help move the slides you're on, if that is Okay with you.

Susan Arday: That's great. Thank you very much. Hi, this is Susan Arday and I'd like to thank you for the opportunity to speak with you today regarding the Quality Payment Program.

As mentioned, my name is Susan Arday, I work at CMS in the Quality Measurement and Value-Based Incentives Group in the Division of Electronic and Clinician Quality. And it's my pleasure to be here with you today.

Next, so this is just a brief disclaimer that Medicare policy changes frequently, the information provided during this presentation is intended to be a general summary. It does not take the place of written law or regulations, and we encourage you to review the specific statutes, regulations, and other interpretive material.

Next, this resource library provides a wealth of information for the Quality Payment Program and can be found in the link provided on the slide. I highly recommend that you take the time to go in there and figure out, familiarize yourself with the material in there.

Next slide please, so the Medicare Access and CHIP Reauthorization Act of 2015, what we call MACRA, requires CMS to implement an incentive program referred to as the Quality Payment Program that provides two basic participation tracks. And those tracks include the Merit-Based Incentive Payment System, MIPS, and if someone decided to participate in MIPS, the eligible clinician group will earn a performance-based payment adjustment through MIPS.

The other track is Advanced Alternative Payment Models, also referred to as Advanced APMs. And if a clinician or group decides to take part in an

Advanced APM, they may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

Next slide please, in addition, there are some key considerations or goals to the Quality Payment Program and those are to improve beneficiary outcomes, reduce burden on clinicians, increase adoption of Advanced APMs, maximize participation, improve data and information sharing, ensure operational excellence in program implementation, and deliver IT systems capabilities that meet the needs of users.

For more information on the Quality Payment Program, please visit qpp.cms.gov. The link is provided on the slide.

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

We are currently in Year 3 of MIPS under the Quality Payment Program, so 2020 will be what is referred to Year 4.

Next slide please, so let me get into a little detail here surrounding Year 4 2020 in this slide. As a reminder, MIPS is made up of four performance categories which include quality, cost, improvement activities, and promoting interoperability as shown on slide. Eligible clinicians have the opportunity to earn 100 possible points across all these categories.

So in the calendar year 2020 Physician Fee Schedule proposed rule, we propose that the weight of the quality performance category will be reduced from 45 to 40 points, and the weight of the cost performance category we've proposed to increase it from 15 to 20 points, while the points awarded to the other two categories, PI and AI will stay the same, so the 15 points for improvement activities and 25 points for promoting interoperability.

All performance categories are calculated for MIPS final score and the points from each performance change are added together to give a MIPS final score.

Next slide please, eligible clinician for MIPS include physicians, physician assistants, nurse practitioners, clinician nurse specialists, and certified registered nurse anesthetists.

For Year 3 of MIPS, the following clinicians have been added to that list, including physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, registered dieticians, and nutrition professionals.

CMS is very excited to include more specialists as we work to make reporting for MIPS more comprehensive and inclusive. However, in this particular cycle proposed rule, we did not propose to expand this definition for the 2020 performance period in MIPS.

Next slide please, the threshold only includes MIPS eligible clinicians billing more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule, and furnishing covered professional services to more than 200 Medicare beneficiaries a year, and providing more than 200 covered professional services under the Physician Fee Schedule.

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

Next slide please, so what this slide highlights here is those who are exempt from MIPS in calendar year 2020 and that includes those who are newly enrolled in Medicare, including those who are enrolled in Medicare for the first time during the performance period. But they'll be exempt until the following performance year.

Also those other groups that are exempt from MIPS in 2020 are those who fall below the low-volume threshold as described on the prior slide, and the other exempt group is those who are significantly participating in Advanced APMs which would mean they receive 25% of their Medicare payments by Advanced APMs or they see 20% of their Medicare patients through an Advanced APM.

Next slide please, opt-in policy for MIPS allows eligible clinician who are excluded from MIPS based on the low-volume threshold determination to not be excluded. So that option is available for MIPS eligible clinicians who meet or exceed at least one of the low-volume threshold criteria.

The possible opt-in scenarios are displayed right here on the chart in the slide and you'll see the line 1, for example, that’s a clinician who meets all three low-volume threshold criteria, and therefore that clinician would not be eligible to opt-in to MIPS.

