Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup Pre-Rulemaking Web Meeting

October 10, 2014

NATIONAL QUALITY FORUM

Agenda

- Welcome
- Meeting Objectives
- MAP Pre-Rulemaking Approach
- Key Issues from the Dual Eligible Beneficiaries Perspective
  - PAC/LTC Programs
  - Hospital Programs
  - Clinician Programs
- Opportunity for Public Comment
- Next Steps

Meeting Objectives

- Provide orientation to the role of the MAP Dual Eligible Beneficiaries Workgroup in providing cross-cutting input during pre-rulemaking
- Consider strategic issues for federal measurement programs relevant to dual eligible beneficiaries
- Provide upstream guidance about measure use issues that other MAP workgroups should consider during pre-rulemaking deliberations

Dual Eligible Beneficiaries Workgroup Membership

Workgroup Chairs: Jennie Chin Hansen, RN, MS, FAAN and Alice Lind, MPH, BSN

Organizational Members

AARP Public Policy Institute	Susan Reinhard, RN, PhD, FAAN
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Gregg Warshaw, MD
American Medical Directors Association	Gwendolen Buhr, MD, MHS, MEd, CMD
America's Essential Hospitals	Steven Counsell, MD
Center for Medicare Advocacy	Alfred Chiplin Jr., Esq, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
iCare	Thomas H. Lutzow, PhD, MBA
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

Dual Eligible Beneficiaries Workgroup Membership

Subject Matter Experts

Mady Chalk, MSW, PhD
Anne Cohen, MPH
James Dunford, MD
Nancy Hanrahan, PhD, RN, FAAN
K. Charlie Lakin, PhD
Ruth Perry, MD
Gail Stuart, PhD, RN

Federal Government Members

Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Venesa Day
Administration for Community Living	Jamie Kendall, MPP

MAP Dual Eligible Beneficiaries Workgroup

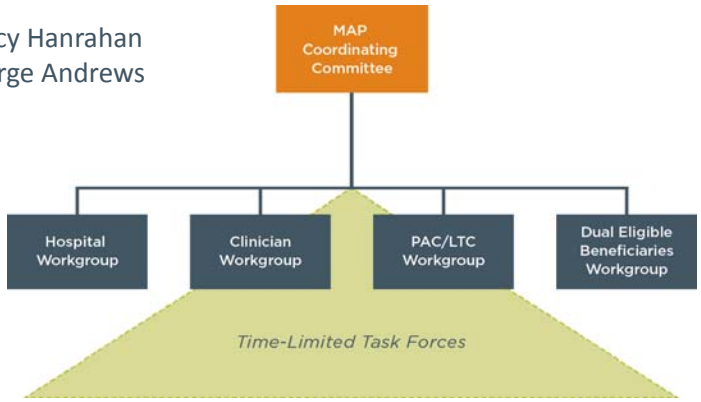
Dual Eligible Beneficiaries Workgroup provides:

- Balanced expertise for CMS and other Federal partners
- Strategy for performance measurement
- High-impact quality improvement opportunities
- Identification of best available measures for the population
- Prioritization of measure gaps
- Ideas for new measures to fill gaps
- **Guidance on applying measures to vulnerable populations**
- **Pre-rulemaking input to HHS on measures for defined programs and settings of care**

MAP Structure

2014/2015 Pre-Rulemaking Liaisons

- PAC/LTC – TBD
- Hospital – Nancy Hanrahan
- Clinician – George Andrews



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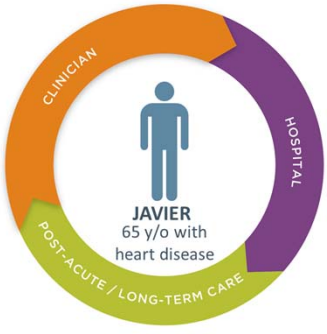
Person-Centered Look at Measurement Programs

A single consumer interacts with many measures over time…

Physician Quality Reporting System (PQRS)

#0018 **Blood Pressure Control** (Cardiovascular & Diabetes Families)
#0326 **Advance Care Plan** (Care Coordination, Hospice, Dual-Eligible Families)



Hospital Inpatient Quality Reporting Program (IQR)

#0289 **Median Time to ECG** (Care Coordination & Cardiovascular Families)
#0141 **Patient Fall Rate** (Safety Family)

Inpatient Rehabilitation Facilities Quality Reporting Program (IRF)

