National Quality Forum

Moderator: MAP Clinician Workgroup
November 9, 2017
1:00 p.m. ET

OPERATOR: This is Conference # 9695169.

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

John Bernot: Well good afternoon, everyone and good morning to those of you out on west side of the country. My name's John Bernot. I am here to open up the MAP Clinician Workgroup Web Meeting here.

We have a pretty aggressive agenda for the next two hours. So, we really truly appreciate you taking the time to come here and spend this with us. I do know a number of you have been doing this in the past and there's also some new faces here. So, we look forward to hopefully making this a pretty productive and informative session and we'll also have a fair amount of time for questions after each session throughout the day.

So at this point, I will turn it over to our chairs, Bruce Bagley and Amy Moyer to kick things off.

Bruce Bagley: Amy, why don't you introduce yourself first.

Amy Moyer: Sure thing. So, this is Amy Moyer. I am in my day job the manager of Valley Measurement of the Alliance for a healthcare purchasing cooperative in the Midwest. So, I use cost and quality measures daily in my work. Been on the Clinician Workers since 2014 and this is my second year co-chairing it, but I had a conflict with the meeting last year. So, I'm looking forward to meeting with everyone and working on the measures and these programs. Thanks.

Bruce Bagley: Great. Good morning. I'm Bruce Bagley. I'm a family physician and this is my third year as co-chair. I actually started with a MAP Clinician Workgroup when it first started a number of years ago and then took a little hiatus and then came back as chair a couple of years ago.

But I most recently have worked with the American Academy of Family Physician as Medical Director for Quality Improvement and also as president and CEO of TransforMED, which was a subsidiary company that helped practices transform to the patient-centered medical home.

So, I'm happy to be back and looking forward to working with all of you on this very important but very time compressed task. As you know we're going to be getting a list of measures under consideration probably around Thanksgiving and then two weeks later we've got a meeting where we have to talk about all that. So, it's a time pressure, but the staff does good work to make it easy for all of us.

So, I think what I'll do now is we're going to review – why don't you move this slide ahead to slide three, please. We're actually going to review some of the overall MAP rulemaking process. We're going to talk a little bit about the Meaningful Measures framework which is a new framework that CMS has been using. We're going to talk later about some of the programs that we're trying to offer for – offer measures to support and then finally we'll have an opportunity at the end for public comment.

So, I think what we'll do first is to have a brief roll call so we know who's on. Now, I realized that some of you were on the All MAP call on Monday of this week and so some of this will be a little repetitive. But for the rest of you, I think this will be good information as a context and a background for us to do our work in December.

So, let's go on to the roll call.

Hiral Dudhwala: This is Hiral from NQF. I'm going to go ahead and just do the roll call here as we know Bruce and Amy. Just hearing an echo, so if everyone can just go on mute unless you are responding to the roll call.

All right so, obviously we have Bruce and Amy are our chairs on the line. Scott Freedman from the American Academy of Ophthalmology?

Scott Freedman: Present.

Hiral Dudhwala: Wonderful. Thank you. (Terry Alderman) from the American Academy of Pediatrics?

OK. Diane Padden, American Association of Nurse Practitioners?

Do we have somebody from the American College of Cardiology, (Paul Coselli) or (William Van Decker)? OK.

David Seidenwurm from the American College of Radiology?

David Seidenwurm: Hi, I'm here. Glad to be back.

Hiral Dudhwala: Thank you, David. (Kevin Balman) from Anthem?

(Kevin Balman): Good afternoon. Present.

Hiral Dudhwala: Thank you. Amy Nguyen from (BAPG), who is a new member organization with us this year?

OK. Scott Furney from Heroinas Healthcare System? Robert Krughoff from Consumers CHECKBOOK? Helen Burstin of Council of Medical Specialty Societies? OK. (Dale Jagoon) from Genentech.

(Dale Jagoon): Present. Happy to join the group for the first time.

Hiral Dudhwala: Thank you. And, (Dale) is also a new – (Dale's) organization is also new for this year. Beth Averbeck from Health Partners?

Beth Averbeck: Good afternoon, Beth Averbeck here.

Hiral Dudhwala: All right, thank you, Beth. Stephanie Glier from Pacific Business Group on Health?

Stephanie Glier: Stephanie Glier, thanks for having me.

Hiral Dudhwala: Thank you. And Ann Greiner from Patient-Centered Primary Care Collaborative? Charlene Ngamwajasat from Primary Care Information Project?

Charlene Ngamwajasat: Good afternoon.

Hiral Dudhwala: Thanks, Charlene. Patti Wahl from St. Louis Area Business Health Coalition?

Patti Wahl: Yes, good afternoon. I'm glad to be back.

Hiral Dudhwala: Thank you, Patti. Next slide please. All right. A couple more before we move on. Our subject matter experts Dale Shaller?

Dale Shaller: Yes. I'm here. Happy to be back.

Hiral Dudhwala: OK. Michael Hasset? Eric Whitacre?

Eric Whitacre: Present. Hello, everybody.

Hiral Dudhwala: Thank you. And Leslie Zun?

Leslie Zun: Yes, good morning or afternoon to everyone.

Hiral Dudhwala: Thank you, (Leslie). OK. And you also see there are federal government member representatives. I will just pull their names out. If you're there please let me know. (Peter Brigg) from CDC?

(Peter Brigg): Hi, I'm Peter. Delighted to be back.

Hiral Dudhwala: Thank you, (Peter). Pierrere Yong from CMS? Girma Alemu from Health Resources and Services Administration?

Girma Alemu: Yes. Present.

Hiral Dudhwala: All right. Thank you, everyone. Back to you, Bruce.

Amy Moyer: Hi, this is Amy. We had the introduction of the Workgroup. Should we circle back? I know there's an NQF project team that's really integral to the work this committee does. And, John, would you be willing to introduce us to them?

John Bernot: Absolutely. Thank you, Amy. So, for those of you that don't know me, my name is John Bernot. I am a senior director and the director of the Clinician Workgroup. I am, like Bruce, a family physician. I'm only practicing part time now but still it is a great experience to be able to work with this from the centralized NQF and then also be experiencing these payment programs on the ground as a physician.

So, I very much look forward to working with those of you, again, and meeting the new participants. I will them also ask Hiral if you could introduce yourself?

Hiral Dudhwala: Hi, I'm Hiral Dudhwala. I'm the project manager. I'm also – I'm new to the MAP Clinician Workgroup. I have a background in nursing and I've been with NQF for the past year so I'm really excited to participate with the workgroup and the work related to this work this year. And (Madison)?

Madison Jung: Hi, my name is Madison Jung. I'm the project analyst. I'm coming up on one year here at NQF. This is my first MAP Pre-rule Making project but I've previously worked on the MAP Dual Eligible project and I'm also working on the MAP Rural Health project this year.

Amy Moyer: Terrific. Thank you all. I look forward to working with you. Now, we'll scroll forward back to the meeting objectives that we'll be accomplishing today. We'll start with a – there will be an orientation to the MAP Pre-Rule Making approach. We will hear about the meaningful measures work that's being done.

We'll have an overview of the MIPS in Medicare Shared Saving Programs and Measures. The programs that this committee makes recommendation for. And then we'll hear from CMS updates on the prior measures under consideration for MIPS program. So, those are measures that we looked at

previously and maybe made some recommendations and closing the loop on what happened with those measures.

So, before we dive into this, are there any questions from the Workgroup? All right, hearing none, I'm going to pass this back to NQF for the MAP Pre-Rule Making Approach discussion.

Hiral Dudhwala: Thank you, Amy. This is Hiral again from NQF. So, we're just going to briefly go over the MAP Pre-Rule Making approach. I know that some of you have been part of this group for several years and also some of you have – were also in attendance to the All MAP meeting this past Monday. So, this might be a review for some of you but there are some new members this year so hopefully this will be helpful.