Line 2 of the chart shows clinicians who meet the first two low-volume threshold criteria, but not the third criteria which represent clinicians who

have more than 200 covered professional services. Now, these clinicians 2 could choose to opt-in to MIPS.

Line 3 of the chart shows clinicians who meet the last two low-volume threshold criteria, but not the first one and that represents clinicians who have more than $90,000 in Medicare Part B allowed charges for professional services a year. And again, these clinicians could opt-in as well to MIPS if they so choose.

Line 4 represents eligible clinicians who meet the first criterion, but not the last two low-volume threshold criteria and that represents clinicians who provide covered professional services to more than 200 Medicare Part B patients during the year. These clinicians could also choose to opt-in to MIPS.

And finally, on line 5, this represents eligible clinicians who do not meet any of the low-volume threshold criteria and therefore would not be eligible to opt-in or out as they would be required to participate in MIPS.

Next slide please, so how was all these lay out? Well, for the 2020 MIPS performance period, also referred to as Year 4, CMS is proposing to maintain the following minimum performance periods for each of the performance categories.

For the quality and cost categories, the full 12 months is required. However, for improvement activities and promoting interoperability performance categories, 90 days is the minimum performance period.

Next slide please, in Year 4 of MIPS, a virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together

virtually. So it doesn't matter what the specialty or location of those eligible clinicians and they can participate as a virtual group in MIPS for a performance period of a year.

So what does a clinician got to do? Well, to be eligible to join or form a virtual group, the eligible clinician needs to be a solo practitioner who exceeds the low-volume threshold individually, and is not a newly Medicare-enrolled eligible clinician, a qualifying APM participant or what you'll hear us refer to in jargon as QP or partial QP choosing not to participate in MIPS; or the virtual group that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

Next slide please, on this slide, I'm highlighting here what the quality performance category is starting with the basics which includes the change in the percent of the final score which is affected by this category. Again, the weighting of a quality performance category has been lowered in the proposed rule for Year 4 from 45% of the final score in 2019 to 40% of final score for 2020.

Overall, though, the requirements remain the same so an eligible clinician should select six individual measures with one being an outcome measure or a high priority measure. If less than six quality measures apply, then the clinician should report on each applicable measure and CMS will evaluate your submission to determine measure applicability validation and the eligible clinician can also select the specialty-specific set of measures to report.

There are several options here. In addition to the weight given to the final score, it's important to understand the data completeness requirements for the quality performance category in Year 4. CMS, we proposed to increase the data completeness requirements to 70% for the 2020 performance period.

Next slide please, this slide highlights changes from Year 3, Year 4 MIPS from a scoring perspective for the quality category. In Year 4, the scoring requirements are the same except CMS, we're proposing to revise benchmarks based on flat percentages in specific cases where it's determined that the measures otherwise applicable benchmark could potentially incentivize inappropriate treatment.

The rest of scoring criteria from Year 4 will be congruent - from Year 3 will be congruent with Year 4 including giving us 3-point floor for measures scored against the benchmark, giving 3 points for measures that do not have a benchmark, or do not meet case minimum, as well as giving a 2-point bonus points for outcomes for patient experience measures, and a 1 bonus point for other high priority measures and for each measure submitted using electronic end-to-end reporting.

So this is an opportunity for small practice bonus of 3 points for MIPS eligible clinicians in small practices who submit data on at least one quality measure. CMS still plans to cap bonus points at 10% of the category denominator for performance year 2020.

Next slide please, topped out quality measure, CMS has finalized a four-year life cycle to identify and remove topped out measures. These measures have a scoring cap of 7 points. However, these topped out policies do not apply to the CMS Web Interface or CAHPS for MIPS. So if a measure has reached an average mean performance rate of 98% or above, CMS may propose to remove the measure during the next rulemaking cycle.

Now, QCDR or qualified data clinical data registry measures differ from MIPS quality measures and do not qualify for the topped out measure cycle.

Next slide please, Okay, so now I'd like to go over the cost performance category very briefly. The cost performance category is now worth 20% of the total weighted score for MIPS.

We are also proposing modifications to the Medicare Spending per Beneficiary or MSPB and Total per Capita Cost measures based on stakeholder input and recommendations from the Technical Expert Panel.

We're proposing changing the approach to proposing attribution methodologies by including the attribution methodology in the measure specifications.

The eight existing episode-based measures for cost added for the 2019 MIPS performance period will be retained in 2020. We are further proposing to add 10 new episode-based cost measures for performance year 2020.