#0418 **Screening for Clinical Depression**(Dual-eligible Family)
#0648 **Timely Transmission of Transition Record** (Care Coordination, Hospice, Dual-eligible Families)

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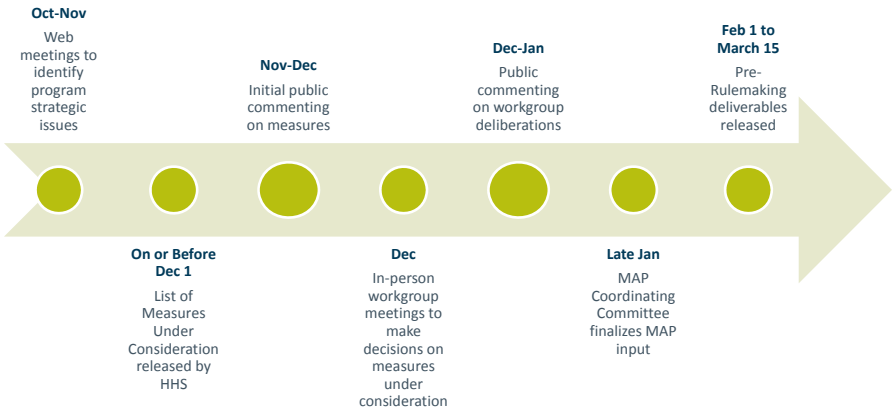
Background on MAP Process Improvement Efforts

- Based on feedback from MAP members, external stakeholders, NQF members, and staff, NQF undertook an intensive process improvement effort on MAP.
- Our goal was to develop a streamlined and manageable process for MAP stakeholders and staff that results in an improved product.

New for 2014-2015 Pre-Rulemaking

- Expanded opportunities to gather public feedback
- Easier access to information through focused products
- Centering decisions on critical program needs and objectives
- Better navigation and focused analysis in meeting materials
- More consistent and transparent deliberations process
- **Dual Eligible Beneficiaries Workgroup provides guidance before other workgroups convene to review measures under consideration, instead of after**

New for 2014-2015 Pre-Rulemaking: General Timeline



Fall web meetings: Focus on prospective and strategic considerations for programs

- Intended to identify and discuss programmatic strategic issues such as:
  - Are the current measures in the program helping to meet the program's overall objectives?
  - Are there ongoing measure implementation challenges or unintended consequences?
  - Are there opportunities to align measure across programs in that setting or across all settings?
- Will be more prospective, as opposed to reviewing measures already finalized in the program

New for 2014-2015 Pre-Rulemaking: More Consistent Deliberations Process and Centering Decisions on Key Program Needs/Objectives

Old

- Variations occurred in reviewing and recommending measures.

New

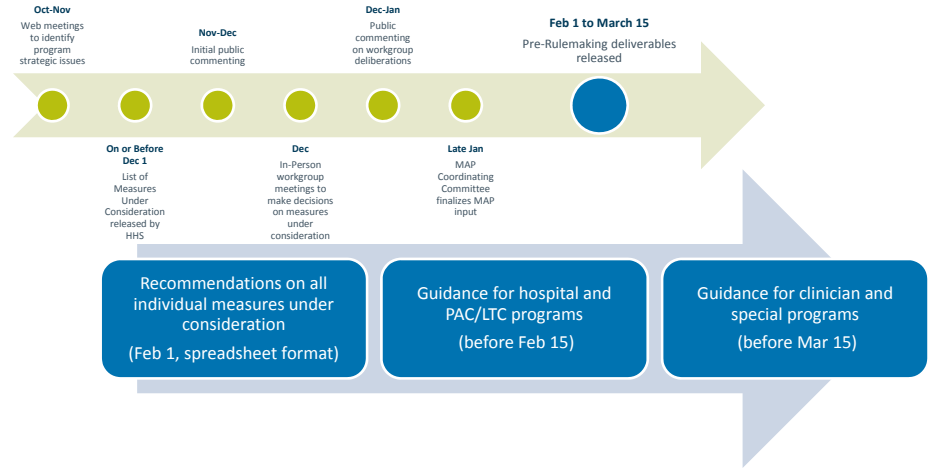
- Consensus is reached when more than 60% agree.
- Using a "consent calendar" format that relies on a defined process for preliminary analysis, MAP workgroups will reach consensus decisions on the use of measures in a consistent manner.
- Members can identify measures that need discussion. Will allow the groups to spend more time on measures where there are differing stakeholder perspectives.