Just a closer look onto some of the steps and recommendations that we'll be going on over the next few months. So, right now in November, some of the key points are that the MAP Coordinating Committee has examined some key strategic issues to inform preliminary evaluations of measures under consideration. And then, we also our MAP Clinical Workgroup meeting today which will familiarize the Workgroup themselves with the finalized program measure set for each program.

And then, in the upcoming months as you all know, we will be – the Workgroup will be evaluating the measures under consideration during their December In-Person Meeting which is informed by the preliminary evaluations completed by the NQF staff.

And then, in January there will also be the MAP Coordinating Committee which will examine the MAP Workgroup recommendations in key crosscutting issue.

Next slide please. All right. This is just a look at the timeline over the next few months. So, obviously we are – at the beginning of this timeline in November with the meetings that are going on right now and so on or before December 1st, we are anticipating the list of measures and under consideration released by HHS. Following that, we will see the initial public commenting period following the release of that list. In December for our Workgroup in

particular, we will be having an In-Person Workgroup meeting to make recommendations on the measures under consideration. So, for the Clinician Workgroup this will be on December 12th, In-Person all day.

For those of you who have obviously participated in previous years, in the past this has been a two-day In-Person, this year it is a one day In-Person. So, I think it'll be a very lively day. So, we just wanted to point that out.

So, following that there will be another public commenting period on the Workgroup deliberations which will occur in December into January. By late January, the MAP Coordinating Committee will finalize MAP input and you will see by February 1st into March 15 Pre-Rule Making deliverables released. So, again, for the Clinician Workgroup, again recommendations on all individual measures under consideration would be finalized by February 1st. And then guidance for clinician and special programs would be due before March 15th. So, that is the upcoming few months which as Bruce had mentioned will be pretty busy.

So, next slide. All right and we will obviously be diving into this deeper today but the programs that are considered by the Clinician Workgroup is the merit-based incentive payment programs – payment system that's – and the Medicare Shared Saving Program, MSSP.

Next slide. And so our goal for today's meeting is really the review of the CMS Meaningful Measures Initiative, review of the structure and priorities of each program and reviewing the list of each program and reviewing the list of current measures in each program.

Next Slide. OK, are there any questions before we move on to the next topic? All right. I will go ahead, Bruce and Amy and I'll pass it on to you.

Amy Moyer: Thanks, Hiral. I believe our next presenter will be (Regina Chou) from CMS talking about the Meaningful Measures framework.

(Regina Chou): Yes, good afternoon, thanks. I'm just going to give you a little background, I am here representing Pierre Yong, he sends his apologies, he was not available to participate in today's meeting.

My clinical background is as a registered nurse and I am a division director in one of the divisions in Pierre's group. My division oversees policy for the quality payment program MIPS and supports the other divisions that do measures as well as we are the lead for physician compare and the sunsetting program of PQRS.

So with that, I'd just like to start off today first before jumping into meaningful measures to say thank you to the MAP for all your incite full input on the MUC list. This really is very valuable to CMS and we appreciate all the time and energy that goes into this work.

So I'm sure many of you have already heard about the LAN summit from last week. And at the LAN summit, Seema presented our focus on the new approach to quality measures at CMS. This new approach is called Meaningful Measures and it really is an approach to focus on meaningful outcomes.

To look at four main areas – usher in a new era of state flexibility and local leadership, to empower patients and doctors to make decisions about their healthcare, to support innovative approaches to improve quality, accessibility and affordability. And lastly to improve the CMS customer experience.

While continuing to focus on quality and value, we propose moving in a new direction and using the following cross cutting principals and considerations for measure development and implementation; address high impact measure areas hat safeguard public health, promote alignment across quality initiative and programs; minimize the level of burden for providers; promote more focus quality measure development towards outcomes that are meaningful to patients, families and their providers; identify the big picture quality issues that are the high priority in improving the health and healthcare of patients and communities; begin to address the evolving measures needs for population-based payment incentives and communicate how CMS programs and measures improve patient's health and how we plan to deliver value, better care, smarter spending, and healthier communities to meet the needs of the patients.

We're moving to slide four and apologies to folks – my slide deck is numbered differently, sorry. If we can move to slide 17.

On this slide, we see where CMS developed the meaningful measures framework to align with CMS goals. It was important that the criteria be meaningful for patients and actionable for providers.

CMS considered multiple inputs for this work which included perspectives from experts and external stakeholders and drawing from existing measure work. A few examples that you can see on this slide are healthcare payment, learning and action network, National Quality Forum and others.

If we can go to the next slide please, as we look at meaningful measurement, the premise is to identify the highest priority area for quality measurement and quality improvement. To do this, we start with the core goals that you see in the center of the circle, then the focus turns to improve CMS customer service experience. Empower patients and doctors, support innovative approaches as well as state flexibility and local leadership.

As we move to the spokes on the wheel, you see the cross cutting criteria principals and this should – I just want to highlight here that this should be part of the evaluation for any measure that we look at.

There are six color coded areas that I'll review in more detail in subsequent slides. I think if you hit enter, they may pop on this slide now – they should merge in, but maybe not.

OK, no problem, we're going to go over them anyway. Go to slide 19. Here they come. I'll just let you see the graphics and then we can go to slide 19.

OK, so the first quality category is make care safer by reducing harm caused in the delivery of care. You see on this slide that there's two main areas. Healthcare acquired infections and preventable healthcare harm.

I just want to give examples – have you notice here that there are examples of illustrative measures, it's certainly not an exhausted list but it's important to call out that if you look at some of these measures, they cross over many

programs and that's intentional. A good example of this is the CLABSI measure that you can see is in six different quality programs.

And we can go onto slide 20. The second quality category is strengthen personal and family engagement as partners in their care. For this we have three areas to measure, care is personalized and aligned with patient's goals; end of life care according to preferences; patient's experience and functional outcome.

Move to the next slide. For category three, we're looking at promote effective communication and coordination of care and there are three meaningful measure areas here. Medication management, addition and readmission to hospitals, seamless transfer of health information. And again you see the same theme carried out here where measures can be seen in multiple programs.

Next slide. Category four is promote effective prevention and treatment of chronic disease. There's five main areas in this category. Preventive care, management of chronic conditions, prevention, treatment and management of mental health, prevention and treatment of opioid and substance use disorders and risk adjusted mortality.

Next slide. The fifth category is work with communities to promote best practices of healthy living. This area has two categories, equity of care and community engagement. We do believe that equity of care and eliminating disparities is broader than measures.

The last category is make care affordable. This category has three main areas. Appropriate use of healthcare, patient focused episode of care, risk adjusted total cost of care.

Go to the next slide please. The meaningful measures framework really will allow for CMS to move towards a more concise and least burden some measure steps that are well understood by stakeholders and helpful in guiding CMS quality efforts.

I can't emphasize enough here that we really want you feedback on the meaningful measures and how we can use them to best achieve our mutual goals of improving quality care for the country. You'll see at this point, your feedback Pierre Yong and Ted Long graciously have provided their e-mails since we don't have a specific e-mail box set up for this. Please send your feedback directly for them; they really do want to hear from you. And now I'll stop for questions and answers.

Bruce Bagley: (Regina), that was great. Does anybody on the phone have any questions? Operator, can you make sure that everybody has the phone available.

Operator: Yes, the lines are open.

Stephanie Glier: Hello, (Regina), this is Stephanie Glier from Pacific Business Group on Health. Thanks so much for sharing this. I know you guys have been a little bit on a road show with it so apologies if some of these questions are repeats from what you have been asked before.

First I'm wondering if you can clarity quickly, if it is possible to clarify that quickly who you intend when you say that CMS customer. I'm not sure whether that means beneficiaries or if it's a broader group of stakeholders.

(Regina Chou): Our CMS customer is a broader group of stake holders. We really view our customers as beneficiaries, as providers, as stakeholders. So it does – we have embarked making that a large list.