We will propose new cost measures in future rulemaking and provide feedback on the episode-based cost measures prior to potential inclusion in MIPS so that increases clinician familiarity with them.

For more information on this regarding MIPS or the cost performance category in particular, please refer to the posted 2019 QPP final rule and keep your eyes peeled for when the final Physician Fee Schedule 2020 Rule will be coming out. That usually comes out in November of each year, so keep your eyes peeled for that.

Next slide please, MIPS scoring improvement for quality include the following in Year 4; eligible clinicians must fully participate. What do I mean

by that? They have to submit all required measures and have met data completeness criteria for the performance period.

If the eligible clinician has a previous year quality performance category score less than or equal to 30%, CMS would compare the 2020 performance to answer assumed 2019 quality performance category score of 30%/

Now, for cost, there will be no cost improvement scoring for MIPS in Year 4 calendar 2020. The cost performance category percent score will not take into account improvement until the 2024 MIPS payment year.

Next slide please, as I mentioned previously, 15% of the final MIPS score will be earned from improvement activities in performance year 2020. And what this slide shows is your basic information regarding improvement activities for Year 4 MIPS as well as the number of activities available, and information regarding nominee improvement activities.

So if you want to participate in improvement activities, you go here and you select Improvement Activities and attest “yes” to completing. Activity weights remain the same in Year 4 as they were in Year 3, so medium equals 10 points; high equals 20 points.

Small practices, non-patient-facing clinicians and/or clinicians located in rural or HPSAs continue to receive double-weight and report on no more than two activities - improvement activities to receive the highest score.

In calendar year 2020, CMS is proposing adding two new improvement activities to MIPS. We're also proposing modifying seven existing improvement activities and removing 15 existing improvement activities.

There have been a number of proposed changes to the improvement activities performance category. We have proposed to modify the MIPS rural area definition by changing the file name to reference FORHP. We removed references to specific accreditation organizations for PCMH or patient-centered medical homes.

We're proposing to increase the group reporting threshold to 50% also. The minimum number of clinicians in a group or virtual group required to perform an improvement activity would increase to 50% if this is adapted in the next rule. We are also proposing establishing factors for removing improvement activities from the inventory through notice-and-comment rulemaking.

And finally, we are proposing to conclude and remove the CMS study on factors associated with reporting quality measures and remove the incentive under the MIPS improvement activity performance category for those study participants. These are the changes we're proposing here.

Next slide please, now this slide gives you some details surrounding the promoting interoperability performance category in MIPS, which got here some basic information regarding the promoting interoperability performance category for Year 4 MIPS and you can see that that’s on the left side of the screen on the slide.

As shown, 25% of the final MIPS score will be earned from the promoting interoperability objectives and measures in 2020 if that's adapted in the final calendar year 2020 Physician Fee Schedule.

Eligible clinicians must use the 2015 Edition of Certified EHR Technology or here it's called CEHRT to receive credit toward this performance category

promoting interoperability. The performance score is based on 100 total points.

So there have been a number of proposed changes to the promoting interoperability performance category. First, we're proposing the Query of Prescription Drug Monitoring Program or the PDMP measure be optional and eligible for five bonus points that makes the e-Prescribing measure worth up to 10 points.

We're proposing changing the Query of Prescription Drug Monitoring Program, PDMP measure to a “yes” or “no” response and that would then be retroactive to program your 2019.

We’ve proposed to remove the Verify Opioid Treatment Agreement measure under promoting interoperability. We've also proposed redistribution of the points for the support electronic referral loops by sending health information measure to the provide patients active to their health information measure if an exclusion is claimed, and that would then be retroactive to program your 2019.

Finally, we've proposed revising the description of the exclusion for the support electronic referral loops by receiving and incorporating health information measure, again retroactive to program your 2019.

Next slide please, next, I just want to very quickly mention some changes to the MIPS performance threshold and payment adjustments which were mentioned in the 2019 QPP final rule.

So these major changes that we're proposing were coming up on - and depending on adoption in the final calendar year 2020 rule would be that the

performance threshold would go from 30 points in MIPS Year 3 to 45 points in Year 4 starting obviously in 2020. We're also proposing the exceptional performance bonus that was set at 75 points that it'd be increased to 80 points for MIPS Year 4 calendar year 2020.