New for 2014-2015 Pre-Rulemaking: Expanded Opportunities to Gather Public Feedback

Opportunities to Engage in Public Commenting

- **Round 1:** Public comment on individual measures immediately after the list of measures under consideration is publicly released.
  - To begin no later than December 1, but likely in mid-November
  - Comments will be taken into account during MAP workgroup in-person meetings.
- **Round 2:** Public comment on workgroup measure recommendations and program strategic issues (~3 weeks)
  - Roughly doubles the amount of time available to review MAP's preliminary recommendations
  - Comments considered by Coordinating Committee when providing final approval.

New for 2014-2015 Pre-Rulemaking: Focusing deliverables on individual measures and broader measurement guidance



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Key Issues for Post-Acute Care and Long-Term Care Programs

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Potential Programs to Be Considered

- **MAP PAC/LTC Workgroup provides input on measures under consideration for the following programs:**
  - Nursing Home Quality Initiative
  - Home Health Quality Reporting
  - Inpatient Rehabilitation Facility Quality Reporting
  - Long-Term Care Hospital Quality Reporting
  - Hospice Quality Reporting
  - End Stage Renal Disease Quality Incentive Payment

Current State of Measurement

- Multiple provider types with varying payment structures and different Medicare and Medicaid requirements;
- Use of multiple assessment tools to capture similar information;
- Heterogeneity of population;
- Frequent transitions;
- Federal reporting requirements differ;
- State of quality not easy to determine; and
- Difficulty of collecting and communicating data across settings and providers.

PAC/LTC High-Leverage Opportunities and Core Measure Concepts

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental health
Goal Attainment	• Establishment of patient/family/caregiver goals • Advanced care planning and treatment
Patient Engagement	• Experience of care • Shared decision-making
Care Coordination	• Transition planning
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions

IMPACT Act

- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a. "IMPACT Act of 2014"
  - Requires post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures;
  - Requires the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes; and
  - Calls for the modification of PAC assessment instruments to enable the submission of standardized patient assessment data and comparison across providers.

IMPACT Act

- Describes the requirements for the creation and reporting of new quality measures that will be implemented over time by PAC providers
- New quality measures will address, at a minimum, the following domains:
  - functional status and changes in function;
  - skin integrity and changes in skin integrity;
  - medication reconciliation;
  - incidence of major falls; and
  - accurately communicating health information and care preferences when a patient is transferred
- Resource use measures will address the following:
  - efficiency measures to include total Medicare spending per beneficiary;
  - discharge to community; and
  - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.

IMPACT Act

- Other notable provisions include:
  - All measures must be NQF-endorsed and go through the MAP process
  - MedPAC is required to study and make recommendations for a consolidated PAC prospective payment system.
  - Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures.
  - HHS is required to conduct studies that examine the effect of individuals' socioeconomic status, race, health literacy, English proficiency, and patient activation on quality and resource use.

Workgroup Discussion

- What would be the implications of the IMPACT Act on the alignment issues across PAC settings and with other settings (e.g., acute care settings)?
- How would this legislation improve health outcomes and experience with care for patients and their families?
- Should the PAC/LTC workgroup discuss other issues?

Key Issues for Hospital Programs

Potential Hospital Programs to Be Considered

- Hospital Inpatient Quality Reporting (IQR)
- Hospital Value-Based Purchasing (VBP)
- Hospital Readmission Reduction Program (HRRP)
- Hospital Outpatient Quality Reporting (OQR)
- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR)
- Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting(PCHQR)
- Hospital Acquired Condition (HAC) Reduction Program
- Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs (Meaningful Use or MU)

Potential Hospital Programs to Be Considered

- These programs address pay for performance and public reporting for a number of care settings:
  - Acute care hospitals
  - Psychiatric units and facilities
  - Cancer hospitals
  - Outpatient settings such as ambulatory surgery centers, emergency departments, and outpatient clinics

Acute Care Hospital Programs

Measures in these programs address:

- AMI care
- Heart failure care
- Stroke care
- Venous thromboembolism prevention
- Pneumonia care
- Child asthma home management
- Surgical care and complications
- Emergency department throughput
- Immunization
- Patient safety and healthcare associated infections
- Consumer experience
- Maternity care
- Mortality
- Readmissions
- Cost