Stephanie Glier: Great, and my second question is probably outside of the scope for the presentation itself. I'm wondering if there is anything that you guys have developed specifically to incorporate the measure gap identification and development and how you're planning to big that into either the existing measure development plan or some other measure development process going on at CMS.

(Regina Chou): Yes, agree that that is out of scope with this discussion. I will say though, there'll be a lot more to come on this and we are starting and in the process of scheduling some Webinars that will give more in depth detailed discussion around meaningful measures and our plan.

Stephanie Glier: Thank you.

(Regina Chou): Sure.

Bruce Bagley: Any other questions?

Scott Freedman: Is there a more detailed explanation of the meaningful measure framework on the CMS website?

(Regina Chou): That's a good question and my engagement team lead just walked out of the room but I do not think we have that up yet. The last I looked, those documents were still going through CMS clearance but we are trying to push that through. So more to come.

Bruce Bagley: OK, any other questions? If not, (Regina), do you want to go on and talk a little about the MIPS program?

(Regina Chou): Sure. Next we're going to talk about the Merit-Based Incentive Program, our MIPS program that I'm sure most of you are familiar with and the purpose of today's discussion is to really just do a very high level overview of the final rule for the QPP for 2018 calendar – 2018 year which is the second year of MIPS.

There will be an opportunity to get involved in many other Webinars that will give much more detail and can go through a 60 to 70 slide deck. The final rule with – the final rule this year again was with comments, similar as what we did for the transition year. This final rule continues to build and improve on our transition year policies. It addresses elements in macro that were not in year one such as including virtual groups. Beginning with calendar year '19, performance facility based measurement and improving scoring. I'm sorry, can you move to the next slide.

That just highlights the – what I just talked about and if we can go to slide 30. This is just an update on the resource library where you can find a lot of valuable information. Let's go to the next slide, 31.

As I'm sure, almost all folks on this call realize, the Medicare Access and CHIP Reauthorization Act of 2015 requires CMS by law to implement an incentive program. This program has been referred to as a quality payment program and it provides two participation tracts, the MIPS track or the advanced APM track. The focus of today's high level overview is for the MIPS track.

Because the quality payment program brings significant changes to how clinicians are paid within Medicare, CMS is continuing to reduce burdensome regulation, provide new incentives and reduce the number of clinicians that must report and give clinicians more time to provide care to their patients in the manner they choose.

We realize this is a big change so we continue to move slowly as we ramp up the year two of QPP. CMS will continue to listen and take actionable steps towards improving health outcomes for all Americans. Next slide, please.

The strategic objective identified for MIPS APM program include improved beneficiary outcomes for patient centered MIPS APM's policy development and patient engagement, enhanced clinician experience through flexible and transparent program design and interactions with exceptional program tools, increase the adoption of alternative payment models moving from volume to value, promote program understanding and participation through customized communication, education outreach and support, improve data and information sharing to provide accurate, timely and actionable feedback to clinicians and other stakeholders, deliver IT systems capabilities that meet the needs of the end user and are seamless, efficient and valuable on the front and back end, and lastly ensure operational excellence and program implementation and ongoing development.

And next slide please. This slide just provides an overview of the legacy programs that were formed into a single program – single improved program, and they were the physician quality reporting system, the value-based payment modifier, and the Medicare HER incentive program for eligible professionals.

The next slide please. This is just a quick overview of the MIPS performance categories for year two. It's comprised of quality, cost, improvement activities, and advancing care information. All performance categories are calculated for the final MIPS score in year two.

Next slide. For the first two years – so just to highlight for clinician eligibility for year two, there is no change, but just to quickly recap for the first two years, those that are eligible to participate are physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified register nurse anecdotist who bill under Medicare Part B.

For third and future years under MIPS, we can expand those that are eligible to include occupational therapist, physical therapist, clinical social workers, dieticians, and others. I just want to highlight that those clinicians that are not currently eligible for the first two years do have the ability to voluntarily report for MIPS.

So we can go to the next slide. And on this slide we're just going to take a look at the change in year two to the low volume threshold. Many small practices did not have to participate in MIPS during the transition year due to the low volume threshold. For 2016, it was set for less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare Part B patients.

We've heard feedback that many small practices are still facing challenges in their ability to participate in the program. Therefore, we are increasing the low volume threshold to less than or equal to $90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B patients. And next slide please.

This slide just highlights the basic exemption criteria for MIPS in year two, and there is no change from year one. So the three exemption criterias are listed. And we can go to the next slide.

For the performance period we did increase the performance period for year two of MIPS. The performance period for quality and cost is 12 months in year two. And we can go to the next slide.

So as I alluded to in the beginning of this talk, we have added virtual groups as a way of participating for year two …

(Kevin Balman): Just a quick question.

(Regina Chou): Sure.

(Kevin Balman): So that last slide – so for 2018 – measurement year 2018, you're saying that physicians will now have to report data for the entire year, correct? 12 months? The entire 12 months of 2018 versus this current year 2017 that could be like varied three months? So for next year, a physician will be required to submit data for the entire year? That's correct?

(Regina Chou): Just to clarify, that is for the entire year for quality

(Kevin Balman): I got it. OK, for quality and cost.

(Regina Chou): Yes. Correct.

(Kevin Balman): OK, but they will have to report for all 12 months, correct?

(Regina Chou): That is correct.

Male: And one last question, Chou – in the previous slide the greater than 30,000, greater than 90,000. So billable – have to bill greater than $30,000 or greater than $90,000, correct?

(Regina Chou): Yes, that's correct.

(Kevin Balman): OK, thank you.

(Regina Chou): Sure. OK, so I think we can go to the virtual group slide. Great. So virtual group can be made up of solo practitioners and groups of 10 of fewer eligible clinicians who come together virtually no matter what specialty or location to participate a MIPS for a performance period of the year. Solo practitioners and small groups may only participate in a virtual group if you exceed the low volume threshold.

And we can go to the next slide. So as you see on this slide, for quality you select six individual measures, one must be outcome or higher priority. You may also select a specialty set of measures.

We previously finalized that the equality performance category would comprise 60 percent of the final score from the transition year and 50 percent of the final score for the 2020 MIPS payment year. While we propose to maintain the 60 percent weight for quality performance, we are not finalizing this proposal. We will be keeping our previously finalized policy to weight the quality performance category at 50 percent for the 2020 MIPS payment year.

For data completion, we are finalizing 60 percent for submission mechanism except web interface and CAHPS. Measures that meet the data completeness criteria will earn one point except for measures submitted by a small practice which will earn three points.

As more of the 80 percent of the MIPS quality measures finalize are tailored for specialists, we continuously work with specialty societies in defining the direction for quality measurement as well the identification of specific quality area gaps. And we can go to the next slide.

Dale Shaller: Excuse me, this is Dale Shaller, (Regina), could you explain a little bit further about the submission completeness criteria? What does it mean to say that 60 percent is acceptable for data completeness? Why wouldn't you want 100 percent? Hello?

(Regina Chou): Yes, hang on one second. So I think the short answer – but there is a more detailed answer than what I'm going to give you – is to decrease the burden on the clinician for reporting. So I think if I had to guess what you're getting at is the 100 percent would be more of a quality objective that you would want to strive towards. Is that why you're asking the question?

Dale Shaller: Yes, I guess I'm just trying to understand why not 100 percent if you're going to require the measures to be reported anyway, and why 60 percent – just what's the thinking that went into your establish in the threshold like that, and

because the 60 percent could be representative or not representative of the entire experience?

(Regina Chou): Right, right. So I think this would be a discussion we can have at one of our like longer webinars that allow for Q&A because if we try to get in the weeds on any one area today, we have a limited amount of time to just do the high level overview.

Dale Shaller: Sure.

(Regina Chou): I'm also happy if you want to shoot me an email too, and so whatever I can in email as well.

Dale Shaller: OK, thank you.

(Regina Chou): You bet.

Bruce Bagley: Are there any other questions? Do you want to finish up, (Regina), and then we'll move on?