And finally, we proposed the payment adjustment which was - it's been proposed now to be increased to plus or minus 9% for 2020 in MIPS.

The payment adjustment and the exceptional performance bonus are based on comparing the clinician's final score to the performance threshold and the additional performance threshold for exceptional performance.

Next slide please, I say this every year, but it's true, CMS definitely understands areas affected by hurricanes and wildfires. They have experienced devastating disruptions in infrastructure and these clinicians in these areas face challenges - tremendous challenges in submitting data under the Quality Payment Program.

So starting with the 2018 merit-based incentive payment system performance period, if a MIPS eligible clinician is affected by extreme and uncontrollable circumstances so, for example, hurricane, natural disaster, or public health emergency, the MIPS eligible clinician, group or virtual group in that situation may qualify for reweighting of any, or all, of the four performance categories in MIPS which again are quality, cost, promoting interoperability, and improvement activities.

We've proposed some changes to this policy in the proposed calendar year 2020 rule. First, we've proposed to extend this to MIPS eligible clinicians participating in MIPS Alternative Payment Models who are subject to the

APM scoring standard and would report on MIPS quality performance category measures.

In addition, we have proposed a new policy to allow reweighting for any performance category if, based on the information learned prior to the beginning of a MIPS payment year, it's determined data for that performance category are just inaccurate, unusable or otherwise compromised due to circumstances outside of the control of the MIPS eligible clinician or its agents.

So I've said a whole lot here. I certainly hope you found this summary of the calendar year 2020 proposed changes by performance category to MIPS helpful.

Again, I say this every time, please, please feel free to review the posted 2019 QPP final rule for more details and when it's published which should be soon, the final calendar year 2020 QPP final rule which is the Physician Fee Schedule.

And you are always free to contact the QPP Service Center at 1-866-288-8292 toll free, Monday through Friday, 8:00 AM to 8:00 PM eastern Time, and you can contact them by email 24/7 365. It might take a little day or two to get back to you any time of the day.

But the email address for them is qpp@cms.hhs.gov for any kind of information. We've got a very elaborate triaging system in there to, you know, get your questions, concerns, and issues to all the right subject matter experts that can help you, you know, figure out what you need to do, or figure out how something might need to be fixed or changed, or whatever.

So I'd like to thank you for your time and attention on this. It's been a pleasure presenting this to you. Thank you.

And now I'd like to hand this over to my colleague, Fiona Larbi, who is going to give us an overview of the Medicare Shared Savings Program. Fiona, would you like me to do the slides or would you prefer that the prior individual continue with that?

Fiona Larbi: Yes, it depends if she wants to continue going through that, it would be fine.

Susan Arday: Yes, no problem. You've got the floor, Fiona.

Fiona Larbi: Thank you, Susan.

Susan Arday: You're welcome.

Fiona Larbi: So as Susan said, I'm Fiona Larbi and I represent MAP in the Division of Program Alignment and Communications as the Shared Savings Program and Quality Team lead.

Next slide, so today I'm going to go over a high level review of the Medicare Shared Savings Program, the quality measure approach and how we assess quality performance, and then a high level overview of our considerations of future quality measurement.

Next slide, the Medicare Shared Savings Program is mandated by Section 3022 of the Affordable Care Act. An Accountable care Organizations or ACOs create incentives for the health care providers to work together voluntarily to coordinate care and improve quality for their patient population.

CMS assesses ACO performance annually based on quality and financial performance to determine shared savings if earned or losses. In order for ACOs to be eligible to share in savings if earned, they must meet our program's quality performance standards and the overall quality score is integrated into the shared savings and losses financial calculation.

In December of 2018, CMS finalized the pathways to success final rule that redesigned the shared savings program. Policies in that rule included a quicker transition to risk, new flexibilities and tools for risk based ACOs to be successful, strengthened program integrity, and a reduction in the shared savings program measure set from 31 to 23 measures.

As of July 1st, 2019, we had 518 ACOs across the nation participated in the shared savings program and they served approximately 10.9 million Medicare fee-for-service beneficiaries.

Next slide, the quality measurement approach is intended to improve individual and population health by addressing patient caregiver experience, care of chronic illness and high prevalence conditions, and care coordination.

The performance year 2018, 99.6%of ACOs financially reconciled satisfactorily reported required quality measures and met the quality performance standard. Across all shared savings program ACOs, the actual - the average quality flow was actually 93%. 93% of ACOs participated in those 2017 and 2018 received quality improvement reward point.