Acute Care Hospital Programs

- Five measures from the dual eligible beneficiaries family of measures are included in one or more programs for this setting (IQR or VBP):
  - NQF #0166 HCAHPS
  - NQF #0228 CTM-3
  - NQF #1659 Influenza Immunization
  - NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure
  - NQF #2158 Medicare Spending Per Beneficiary

Acute Care Hospital Programs

Potential Hospital Measures from the Family:

- NQF #0201 Pressure ulcer prevalence (hospital acquired)
- NQF #0202 Falls with injury
- NQF #0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
- NQF #1626 Patients Admitted to ICU who Have Care Preferences Documented

Measure Gaps Identified by the Hospital Workgroup:

- Pediatrics
- Maternal/child health
- Cancer
- Behavioral health
- Affordability/cost
- Care transitions
- Patient education
- Palliative and end of life care
- Medication reconciliation
- Culture of safety
- Pressure ulcer prevention
- Adverse drug events
- Safety events:
  - Foreign body retained
  - Wrong site/wrong side surgery
  - Sepsis

Workgroup Discussion

- Which measures from the family that should be prioritized for addition to programs addressing acute hospital care?
- Are there additional measure gaps needed to address care for dual eligible beneficiaries?
- What are the highest priority measure gaps for dual eligible beneficiaries for programs addressing acute hospital care?

Inpatient Psychiatric Facility Quality Reporting Program

Measures in this program address:

- Physical restraint use
- Seclusion use
- Discharge on multiple antipsychotic medications
- Post discharge planning
- Routine assessment of patient experience of care
- Use of an electronic health record
- Tobacco use treatment
- Influenza immunization

Psychiatric Units and Facilities Programs

- Six measures from the dual eligible beneficiaries family of measures are included in the IPFQR:
  - NQF #0557 HBIPS-6 Post discharge continuing care plan created
  - NQF #0558 HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge
  - NQF#0576 Follow-Up After Hospitalization for Mental Illness (FUH)
  - NQF #0640 HBIPS-2 Hours of physical restraint use
  - NQF #0641 HBIPS-3 Hours of seclusion use
  - NQF #1659 Influenza Immunization

Inpatient Psychiatric Facility Quality Reporting Program

Potential Inpatient Psych Measures from the Family:

- NQF #0201 Pressure ulcer prevalence (hospital acquired)
- NQF #0202 Falls with injury
- NQF #0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Measure Gaps Identified by the Hospital Workgroup:

- Behavioral health assessments and care in the ED
- Readmissions
- Identification and management of general medical conditions
- Partial hospitalization or day programs
- Psychiatric care module for CAHPS

Workgroup Discussion

- Which measures from the family that should be prioritized for addition to the IPFQR program?
- Are there additional measure gaps needed to address care for dual eligible beneficiaries?
- What are the highest priority measure gaps for dual eligible beneficiaries for the IPFQR program?

PPS-Exempt Cancer Hospital Quality Reporting Program

Measures in this program address:

- Breast cancer care
- Colon cancer care
- Healthcare associated infections
- Surgical care
- Consumer experience

PPS-Exempt Cancer Hospital Programs

- One measure from the dual eligible beneficiaries family of measures is included in the PCHQR program:
  - NQF #0166 HCAHPS

PPS-Exempt Cancer Hospital Programs

Potential Hospital Measures from the Family:

- NQF #0201 Pressure ulcer prevalence (hospital acquired)
- NQF #0202 Falls with injury
- NQF #0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
- NQF #1626 Patients Admitted to ICU who Have Care Preferences Documented

Measure Gaps Identified by the Hospital Workgroup:

- Pain screening and management
- Patient and family/caregiver experience
- Patient-reported symptoms and outcomes
- Survival
- Shared decision making
- Cost
- Care Coordination
- Psychosocial/supportive services

Workgroup Discussion

- Which measures from the family that should be prioritized for addition to the PCHQR program?
- Are there additional measure gaps needed to address care for dual eligible beneficiaries?
- What are the highest priority measure gaps for dual eligible beneficiaries for the PCHQR program?

Outpatient Care Programs

Measures in these programs address:

- Fibrinolysis
- Transfer times
- AMI care
- Surgical care
- Imaging use
- EHR use
- ED throughput
- Influenza vaccination
- Appropriate colonoscopy use
- Cataract surgery outcomes
- Patient safety

Outpatient Care Programs

- No measures from the dual eligible beneficiaries family of measures are included in one or more programs for this setting (OQR or ASCQR).