(Regina Chou): Yes. So let's – as we look at slide 41, this just is going over the scoring policy for MIPS and there – I won't elaborate on this – there are no changes form the transition year. And we can move onto the next slide.

And this next slide talks about topped out measures, and, just real quickly, topped out measures will be removed and scored on a four-year phasing out timeline. Topped out measures with measure benchmarks that have been topped out for at least two consecutive years will earn up to seven points. The seven point scoring policy for six topped out measures identified for the 2018 performance period.

And I apologize that this side references that they will be on the next slide which I did not include in this deck, so I will quickly just give you a brief name and the ID number. Those measures are perioperative care, quality measure ID 21; melanoma, quality measure ID 224; perioperative care, quality measure ID 23; image confirmation of successful excision of image localized breast lesion, quality measure 262; optimizing patient exposure to

ionizing radiation, quality measure ID 359; chronic obstructive pulmonary disease, quality measure ID 52.

And topped out measures do not apply to CMS web interface measures, and we will monitor for differences with other submission options. And CAHPS will be addressed in future rulemaking. And we can go to the next slide.

We finalized the cost performance category weight at 10 percent of the MIPS final score for year two after being weighted at 0 percent in the 2017 transition year. We are required by law to weight the cost performance category at 30 percent beginning in year three of the program.

Measures include Medicare spending per capita, Medicare spending per beneficiary and total per capita measures per costs. For 2018 MIPS, we won't use the 10 episode-based measures adopted for 2017 performance period. We are developing, however, new episode-based measures with stakeholder input and soliciting feedback on these measures. We expect to propose new cost measures and future role making and solicit feedback on episode-based measures that are included in MIPS.

And the next slide please. So MIPS score again – this just highlights the MIP scoring improvement for quality and cost. For quality, improvement scoring will be based on a rate of improvement such that higher improvement results and more points for those who have not previously performed well. Improvement will be measured at the performance category level up to 10 percent points available in the quality performance category. And cost improvement scoring will be based on statistically significant changes at the measure level and up to 1 percent point available in the cost performance category.

And the next slide. This slide overviews improvement activities which comprise 50 percent of the final score. There's no change in the number of improvement activities, MIPS clinician and small practices, and in rural areas we'll continue to report on no more than two to achieve the highest score.

For patient centered medical homes, this slide highlights that we finalize the term "recognize" as equivalent to the term certified as a patient centered

medical home are comparable specialty practice. And 50 percent of the practice sites within a (TIN) need to be recognized as a patient centered medical home for the (TIN) to receive full credit for this improvement activity. And next slide.

We continue to focus on incentivizing the youth of health IT as it's an important aspect of care delivery. Processes described in many of the proposed new improvement activities, we intend to issue more detailed guidance about improvement activities such as allowing attestation to reduce burden.

Our goal is to allow flexibility and performing activities and avoid complex reporting requirements. And next slide, this slide just overviews the advancing care information and changes for next year too. Next eligible commissions may use either 2014 or 2015 cert or a combination. In 2018 a 10 percent bonus is available for using only 2015 addition cert.

Measures and objectives the MS finalizes exclusion for e-prescribing and health information exchange. With regards to scoring there's no change to the base score requirements. For the performance score the next eligible commissioning groups will earn 10 percent are reporting to one of the public health and clinical data registry reporting measures as part of the performance score. For the bonus score a 5 percent bonus is available for reporting to an additional registry not reported under the performance score. And additional improvement activities are eligible for a 10 percent advancing care information bonus completion of at least one of the specified improvement activities using cert.

The total bonus score available is 25 percent. And next slide please. For the next threshold and payment adjustments we finalized as proposed. We set the performance threshold at 15 points. Additional performance thresholds stay at 70 points for exceptional performance. And payment adjustments for 2020 payment year ranges from minus five to plus five percent. And full participation in Mist could mean – would mean that the carnation should at least meet the following criteria. Report six quality measures, report four

medium weighted or two high weighted improvement activities and report five advancing care information measures.

And the next couple of slides I just want to talk to extreme and uncontrollable circumstances. So for next year two CMS knows that areas effected by recent hurricanes, specifically hurricanes Harvey, Irma, and Maria have experienced devastating disruption in infrastructure. We've addressed extreme and uncontrollable circumstances for both that transition year and year two.

For the transition year if our next eligible commissions cert is unavailable as a result of an extreme and uncontrollable circumstance. The next eligible commission may submit a hardship exemption application to be considered for re-weighting for advancing care information performance category.

The application deadline is December 31, 2017. Then we can go to the next slide and this slide highlights extreme and uncontrollable circumstances in year two. The final rule with comments for year two extends the transition year hardship exception re-weighting policy for the advancing care information performance group to now include quality cost and improvement activities.

This policy applies to the 2018 NIFS performance category. The hardship exemption deadline for this is December 31st. And the last slide please. We believe the automatic extreme and uncontrollable circumstance policy will reduce clinician burden during a catastrophic time. And we will also align with Medicare policies and other programs such as the hospital IQR program.

Under this policy we will apply extreme and uncontrollable circumstance policies for the MIPS performance categories to individual MIPS eligible clinicians for 2017 MIPS performance without requiring a MIPS eligible clinician to submit an application when we determined that a triggering event, that a hurricane has occurred and that clinician is in the effected area.

We will automatically waive the quality improvement activities and advancing care information for (performance) category at 0 percent of the final score. Resulting in a final score equal to the performance threshold

unless the MIPS eligible clinician emits MIPS data which we would then score on a performance category by performance category basis like all other MIPS clinicians.

And I thank you for allowing me to talk about MIPS year two today. And look forward to the opportunity for you to hear more in depth discussions at a later time.

Bruce Bagley: That's great (Regina), thank you for that extensive coverage of that, it's – I've heard it a number of times and I learn something every time, so it's – it's a lot involved. Yes, John did you have any comments?

John Bernot: No comments on that particular other than to say thank you so much (Regina) for both of those. Some very thoughtful discussions and really taking a ton of information and giving it to us in an efficient manner. I can pick up though Bruce if you would like me to on the role of the map or if you would prefer to see if there's any questions for (Regina) we could that right now also.

Bruce Bagley: Why don't we just see if there are any questions before we move on.

Male: Yes, I have one quick question, (Regina) can you quickly comment on the advantage of small groups or solo practitioners from an in-virtual group for reporting?

Ashley Spence: Hi this is Ashley Spence at CMS. So one of – we get this question a lot by the way. So one of the advantages would be that aren't bound by geographic location, so a virtual group wouldn't – could mean that if you – if individual small groups meet the threshold then you can join together with (inaudible) on the other side of country to really maximize your participation in the program. So that's generally the main benefit.

Dale Shaller: So there doesn't need to be an organization period – this is Dale Shaller and I just want to kind of understand again a little bit about that. If you can group up virtually from one end of the country to the other, you don't have to have some sort of organization routine based relationships with each other?

Ashley Spence: There is actually, they have an agreement. In the Resource Act of .U2 is in the CMS the quality of payment program resource library. We have a virtual group's tool kit that actually has samples and all of the information that would make sense for groups – small groups that want to join, but yes there is an agreement – a written agreement between groups that CMS would have on file for a small group that formed for a tool group.

Dale Shaller: But if I'm a solo practitioner and I'm performing at an extremely high rate, would there be any advantage for me to form a virtual group?

Ashley Spence: So it depends, so it depends if you – if you are performing at a high rate for quality measures, but maybe you don't have certified EHR technology and you want to partner with another group that maybe is an early adopter of EHR. And that they're – that's kind of their niche where they perform high then in that instance if you both meet the threshold kind of all those requirements then it might make sense. Because then together you two could maximize participation in the program.

Dale Shaller: Got it, that clarifies it. Thank you very much.

Ashley Spence: Yes.

Dale Shaller: One other question if I may?

Male: Go ahead please.