For 2018, 30 ACOs benefited from the shared savings program extreme and uncontrolled circumstances policy, and was designated to serving an actual disaster emergency area.

ACOs achieved higher average performance rate on 13 of the 14 CMS Web Interface measures compared to non-ACO group practices also using the web interface. An ACO in risk-bearing track exhibits similar quality performance compared to the non-risk-bearing tiers, average of 92.92% versus 92.89% respectively.

So we already had some discussion of what we had proposed in the Physician Fee Schedule. We went through the measures - potential measure changes to the CMS Web Interface with the removal of the flu vaccine and the possible addition of the Adult Immunization Status measure.

Also, we are updating guide on (numerator guidance) for ACO-17, the Prevention Care and Screening Tobacco Use measure to revert it back to how it's proposed in the 2017 final rule. And another big aspect of our comment was a common solicitation that we added to the 2020 Physician Fee Schedule. There's still (unintelligible) the shared savings program quality score with the MIPS quality performance category score.

So ACOs that are participating provides us and supply dedicated process to performing well on quality metrics. We believe that aligning quality metrics across programs will reduce (unintelligible) and will allow ACOs to more effectively target those resources towards improving care.

Next slide please. On my screen, I think I'm frozen, we should actually be on Slide 62 of the actual attachment that I had in the appointment. But I think that might be the 64, 65, or 66 on your screen that you have there. The shared savings program - sorry.

Kate Buchanan: Fiona, this is Kate Buchanan at National Quality Forum. I just want to check we are on the slide that says overview of quality measurement approach?

Fiona Larbi: Yes, I mean, it should list the domains and then actually the quality data collected by the following mechanisms. That's the one that I'm on now, but my screen has frozen so I can't - I'm stuck so I cannot refer back on my screen.

Kate Buchanan: Okay, and sometimes that happens with the provider. It may work if you refresh your browser. If you don't, we'll comfortable with that. If you just keep on saying next, I'll make sure I'm moving the slides along so that it would be easy.

Fiona Larbi: Okay, all right then, sorry. So the shared savings program quality measures are currently consisted of 23 measures following four domains. It is divided by the ACOs through the CMS Web Interface, populated by CMS for ACOs from administrative claims data, populated by patient experience of care survey served with the CAHPS ACO Survey.

The number of measures within the four domains have changed over time to reflect changes in clinical practice, moved towards more outcome and high priority measures, aligned with other quality payment programs and reduced burden. However, the overall structure of four equally-weighted measure domains has remained consistent in determining ACO quality performance and the shared savings program which was established in 2012.

Next slide, CMS designates the quality performance standard in each performance year. Quality performance standard is the overall standard the ACO must meet in order to be eligible to share in savings. The first performance year of an ACO subsequent agreement period, CMS defined the quality performance standard at the level of complete and accurate reporting for all measures, otherwise known as pay-for-reporting.

During the second through fifth performance years of the eighth year's subsequent agreement period and all years of subsequent agreement periods, the quality performance standard will be saved in the eighth year. It must continue to completely and accurately report all measures. But the eighth year will be assessed on performance based on the quality performance benchmark and minimum attainment level of all measures.

In order to be eligible to share in savings, ACOs must meet minimum attainment in at least one measure in each domain. The minimum attainment level for pay-for-performance measure is set at 30% over 30th percentile of the performance benchmark. The minimum attainment level for a pay-for-report that I already mentioned is set at the level of complete and accurate reporting.

So the next several slides actually go through the measures within the domains, within the shared savings program. I'm not going to go through and read all of those. I'll just let you look at those at your own leisure.

And then the final slide, you should see future measure considerations. So finally, in line with our common solicitation of the 2020 Physician Fee Schedule, we're interested in feedback on how better to align the shared savings program measures and scoring methodology with other value-based payment programs including MIPS.

Thanks, and now I would thank you for the opportunity to go through a high level overview of the shared savings program. I will now hand this back over to the Part D folks, I think Elizabeth Goldstein who's going to be doing that presentation.

Elizabeth Goldstein: Thanks. Hi, this is Liz Goldstein, I'm director of the Division of Consumer Assessment and Plan Performance at CMS and I would give a high level overview of the Part C and D Star Ratings Program.