Outpatient Care Programs

Potential Hospital Measures from the Family:

- NQF #0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Measure Gaps Identified by the Hospital Workgroup:

- ED overcrowding
- ED wait times
- ED disparities in care-disproportionate use by vulnerable populations
- Cost
- Patient reported outcomes
- Patient and family engagement
- Follow-up after procedures
- Fostering ties to community resources to enhance care coordination
- Setting-specific CAHPS modules
- Complications including anesthesia related complications

Workgroup Discussion

- Which measures from the family that should be prioritized for addition to programs addressing outpatient care?
- Are there additional measure gaps needed to address care for dual eligible beneficiaries?
- What are the highest priority measure gaps for dual eligible beneficiaries for programs addressing outpatient care?

Key Issues for Clinician Programs

Physician Quality Reporting System (PQRS)

- **Program Type:** Incentive
- **Incentive Structure:** Beginning in 2015, a downward payment adjustment of -2 percent will apply to eligible professionals (EP) who do not satisfactorily report data on quality measures for covered professional services or satisfactorily participate in a qualified clinical data registry.
- **Program Goal**: Encourage widespread participation by eligible professionals to report quality information.

Physician Quality Reporting System (PQRS)

Program Updates (Proposed PFS Rule for 2015):

- 18 cross-cutting measures that can be used by all EPs – based on the recommendation of a core set from the MAP.
- Measure turnover:
  - Add 28 new individual measures and two measures groups:
    - Sinusitis Measures Group
    - Acute Otitis Externa Measures Group
  - Remove 73 measures for a variety of reasons:
    - Measure steward will no longer maintain the measure: 18
    - Performance rates consistently close to 100%, i.e., "topped out": 27
    - Measure does not add clinical value to PQRS: 6
    - Measures a standard of care: 14
    - Evidence and guideline change: 2
    - Duplicative measures: 6

Physician Compare

- **Program Type**: Public Reporting
- **Incentive Structure**: None
- **Program Goals**:
  - Providing consumers with quality of care information that will help them make informed decisions about their health care.
  - Encourage clinicians to improve the quality of care they provide to their patients and create incentives to maximize performance.

Physician Compare

Program Update (Proposed PFS Rule for 2015):

- All PQRS measures are available for public reporting.
- Measures will be publicly reported in two ways:
  - Measures of specific interest to consumers and beneficiaries will be posted on the physician's webpage
  - Other measures in a downloadable format
- PQRS measures will be tested for reliability and validity prior to being reported on Physician Compare

Value-Based Payment Modifier and Physician Feedback Programs

- **Program Type**: Incentive
- **Incentive Structure**: In order to avoid an automatic negative two percent ("-2.0%") Value Modifier payment adjustment in CY 2016, Eligible Professionals (EPs) in groups of 10 or more must participate in and satisfy the PQRS requirements as a group or as individuals in CY 2014
- **Program Goals:** The Physician Feedback/Value-Based Modifier Program provides comparative performance information to physicians as one part of Medicare's efforts to improve the quality and efficiency of medical care and payment adjustment of Medicare FFS reimbursement based on performance on quality and cost measures.

Value-Based Payment Modifier and Physician Feedback Programs

Program Updates:

- Physicians in group practices of 100 or more eligible professionals (EPs) who submit claims to Medicare will be subject to the value modifier in 2015, based on their performance in calendar year 2013.
- Physicians in group practices of 10 or more EPs will be subject to the value modifier in 2016, based on their performance in calendar year 2014.
- For 2015 and 2016, the Value Modifier does not apply to groups of physicians in which any of the group practice's physicians participate in the Medicare Shared Savings Program, Pioneer ACOs, or the Comprehensive Primary Care Initiative.

Value-Based Payment Modifier and Physician Feedback Programs

Program Updates:

- All physicians who participate in Fee-For-Service Medicare will be affected by the value modifier starting in 2017.
- Quality-tiering is the methodology that is used to evaluate a group's performance on cost and quality measures for the Value Modifier. Cost and quality measures are used to determine the payment modifier. Measures are collected for one year to establish benchmarks prior to use in determining the payment modifier.
- The 2015 PFS Proposed Rule proposes increasing the amount of payment at risk under the Value Modifier from 2% in CY2016 to 4% in CY 2017.