Dale Shaller: Sure, with respect to topped out measures. Since not – since reporting on the given measure could be voluntary it seems reasonable to assume that the best performers are going to be reporting on measures. Are we concerned that we might be retiring measures prematurely before there's universal high performance?

(Regina Chou): So I think for that—that's why we're taking a four kind phased approach to this. So we're not moving – we don't want to move too quickly.

Ashley Spence: And then in the interim, this is Ashley again. So in the phase in or out approach I guess I'd rethink about it that way is as we start to phase out those

process measures. At the same time we're still developing measures that meet the need for specialties, but in a more outcome and space way. So we're not just doing away with measures, but trying to replace them with measures that are meaningful or a little more meaningful. And that is process space.

Dale Shaller: Thank you.

Bruce Bagley: OK if there are no other questions or comments maybe we can move on? Is (Robby Acann) on the phone?

(Robby Acann): Hi yes.

Bruce Bagley: Hi there, welcome. And you're going to give us an overview of a MSSP.

Female: Hi Bruce, actually John is up next to give the role of MIP.

Bruce Bagley: All right thank you for keeping me on track, thanks.

Female: No problem. John are you on? If you're on, you're on mute. OK all right I think we must have lost John somewhere here. Well maybe we can move on to (Robby) and then John can come back to this. OK we'll move ahead with the slides.

(Robby Acann): Thank you, and I'm (Robby Acann) from the Division of Shared Savings program within our CMS performance based payment policy group and I'll be providing an overview of the Medicare shared savings for the room for you today. You could probably jump to the next slide. Here's an overview of what I'll be covering in my presentation today, so I'll be providing an overview of the program sharing our recent 2016 performance year results.

Reviewing our quality measurement approach with them within the shared savings program, which also includes the quality measures and our quality performance assessment approach and then also I'll be covering future measure configurations. If you could jump to the next slide please. Thanks.

So the Affordable Care Act section 3022 mandated the Medicare shared savings program. Accountable care organizations or ACOs create incentives

for healthcare providers to work together voluntarily to coordinate care and improve quality for their patient population.

As of January 1 of this year we have 480 shared savings – shared savings program ACO participating in the program who are serving approximately nine million Medicare faithful service beneficiaries. We have seen a mass of (inaudible) ACO performance annually based on quality and financial performance to determine shared savings or losses.

In order for ACOs to be eligible to share in savings if earned, they must meet our programs quality performance standards. Shared savings and loss of financial calculations integrate the overall quality score. Next slide please. So as I mentioned earlier we want to share some of our 2016 performance year results in both quality and financial performance.

We had 432 ACOs participating in the 2016 performance year. And 99 percent of ACOs completed quality reporting and met the quality performance standard to be eligible to share in savings if earned. ACOs have participated in the shared savings program and report quality measures in both 2015 and 2016, improved on 94 percent of the quality measures that were reported in both years.

93 percent of ACOs received bonus points for improving quality performance in one of the four quality measure domains. To calculate quality improvement reward points there must be two consecutive years of reported data, so more than 90 percent of ACOs who are in their second or third performance year of their first agreement or second agreement period with the shared savings program, during 2016 increased our overall quality performance score through quality improvement reward points in at least one of the four quality domains.

Next slide please. In performance year 2016 134 ACOs earned shared savings payments. And the number of ACOs that have generated savings have had a positive trend. For performance year 2016 and 2015 31 percent of ACOs generated saving above their minimum savings rate compared to 28 percent in 2014. ACOs must meet or exceed the minimum savings rate to get a shared savings payment.

ACOs with more experience in the program are more likely to generate savings for performance through 2016, 42 percent of ACOs that started in 2012 generated savings above their minimum savings rate compared to 36 percent of ACOs who started in 2013, 36 percent of the 2014 starters, 26 percent of the 2013 and 18 percent of the 2016 starters.

In addition, on average, ACOs that are (physician) led have better results so in performance year 2016 a higher share of the physician only ACOs has shared savings, 41 percent, compared to ACOs with the hospital at 23 percent. In performance year 2015 physician only ACOs were also more likely than ACOs at hospital to have shared savings. This is also the case for performance year 2014.

And next slide please. Now focusing on our quality measurement approach, which is developed and intended to improve individual health in the health populations adjust quality aims such prevention, care of chronic illness, and high prevalence conditions, patient safety, patient and care giver engagement, and care coordination, support the shared savings programs goal of better care, better health and lower growth and expenditures, aligned with other quality incentive programs, including quality payment program.

Next slide please. Around performance year 2017, and also, action for performance 2018, there's 31 quality measures that are separated into four key domains. We have the patient care giver experience, care coordination, patient safety, preventative health, and the at risk populations domain that make up our quality measurement approach.

So the quality approach for these 31 measures though are collected through four mechanisms which include a patient survey, we use the CAHPS for ACO survey, Medicare claims data, Advancing Care Information data, and CMS web interface data that is reported by ACOs.

Next slide please. I'll now begin going over at a high level our measure set, so the first domain that we have here is our patient care giver experience domain and it contained eight measures from the CAHPS for ACO survey. Which is based – which is built off the clinical group CAHPS survey. Our

care coordination patient safety domain contains 10 measures. Most of these (claim) measures are calculated using Medicare claims data. ACO11, I want to highlight this one, is the use of certified EHR technology measure and it's calculated using MIPS Advancing Care Information data.

In addition, within this domain we do have two measures the ACO 12 and 13, which are medication (req) conciliation post discharge and the screening for future follow up basic measures, which are collected from – which are collected from the ACO through the CMS web interface.

Next slide please. OK so our third domain is the preventive health domain and it's comprised of eight measures. All of these measures are reported by ACOs so the data is collected through the CMS web interface.

Next slide please. And then finally we have the clinical care for at risk population domain, it contains five CMS interface measures. Although, ACO 27 and 41, the diabetes individual measures that are listed here, they are individual measures but they make up our diabetes composite measure. The composite measure is scored as a single measure though.

All right. Next slide. Since they're not going over our quality performance assessment, so we at CMS designate the quality performance standards depending on how long the ACO has been in the program and this table is really helpful in sort of understanding how this works. So for ACOs in the first year of their first agreement, they enter into three year agreement with CMS.

So the first year of the first agreement PY1 which we often refer to as pay for reporting, to be eligible to share in saving they've earned the ACO must completely and accurately report all quality measures. This will then qualify the ACO to share in the maximum sharing rate for payment.

And for ACOs in their second or third year of their first agreement or if they're in their subsequent agreement if they in any further performance year that they may be in, they're in what we call a pay for performance year.

So to be eligible to share in saving, if earned, they must not only continue with completely and accurately reporting all quality measures, that they also need to meet minimum attainment on at least one measure in each domain. And minimum attainment is further defined as the 30 percentile bench mark for those measures that are identified as paid for performance and then for paid for reporting measures they are set at complete and accurate reporting.

But by meeting the quality performance standard, the final sharing rate for determining their shared saving or losses is determined based on their quality measure performance. The ACOs due on points based on their individual measure performance and can earn up to four quality improvements points per domain.

Each of the four domains that we quickly went over are equality weighted and then there's an over all quality score that is determined. We do establish performance bench marks for measures and they're set for two years to support ACL quality improvement efforts.

When we do introduce a new measure to the measure set, they're set at pay for reporting for two years before being phased into pay for performance to allow ACOs to become familiar with the measure but also so that we can have a year of data to be able to calculate a bench mark before we can transitions it to pay for performance. There are four measures that are finalized for pay for reporting all years. We do provide a schedule for how these measures phase in from paid for reporting to performance.

Next slide, we can go over the next slide. So in this slide we were hoping to share our consideration so when we develop the measures under consideration list and then when you will later review that list in December, we would really appreciate your input on our MUC list but also on potential measures for the future of the shared savings program. It's important for us to maintain alignment across various quality reporting initiatives.