So the Part C and D Star Ratings Program is a quality program that we have for Medicare Advantage contracts that offer prescription drug coverage or Part D as well as for standalone prescription drug plans that are just offering drug coverage. In most cases, it's supplementing the benefits they're receiving through the original Medicare program or fee-for-service Medicare.

Just to - on the next slide, just to give you a little background, in 2019, there were approximately 66 million Americans that were enrolled in Medicare and about 43% of them were enrolled in either cost of Part C plans or Medicare Advantage plans. And through a Part C or Medicare Advantage plan, they receive most the health services.

For some of the contracts or most of the contracts, also in addition to the health plan services, they also offer drug coverage or often you'll hear referred to as Part D. There is about 39% of Medicare beneficiaries are enrolled in standalone Part D plans, often we refer to them as prescription drug plans or PDPs. This is just to give you a little background of, you know, who this program is impacting.

The next slide, for the goals of the star ratings program, we have multiple goals. One of the primary goals of this program is publicly reporting this information on the Medicare.gov Web site, it's a tool called Medicare Plan Finder. And so there's quality information on this tool, with benefit and cost information to help Medicare beneficiaries or their family members choose a plan each year.

So this tool gets lots of traffic during the open enrollment period that opens October 15th. So we refresh our data every year in October for open enrollment.

The data are also used for quality improvement. Both our health and drug plans are very focused on the star ratings measures and looking at ways to improve the quality of care.

They are also used for marketing, so I'll explain a little bit more about how it's used for marketing. For Medicare Advantage contracts or Part C health plans, there are financial incentives that are referred to as quality bonus payments. I'm going to go quickly through each of these different areas.

So for Medicare Plan Finder and this is - we just pulled a couple of examples for you to see. When you - on this tool, you're able to compare up to three plans at a time. So you can see in this comparison that we did, it displays a plan what we call the overall star rating for the highest rating for that contract.

You can click on Plan Details and once you click on that, you get a lot more information about the quality of that plan. And we have different icons and I'll be talking about this in a moment to highlight high-performing contracts. So on our rating system, it's pretty hard to get 5 stars for this overall rating so we do highlight that on our Web site. At any given year, we may have between 20 to 25 contracts around the country that get this highest rating.

Next slide, this just gives you a feel for that type of information that you can drill down to. So here is the overall star rating. We also include different summary ratings for health plan quality as well as drug plan quality, and then you can continue to drill down to information at the measures level.

Next slide, the second goal as I noted for the program is quality improvement. This I should note in particular for Medicare Advantage where there are strong financial incentives, our plans really do focus on quality improvement activities and we have seen dramatic shifts in the performance over time in this program.

Next slide, so we have a report for high-performing plans. These are contracts that receive an overall rating of 5 stars. We do put an icon on this Web site to highlight that they received 5 stars. We also allow other benefits for 5 star plans. So this is both for Medicare Advantage contracts as well as for our standalone prescription drug plans.

So, normally, beneficiaries enroll during this open enrollment period. But for - if a beneficiary wants to enroll in a 5-star plan, they can do it year-round. So they get what we call special election period to be able to enroll in these plans year-round and 5-start plans also may market year-round, not just during this open enrollment period that we're going through right now.

So this is really even for prescription and drug plans that do not have that financial incentive, this does create incentive to do well in our quality program to be able to market and get more enrollees all year-round.

We also - in our materials, our Web site, and different materials, we also highlight consistently low-performing plans. And so for low-performing plans, they have to have gotten less than 3 stars on their Part C or Part D summary rating for at least three years. So this is another way we're trying to incentivize quality improvement is to highlight these low-performing plans.

On our Medicare Plan Finder Web site, for other contracts or plans, there's an ability to enroll online just like a little button, and so the beneficiary can click that button and enroll in a plan for the coming year.

However, if a plan gets this low-performing icon, we disable that online enrollment capability. So it really allows a beneficiary to think, you know, "Do I really want to enroll in a low-performing contract?" And so they have to actually contact the plan directly to enroll in a low-performing plan.

We also - CMS every fall sends out letters to beneficiaries in these low-performing plans and explain to them, "You know, your plan is not doing so well in terms of its quality and you may want to switch to a higher performing plan."

So this again has resulted in a lot fewer low-performing plans. Years ago, we may have 20 or 30 of these contracts every year. Now, you know, some years, we don't have any. Some years, we may have about five or so of these low-performing plans.