PQRS: Critical Program Objectives

- To encourage widespread participation many measures are needed for the variety of eligible professionals, specialties and sub-specialties.
- Measures chosen by EPs for PQRS will be reported on Physician Compare and used for the Value Based Payment Modifier.
- NQF-endorsed measures are preferred for public reporting programs over measures that are not endorsed or are in reserve status (i.e., topped out); measures that are not NQF-endorsed should be submitted for endorsement or removed.

PQRS: Critical Program Objectives (con't)

- For measures that are not endorsed, include measures under consideration that are fully specified and that:
  - Support alignment (e.g., measures used in other programs, registries)
  - Are outcome measures that are not already addressed by outcome measures included in the program
  - Are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures
- Include more high value measures, e.g., outcomes, patient-reported outcomes, composites, intermediate outcomes, process measures close to outcomes, cost and resource use measures, appropriate use measures, care coordination measures, patient safety, etc.

PQRS: Critical Program Objectives (con't)

Specific to public reporting:

- Include measures that focus on outcomes and are meaningful to consumers (i.e., have face validity) and purchasers.
- Focus on patient experience, patient-reported outcomes (e.g., functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care measures.
- To generate a comprehensive picture of quality, measure results should be aggregated (e.g., composite measures), with drill-down capability for specific measure results

PQRS: Critical Program Objectives

Specific to payment:

- Include measures that have been reported in a national program for at least one year (e.g., PQRS) and ideally can be linked with particular cost or resource use measures to capture value.
- Focus on outcomes, composites, process measures that are proximal to outcomes, appropriate care (e.g., overuse), and care coordination measures (measures included in the MAP Families of Measures generally reflect these characteristics).
- Monitor for unintended consequences to vulnerable populations (e.g., through stratification).

Medicare and Medicaid EHR Incentive Program

- **Program Type**: Incentive
- **Incentive Structure**:
  - **Medicare**: Up to $44,000 over 5 continuous years. The last year to begin the program is 2014. Penalties take effect in 2015 and in each year hereafter where EPs are eligible but do not participate.
  - **Medicaid**: Up to $63,750 over 6 years. The last year to begin the program is in 2016. Payment adjustments do not apply to Medicaid.
- **Program Goals**:
  - promote widespread adoption of CEHRT by providers
  - Incentivize "meaningful use" of EHRs by providers

Medicare and Medicaid EHR Incentive Program

Program Update:

- For Stage 1 (2014):
  - New objective –"Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the eligible professional."
  - The separate objective to report clinical quality measures (CQMs) will no longer be required for Stage 1 for eligible professionals, eligible hospitals, and CAHs. Reporting CQMs will still be required in order to achieve meaningful use.

Medicare and Medicaid EHR Incentive Program

Program Update:

- For Stage 2 (2014):
  - The earliest providers will demonstrate Stage 2 of meaningful use is 2014.
  - For Stage 2 (2014 and beyond): Eligible Professionals must report on 9 total clinical quality measures that cover 3 of the National Quality Strategy Domains (selected from a set of 64 clinical quality measures).
  - CMS is not requiring the submission of a core set of electronic CQMs (eCQMs). Instead, CMS has identified two recommended core sets of eCQMs—one for adults and one for children—that focus on high-priority health conditions and best-practices for care delivery.

Medicare and Medicaid EHR Incentive Program- Critical Program Objectives

- Include endorsed measures that have complete eMeasure specifications available.
- Over time, as health IT becomes more effective and interoperable, focus on:
  - Measures that reflect efficiency in data collection and reporting through the use of health IT
  - Measures that leverage health IT capabilities (e.g., measures that require data from multiple settings/providers, patient-reported data, or connectivity across platforms to be fully operational)
  - Innovative measures made possible by the use of health IT
- Alignment with other federal programs, particularly PQRS.

Workgroup Discussion

- Questions, comments, or recommendations related to the Clinician measurement programs?

Opportunity for Public Comment

Next Steps

- Web Meetings (October/November)
  - PAC/LTC Workgroup Web Meeting
  - Coordinating Committee Web Meeting
- In-Person Meetings (December/January)
  - Hospital Workgroup In-Person Meeting
  - Clinician Workgroup In-Person Meeting
  - PAC/LTC Workgroup In-Person Meeting
  - MAP Coordinating Committee In-Person Meeting
- **More Duals-specific meetings to be convened in February-April 2015**

Thank You for Participating