So when considering measures, we do our best to align with other value based purchase initiative which is MIPS – MIPS in this value based purchasing program. So currently, measures (within our) measure set align with (Amelia

Hart's initiative) and the core quality measure collaborative recommendations. Measures aligning with MIPS do include those reported through the CMS web interface and the CAHPS for ACO survey.

We are sensitive to administrative burdens for reporting and do our best to leverage existing data collection methods for measures. So for instance, for performance year 2017, the quality payment program will use the ACO reported CMS web interface data to calculate the quality performance category for all MIPS eligible clinicians participating in the ACO.

In addition, the ACI reported data that is submitted to the quality payment program will then be used to calculate the ACO11 quality measure for the shared savings program. And then finally when considering measures, we focus on identifying measures that address national quality strategy and CMS quality strategy goals and priorities. That's all I have to go over, but if there are any questions?

Male: Does anybody have any questions? And if not, John are you back on the line?

John Bernot: I am, can you hear me?

Male: I can now. Would you like to comment on the MIPS program, slide 75 or would you like to go back to – I'm sorry, (MS) said Pierre would you like to go back to MIPS?

John Bernot: If it's OK I'll go back to slide 54 – if that's OK here on Madison?

Male: OK, great. Go ahead please.

John Bernot: OK, and first of all, let me do apologize. For some reason I could hear everything going on but it was clearly, you were unable to hear me. I'm going to very quickly over the next five or six minutes, go over two things for each program. One is the priorities and needs for the program that CMS kindly gives to us for supporting the group and so the group knows what we are looking for.

The second thing is a very, very high level overview of the composition of the measures within the program. Now let say it's high level because it's going to just give a flavor of what's in there now and I'll talk about how we'll do some evaluations of the measure of that are actually off line after this particular meeting.

But for the MIPS program there's some priorities that are laid out by CMS and I think these are very common but I want to make sure that we are thinking about this as we're looking at the overall measure portfolio. The first one is being an outcome measure we've heard this movement from process to outcome for a very tightly linked outcome measures. We've heard also about this special for the need for relevant measures for specialty providers and I will show a graph of how the measures line up very shortly.

Some of the high priority domains, I won't read those here to you but if you could take a look at the different type of measure, these are the high priority measures where we want to be adding to the MIPS portfolio. And lastly, just as another priority in need was just to mention that (Macro) is requiring that this mission of a new measure has been submitted for publication in an appropriate peer review journal.

Next slide please. Some other thoughts from CMS regarding the MIPS portfolio that these – just to let folks know, these will be available for public reporting on (physician compare). We are looking when we start evaluating the measures, for fully developed and tested measures ready for implementation; measures that aren't duplicative and I thought that Regina did a good job of explaining the (topped out) process and that's something we'll be trying to avoid. Next slide, please.

This is where I mentioned that the – we'll talk a quick bit about the portfolio itself. And being able to see how this aligns with the priorities that have been laid out where you may have seen that the person and caregiver center experienced an outcome which is at the bottom of this, clearly has many fewer measures than things such as effective clinical care.

And I just wanted to put this out here so you can see the type, the distribution based on the MIPS measure domain. Next slide? As you know, or may know, the MIPS program does not require NQS measurement endorsement for a measure. It does require a lot of the components or attributes that endorsement entails, such as it has to be fully tested, reliable valid measures is what CMS is looking for.

But I put this out here to show we're about 50/50 right now. There is an asterisk saying this is a status as of October 2016 and I put that out there because endorsement status can change on measures through our endorsement process. But this gives you a feel for how many measures are endorsed versus not endorsed. Next slide, please.

Also here, this is the measure type. Getting to some of our previous conversations here, I put this so you can see the clear overwhelming nature of the process measures. This goes in line with the priority to move more from the process toward the outcome or the patient experience engagement measures.

Next slide. And lastly, I laid out the measures for your review by the specialty sets, these are the specialty sets that the quality payment program and CMS set. I will say, just so you can see the note at the bottom, that a measure can be part of more than one specialty set. So these are not mutually exclusive sets, so of course if you added those numbers up, it would exceed 271 on this particular slide.

Nevertheless, I do think you can see areas that are rich in measures such as general practice family medicine and then other areas that have a lot lower count of measures such as radiation oncology.

OK. (Can) you jump to a slide 77, we will very quickly go over the MSSP program in a similar fashion and then briefly discuss how we will talk about these measure sets. Great, so just to make sure I'm being clear, that was the MIPS priorities. The MSSP priorities, I will go over here, not that they are very different a lot these overlap a lot. Which is great, as move towards

alignment in these sets, but outcome measures come up right across – as the first one on this also.

Targeting the needs and gaps and care for Medicare (frequent servers) and their caregivers, so this is saying, we're looking for measures here in the gap areas. Alignment with other programs, such MIPS, those that support both individual improvement as well as population health improvement and keeping in mind alignment with the recommendations for the core measures collaborative.

Next slide, please. And as (Robbie) had mentioned a bit about the domains, you can see the distribution here which is relatively balanced in the current measure portfolio, right here. And next slide. This is a slide giving the endorsement status for MSSP measures similar to what we showed in the MIPS program. There are more endorse measures in MSSP than we saw, more higher percentage I should say of endorsements (when) MSSP versus MIPS program.

And one more slide. This also shows the distribution, I think it's good for a comparing contrast to the MIPS were we saw it was two-thirds in MIPS program that were on the process side. And the MSSP is actually less than half, which a higher percentage patient reported outcomes than we saw across the MIPS program.

OK, next slide. And I put this slide out here not for us to discuss right now, but one of the things we tried to do is to really take a lot and look at the gaps that might be present. And again the gaps could be based on those domains that we looked at, it could based on the specialty sets in MIPS. And we really asking everyone on the committee to take a thoughtful approach to this and think about where the measure sets can be improved.

I will say we are working with CMS to decide how to facilitate this. Some of it may depend on how many measures we have on the MUC list and whether we will have time to discuss this at the December meeting. Alternatively this may be something that's done in something such as the survey for the group.

In fairness I don't think we would do it justice even if we did try to talk about this today as you really have not even been able to see the frameworks with a whole lot of time to think about this. But going forward will provide some very explicit directions of when we want to talk this and what questions we want to ask. And we'll also make sure we facilitate this again, either offline, between the meetings, or we will let you know if we're going to spend some time at the December meeting and talk about it in person.

So I will pass back to you Bruce to see if there any questions on what I went over, if not we will be able to move onto the next section.

Female: Bruce or Amy, are either of you on call?

Amy Moyer: Oh …

Bruce Bagley: I was – this is Bruce. I was talking away on mute.

Female: OK.

Bruce Bagley: So Amy why don't take over.

Amy Moyer: Sir thanks. Our next presenter, we were going to go back to it looks like (Regina) to talk about some updates on prior measures from the MUC list in previous years.

(Regina Chou): Yes, great so thanks. Before I start, can I ask, we seem to have had on our end a couple folks that were supposed to be able join remotely and they've not been added speaker rights.

So I have sent them a different number to see to see if that was issue, but I'm wondering if the organizer is able – would be able to check and grant speaker right access to (Jamie Welsh) and (Kathy Kane).

Madison Jung: Heard you – this is Madison. Yes, our operator (Kathy) is working on that right now.

(Regina Chou): Excellent. OK, great. Thank you. So then I'm just going to tee this off and then I'm going to turn it back over to Madison. But I just want to kind of at a high-level, talk about the purpose of the feedback loop.

That is a new process and the feedback loop is really to provide updates on our measures that we've presented to the MAP last year on the measures under consideration list. To just allow for this continued back and forth discussion in a more kind of lively communication I think.

We choose measures – in doing this we choose measures that have updates on the measures and then engage or had a robust discussion on the MAP last year. So with that I will turn back over to Madison to run through this presentation.

Madison Jung: Great. Hi, again this is Madison Jung, I'm the project analyst. The first measure we will start off with is bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy.