The next area that I'll touch on just very briefly is that there are financial incentives for Medicare Advantage plans, and so they get quality bonus payments that are based off of our 5-star quality rating system. And so there is a percentage increase that they get to their payments if they score 4 stars or more for their highest rating that we give them.

It also impacts rebates of the plans received and those rebates are tied to the contract's star rating. So there is a lot of focus on the plans to get 4 stars or more in our rating system to ensure that they're getting these quality bonus payments.

I'll spend a few moments now talking a little bit about our methodology for the star ratings program. We do look at consensus-building entities such as National Committee for Quality Assurance, Pharmacy Quality Alliance for measure concern development, specifications of measure.

We do spend time every year reviewing our measurement set. Our hope is to - over time, to move to more outcome measures. We do - as we retire measures, we do move them to our CMS display page and this is, you know, for certain measures that we are retiring.

So, for example, the BMI measure where it's really topped out and NCQA is I think moving eventually to retire that measure. We would not move that to the display page. But there are other measures that we move to the display page so we can continue to monitor them. We put in the appendix a list of all the measures for the 2020 star ratings program for you to review, you know, at your leisure.

On the next slide, I'm just going to explain a little bit about the structure for the star ratings program. So at the highest is our overall rating and Medicare Advantage contracts that offer Part D coverage get this overall rating, and it basically summarizes the performance on measures related to both Part C and Part D.

So just to note for the Part C or Medicare Advantage program, we currently have 33 measures. For the Part D program, we have 14 measures. Across both Part C and D, there are two measures that are the same for Part C and Part D. So there are 45 unique measures across this program.

So, basically, that overall rating is a weighted average of the stars, the measure level stars. We have a number of adjustments that go into it to account for things such as socioeconomic status and consistently higher performance. So there are some, you know, a few adjustments to that overall rating. But basically it's a weighted average of the measure level stars.

We have two summary ratings, one for Part C and one for Part D. So a Medicare Advantage contract that offers prescription drug coverage will get a Part C summary rating and a Part D summary rating. And Medicare Advantage contract that doesn't only offer health benefits will just get that Part C summary rating.

And a standalone prescription drug plan or a PDP will only get the Part D rating and those would be - you know, for a prescription drug plan, a Part D rating is the highest rating that that type of contract would get.

Under these two summary ratings, we have five domains under Part C and four domains under Part D. And these domains are really topic areas and I'll go into that in a moment. And then under each domain, we have the various measures. And as I just said, there are 45 unique measures in our program currently.

On the next slide, it lists the different topic areas or domains for Part C and Part D. Some of the domains you'll see are very similar across C and D such as, you know, customer service and member experience with the plan. Other domains are unique across the two programs. Also, the complaints and changes in performance which include our improvement measures are the same across C and D, or similar across C and D.

You can go to the next slide, we do put in emphasis in the program on improvement. I think we have a little different take on improvement than some of the other programs. So we look at changes in performance at the measure level from one year to the next.

We're, though, taking into account if there are statistically significant changes, whether it's improvement or a decline in performance. So we're really looking at that improvement. So a contract for the Part C improvement measure may get 1 star and that would highlight that there's more decline in performance - significant decline in performance for that contract. If they're getting 5 stars, there is significant improvement. 3 stars basically for this measure kind of the improvement and the decline is kind of evening out across the various measures.

Next slide, we do weigh the different types of measures in the star ratings program. So the two improvement measures, we have one for Part C and one for Part D that I just mentioned, get the highest weight in our program with the rate of 5. Outcomes and intermediate outcome measures get a rate of 3. Patient experience and complaint measures get a rate of 1.5. Access also rates at 1.5 and process measures get a rate of 1.

Just to note, with next year's star ratings which will be our 2021 star ratings, the weight for patient experience and complaints, and access measures will increase to 2. We also - as new measures are introduced into the star ratings program for that first year, they always get a weight of 1 and then will go to whatever weight is relevant for the type of measure.

So as we look at enhancements to the star ratings program, we really are trying to make sure we're improving the transparency around the calculations. We want to always - as we make tweaks to methodology, incentivize plans to

continue their quality improvement activities, and we also want to make sure our calculations really truly reflect the quality of care provided.

One recent enhancement to our program that's relevant for this group is that we have traditionally made changes to the star ratings methodology, including adding measures through the - what we call the call letter process each year. And so this is part of an announcement that goes out each year, giving information for contracts to be able to submit bids to CMS for the following year.

And so contracts have traditionally have an opportunity to comment on the methodology through this call letter, you know, advanced announcement process. But we had moved to codify in regulations the methodology. And the first year that this is relevant for is for the 2021 star ratings which cover primarily the 2019 measurement year.

So as we add new additional measures to our program, we will be submitting them through the MUC process. So that's why this is the first time we're going through this process, so now starting for next year, our methodology is in regulation and we will - as we introduce new measures to the program, we will be going through the MUC process.

Just to also - on the next slide, Okay, Okay, it went too far, so I'm on the high-performing contracts. Just to note, we do have lots of discussions with both health and drug plans about their quality improvement activities and a big theme that we have seen for our high-performing contracts is that they tend to focus on the needs of each enrollee rather than focusing on a particular star ratings measure. So when they, you know, focus on the overall needs of their enrollees, they tend to do very well in our star ratings program.

So there are a number of additional resources if folks are interested in learning more about our star ratings program. We have technical notes that we put out each year that probably about 180 pages with all of the details about the methodology and all the measures included.

We have presentations, fact sheets. We have the Excel versions of the data all on this Web site listed on this slide. We also have a mailbox for any questions that you may have. So if you do have any questions about this program given it's new for this process, you know, please let us know.

And as I said, the next other slides are appendix with each of the measures included in each of our nine different domains. So you can review that, you know, at your leisure. So I think that's it. If anyone has, you know, any questions, I'd be happy to answer them.

Samuel Stolpe: Any questions from anyone in the workgroup? I'm not hearing any. Thank you.

Jordan Hirsch: NQF would like to open up the line for opportunity for public and member comment. You may also use the chat function if you'd like us to read your comment aloud. Hearing none, we're going to move on to next steps.

So as Sam mentioned earlier on this webinar, the release of MUC list is due out by December 1st. Based on its release, that will be the first public commenting period.

The rural workgroup web meetings will be on November 18, 19 and 20. And the in-person MAP workgroup meetings will be the first week of December with PAC/LTC on December 3rd, hospital on December 4th, clinician on

December 5th, and then the coordinating committee in January, with the public commenting period number 2 being from December 18th of 2019 until January 8th of 2020 for a - I believe a 21-day public commenting period.

A list of resources that can be found on the NQF MAP Clinician SharePoint; the CMS' measurement needs and priorities document, pre-rulemaking URL, and the MAP member guidebook. And these can also be found on NQF's public page for MAP Clinician.

Any questions? All right, moving forward, our contact information, you can either go to the SharePoint site or email us at mapclinician@qualityforum.org.

And finally, a preview of the annual conference for next year, driving values through the next generation of quality and a sneak peek at some of the conversations that will be taking place during that annual conference. Thank you very much.

Samuel Stolpe: Very good. Thanks, Jordan. On behalf of the NQF staff, I just wanted to say one more word of thanks. We very much appreciate our two co-chairs, Dr. Bruce Bagley, Dr. Robert Fields, for their leadership and for helping to moderate this session.

Big thanks to our CMS colleagues for being on the line to take - to trying to walk us through those programs. And thanks to each of you for joining us today. We're very much looking forward to the cycle. We're excited about the work and recognize the importance of your contributions. So again big thanks to you and we'll hand it back over to Rob and Bruce for any closing remarks.

Bruce Bagley: Yes, this is Bruce Bagley. Just other thing, at some point, we need the introduction to the file that you sent out with all the information on it so people will have a way to navigate that. So we probably will have to arrange for that at another time.

Samuel Stolpe: All right, very good. Thanks, Bruce. Dr. Fields?

Robert Fields: No, thank you again for everyone's time. I think one of the things that will probably come from the live meetings also I think for some of the stakeholders that are on the ACO side is some discussion around the - in their quest to sort of harmonize measures, the strategy about assessing ACOs using the QPP criteria.

I think that will probably generate some discussion during the live sessions. I know that's been the hope from the federal side and it would be a - I'm interested to hear some of these ACOs, stakeholders on - in the workgroup struggling with that context as it's referring to the QPP for the quality measures they fill, so look forward to the discussion in December.

Samuel Stolpe: All right, thanks very much, everybody. We will be seeing you on December 5 here at NQF headquarters. And in the meantime, be safe and we'll see you soon. Thanks very much.

Jordan Hirsch: Bye-bye.

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