The MAP recommendation from last year's cycle was refined and resubmit prior to rule-making. And in interest of time I won't read the whole rationale, but the last sentence highlights the MAP recommends resubmission after addressing the measures specification and testing concerns. I believe the developer Oregon Urology Institute should be on the line, do we have Rachel Buchanan with open-line?

Rachel Buchanan: Yes, can you hear me?

Madison Jung: Yes, we can.

Rachel Buchanan: All right, so we did take into consideration what was recommended and we did refine the description of the measure to include in rather than any prior (ADT) use to actually be (ADT) use and for an anticipated period of 12 months of greater.

And we also were approached by Mathematica Policy Research, MPR after the MUC and they guided us through the process of developing this measure. We tested it in Bonnie and got all of the measure submitted and it's actually

on the final rule for CMS645 version one, it is a process measure, though. So as far I know 2018 it will be available to be used.

Madison Jung: Great, thank you for that update.

Rachel Buchanan: OK.

Madison Jung: Any questions from any committee members? OK. Hearing none, I will move on to the next one then. Thank you, Rachel.

The next measure is prevention of post-operative vomiting combination therapy for pediatrics. It was MUC16-312, the recommendation was conditional support for rule-making and the conditional support was pending (inaudible) and endorsement. The measured (steward) is American Society of Anesthesiologist and I believe we should have (Toni K.) on the line. (Toni) are you there?

(Toni K.): Hi, this is (Toni), can you hear me?

Madison Jung: Yes, we can.

(Toni K.): Hi, so this measure – this has been finalized for MIPS 2018, as MIPS number 63 and we are planning to submit this in the coming spring cycle of submissions for NQS endorsement. There otherwise, we haven't made really any significant changes to this measure as part of the rule-making process.

Madison Jung: OK, thank you (Toni). Thank you for that update. Committee members any comments, questions?

Male: I'm sorry on the previous slide the recommendation was refined and resubmit and is it being resubmitted? Is it going to be used for reporting in 2018? Are we going to reevaluate it?

(Toni K.): It will be available for reporting in 2018.

Male: So if we – if the MAP recommends refine and resubmit, why isn't get resubmitted for reevaluation?

(Toni K.): You know I will say, this is our first quality measure that we've tried to submit. And after it was suggested to be resubmitted Mathematica Policy Research, which is a subcontractor with CMS contacted us to guide us through the process to get on to the finial rule. So I – I will admit I – I guess guidance would be needed for us about when we would need to do the MAP submission. If it's already been a – now a final rule.

Stephanie Glier: This is Stephanie Glier, I think that's actually a question for CMS why CMS choose to include the rule – include the measure in the final rule rather then sending it back to MAP for – for reconsiderations.

(Regina Chou): So hi this is (Regina Chou). What I'd like to do is take this discussion off-line because it's a conversation that I would want Pierre Yong involved in. So if we could kind of have this at a later date.

Amy Moyer: OK, all right then. No comments for this – this one we just went over, 312? OK I'll move on then.

The next one we have is uterine artery embolization technique documentation of angiographic end points and interrogation of ovulary arteries. That was MUC16343 their recommendation is to refine and resubmit prior to rule making. The last sentence highlights MAC recommends that if an outcome measure is not feasible at this the measure should be resubmitted with testing that supports variation at the individual clinician level.

The steward is Society of Interventional Radiology. I have as a speaker (Zoel Hydari).

(Zoel Hydari): Hi yes this is (Zoel Hydari). I apologize about the background noise. We – we do appreciate the feedback we received from MAP. We are still actively collecting data through the IR registry to ensure the robustness of testing data. We do expect to refine the measure and resubmit in 2018. It will most likely change to a process measure.

Amy Moyer: OK. Thank you for that update. Committee members any questions or comments? OK.

Male: Hi …

Amy Moyer: OK, go ahead.

Male: I was going to ask why you are changing it from sort of an intermediate outcome type measure to a process measure. What changes would occur as you did that?

(Zoel Hydari): I'm sorry you – you asked what changes would occur as a result of doing that?

Male: Correct yes.

(Zoel Hydari): I think that's the feedback that we've received that this is – seems like it's more of a process measure. And so I guess we're taking that into consideration. It – it's not final how we're going to kind of revise this measure. But that's something we're considering.

Amy Moyer: OK, thank you for that. Any – any other questions? All right we'll move onto the next measure then.

The next measure is average change in back pain following lumbar discectomy and or limit – lemon – limit (inaudible) excuse me. Conditional – the recommendation was conditional support for rule making. Conditional support was given pending NQF endorsement and testing that supports variation at the individual clinician level.

The steward is Minnesota Community Measurement. I have Colleen Pitzen down as the developer. Are you on the line (Colleen) or Collette?

Collette Pitzen: Yes, this is Collette, can you hear me OK?

Madison Jung: Yes.

Collette Pitzen: Fabulous, thank you for the opportunity to come and speak to the MAP Clinician Group today. I do have a couple of updates. We have three measures that are under consideration in the 2016 that have as the other measures, they have been included in the finial rule making process.

At the time of – so this measure for average change in back pain for discectomy and laminectomy, if the patient reported outcome measure in which the average change of calculated based on the patients pre-operative pain scale to their post-operative. In this case's population, it's three months post op and measuring that average change. The MAP recommendation was to consider and do testing at an individual clinician level and indeed we do have the capability to do that and we provided some information back to the MAP as prior to this meeting.

However, we have a couple of cautions in the consideration of reporting at the individual clinician level. While variation can be demonstrated, there may be some concerns with volume of procedures, so that would come with some cautions in reporting at that level. There is a wide variation in volume, this is not a hugely – there are not hundreds and thousands of patients undergoing this procedure.

Our second concern is a philosophy and the reality of team-based care in affecting the outcomes for this patient. And then the second recommendation was to submit this measure for endorsement, we would have done that in the prior year, however until recently, there was not a project open for us to submit these measures. We do have an endorsed measure for functional status that is similar in measure construct.

And then I just wanted to share too, that there's been additional discussions with CMS over this year about the desire to be able to provide bench marks which is a little bit difficult with a continuous variable measure. Although we can and do publicly report the differences in improvement in patient's pain post-operatively, it is difficult to provide a benchmark so we will be reconvening the measured development group to consider either the development of benchmarks based on the average change or consideration of a target based measure.

Madison Jung: Great, thank you, Collette.

Collette Pitzen: Sure.

Madison Jung: Any questions or comments from the committee?

OK, hearing none. We'll move on. The next measure is average change in back pain following lumbar fusion; this was (MUC 1688). Same, again the MAC recommendation was conditional support for rulemaking, the conditional support was pending and endorsement and testing, that supports variation at the individual clinician level. And again the Steward is Minnesota Community measurement.

Collette Pitzen: Great, thanks, Madison, I just wanted to point out this measure is similar in construct to the previous measure, however this is a different population of patients with a more intense procedure, this is lumbar fusion and we're following these patients one year post-operatively, so their average change in back pain in measured pre operatively and post-operatively at one year.

The MAP recommendations were the same, and we did provide individual clinician data so again we have that capability however with the same cautions, thanks.

Madison Jung: Thank you, any questions or comments from committee members?

OK, hearing none, we'll move on to the next measure. The next measure is average change in leg pain following lumbar discectomy and or laminectomy. The MAP recommendation is conditional support for rulemaking and the conditional support was pending NQF endorsement and testing that supports variation at the individual clinician level. Again, this measurement is stewarded by Minnesota community measurement.

Collette Pitzen: Great, thanks, this is Collette again. If you haven't figured it out, I just want to point out that we have kind of a suite of measures for two populations of patients. The lumbar discectomy and laminectomy patients that are assessed pre-operatively and post-operatively at three months and we assess functional status, quality of life and pain.

And we're talking about pain in two separate areas because patients with back pain or that are experiencing disc problems at this level, they can present either with back pain, or leg pain or both but not every single patient has both

back pain and leg pain. So this is a measure of leg pain following lumbar discectomy or laminectomy.

Again, we received conditional reporting and provided information at the individual level that does demonstrate variation however with some cautions related to volume. And pending further discussions with our measure development and workgroup, we do intend to submit these three measures for endorsements in a future cycle. Thanks.

Madison Jung: Thank you for that update and thank you for your presentation of all three. With that, I'll turn it over to Amy or Bruce to facilitate any questions and if no questions are asked, (we will follow) into public comments. Amy, Bruce?

Bruce Bagley: I'm on, it's Bruce, any questions at all for those, you know we got some feedback for some of the recommendations we made last year. Any questions either on the measures themselves, probably not appropriate to spend a lot of time talking about the measures, but how about the process, does this help full in terms of when we look at the MUC list for this year about what actually happens to some of these measures?

Beth Averbeck: Hi, Bruce, it's Beth Aver back in, thanks, Collette. Collette and I worked at Minnesota Community Measurement and I think it's really helpful to know what happened to the recommendations from last year as far as some of the specific measures so I appreciate adding that as a follow up for us for this year. Thank you.

Bruce Bagley: Thanks for that, Beth. Any other comments or questions?

Stephanie Glier: Yes, this is Stephanie. Just to reiterate what we covered briefly before and I don't think we need to talk about it now. But it probably would be helpful to have a little bit of conversation maybe at the beginning of the In-person meeting to talk about what does happen with the revise and resubmit recommendations.

I understand that CMS has the discretion to choose what they want to do with MAP's recommendation to them about the MUC list. But I think for us, understanding what goes into CMS's decision about whether to move forward

with the measure even if MAP has recommended a resubmission would be helpful. And that probably would help us with our voting process as well.

Bruce Bagley: And (Regina), I understand that Pierre does plan to be at the meeting and we can make sure that he talks a little bit about that at the beginning.

(Regina Chou): Yes.

Scott Freedman: Not to belabor the point Bruce but again, I like to, Stephanie has been doing this for years, she knows more than I do but it just doesn't make sense to me, I'm a reasonable guy, that if we recommend resubmit and it doesn't get resubmitted, that defeats the whole purpose of our recommendation.

Bruce Bagley: Well resubmitted to whom? I guess that's the question.

Scott Freedman: I think it's supposed to go back to this committee. I would imagine, don't you?

Bruce Bagley: I think that may not be the case, so we do need to clarify the process.

Scott Freedman: That would be an excellent, that'd be an excellent point.

Bruce Bagley: Yes, absolutely. I think it actually goes under a separate process but let's get that clarified because I think there was some confusion about that last year as well.

(Regina Chou): OK, thanks.

(Peter Brigg): And Bruce, this is (Peter). The only other process suggestion I might have is that for those of us who drop in and out episodically on some of these measures, it might have helped me to get written material prior to the meeting and then hear a discussion as opposed to hearing an oral discussion in this meeting, so just something for NQF to consider whether this is the easiest format or whether – I think it's a great idea to give a format – information on what happened, whether a verbal, whether a short verbal update is the best way to do that or not, I'm not sure.

Bruce Bagley: Thanks for that, any other comments or questions? Then I guess it's time to open up for public comment if there are no other questions from committee.

Operator: At this time, if you would like to make a comment, please press star then the number one.

We do have a question from the line of Koryn Rubin with AMA.

Koryn Rubin: Hi, this is Koryn Rubin from American Medical Association. Thanks for the overview and the re-introduction of the MAP process and the decision trees.

I have two questions related to the last agenda item. In terms of with refine and resubmit in the discussion, it would be helpful to gain clarification on what the intended process is. I think that times people have thought that would – that means that you bring it back to the map again for you know another MAP review and discussion.

I think it's hard to follow when you know it's only just kind of just a brief highlight that occurs over the last few minutes and you're not able to really have a dialog. But with the Minnesota Community Measurement measure, I don't know if the woman from Minnesota can answer this question or perhaps CMS. It was highlighted that there's difficulty with creating a benchmark for continuous variable measures. And given the importance of functional status measures as they relate to outcomes and that many measures are based on time variables, I'm trying to understand why CMS can't create a benchmark for it.

I know in the hospital program, there are continuous variable measures that are part of the IQR and hospital compare and so there are benchmarks for it and CMS has been able to perform and create benchmarks. So any insight would be helpful.

Beth Averbeck: Yes, hi, this is Beth Averbeck and I don't know if Collette left the call or not. But I am from Minnesota and work some with Minnesota Community Measurement and if my understanding is correct, it's a new measure. It has been publically reported but we may not have longitudinal results to be able to identify what a best practice benchmark might be at. And the numbers are

small so given that it's new it's – I just wonder if we just haven't had it – had it there long enough to be able to establish benchmarks.

Collette Pitzen: Minnesota Community Measurement thanks Beth for jumping in there and that is completely accurate. In fact our measure development workgroup is convening in a couple of weeks to start making some decisions about what we would recommend as a benchmark.

Koryn Rubin: OK, so it's not necessarily like a fundamental – like a program issue that CMS is having difficulty with benchmark is because it's new and everything that goes into a new measure around sample size and determining where the evidence is.

Collette Pitzen: That would be correct.

Koryn Rubin: Thank you.

Bruce Bagley: Is there any other public comments?

Operator: There are no other public comments at this time.

Bruce Bagley: OK. Amy, do you have any other comments before we move to next step?

Amy Moyer: I don't other than I do agree it would be helpful for the voting process to better understand what the recommendations for the committee result in downstream process (was).

Bruce Bagley: I hear kind of a general call for a specific agenda item about that, hopefully lead by a CMS. So John and team, would you make sure that gets on the December agenda?

John Bernot: Absolutely, Bruce, thank you.

Bruce Bagley: OK, Madison, I think you're next up.

Madison Jung: Thank you, Bruce. OK, for our final few slides, we'll go over the next steps. This is the pre-rule making time line that you've seen before and Hiral presented. Just some key timelines to keep in mind for you, pending the

release of the MUC list, we will have a public comment period prior to our December 12th in-person meeting.

The public comment period will vary depending on when the MUC list is released. But it will – we'll have one public comment period before the in-person, December 12th and then another public comment period generally 14 days following that in-person meeting.

Following that, we'll have the MAP coordinating committee meet in-person in January of 25th to 26th. These are just some resources for you committee members for you to look over prior to the December 12th in-person meeting.

Do we have any questions about the next steps?

Bruce Bagley: This is Bruce, I just had one comment. Those of you who are actually on the committee should have received an e-mail today about registration hotel, air flights, that sort of thing. If you did not, please contact the NQF staff and we'll make sure you get that.

Madison Jung: Yes, thank you for that reminder, Bruce. OK …

Bruce Bagley: … any other comments or questions? OK. If there are no other comments or questions, I'd like thank everybody who participated today and look forward to the December meeting. I realize a lot going to be going on between now and December and we'll ask the staff to make sure we have a regular update on the progress of when the MUC list actually comes out and where we are in the process.

Obviously, the sooner that we can get the list out to everybody on the committee the better. So we're – that's always been our attempt to do that.

I would suggest and remind the committee members that during the face to face meeting, we use a process called a consent calendar. So if there are four or five measures in a particular domain, we will see the recommendations from the staff. And if there are no objections to the recommendations from the staff, we might vote on all of those measures as a single block.

In order for that to have some discussion, you may have to pull it off the consent calendar. So it kind of assures that everybody does their homework ahead of time to see which measures they have a question about so that we can get some conversation going about those measures.

And if there's anything you would like NQF staff to do before the face to face meeting about a specific measure then that would be even more helpful if you'd contact us about that. Any other comments, Amy or John or Hiral? Or Madison?

Amy Moyer: None from me.

Bruce Bagley: OK. Well, if there's no other comments, thank you all for spending time with us this afternoon and thanks for – from our guests from CMS and we look forward to seeing you all in about a month in December. So thanks a lot. Bye-bye.

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