NATIONAL QUALITY FORUM

Moderator: Benita Kornegay Henry
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1:50 pm CT

Suzanne Theberge: Hi. This is NQF we've heard a few beeps, who's just joined?

Aaron Garman: This is Aaron Garman.

Ira Moscovice: And Ira Moscovice.

Suzanne Theberge: Great, welcome. We'll be getting started shortly.

Aaron Garman: Thanks.

Suzanne Theberge: Hi. This is NQF we've heard a few beeps, who's joined?

Erika Thomas: Hi. This is Erika Thomas from ASHP.

Suzanne Theberge: Thank you.

Dr. Michelle Schreiber: Hi, this is Dr. Schreiber. I've joined the call.

Suzanne Theberge: Great, thank you. We'll be getting started in a few minutes. Welcome everyone. We'll be getting started in just a couple of minutes. There is a few people still dialing in, so we're going to wait a moment for those lines to connect.

Hello everyone, thanks for joining. We're just going to wait one more minute for last couple of lines to finish connecting and then we'll be getting started. Thanks so much for joining us today.

All right, hello everyone. Welcome to the NQF MAP Rural Health Workgroup Orientation for the 2019 pre-rulemaking activities. Thank you so much for joining us this morning or this afternoon depending on where you're dialing in from.

This is Suzanne Theberge. I'm the Senior Project Manager on the team. I'm going to give a couple of brief housekeeping remarks and then I'm going to turn it over to Karen for some welcoming remarks.

First of all, thanks so much for joining us. And second, we do ask that workgroup members dial in to both the phone and the webinar. If you'd like to speak or ask a question, you will need to be on the phone line. But if you are on the phone and the webinar, please do put yourself on mute on the phone and turn your computer speakers off to reduce any feedback or background noise.

If you have any questions, feel free to submit attach or speak up or raise your hand on the webinar and we'll do our best to answer those questions as soon as possible.

So with that, I will turn it over to Karen to make a few welcoming remarks. Karen?

Karen Johnson: Thank you Suzanne. My name is Karen Johnson. I am a Senior Director here at NQF and I just wanted to say thank you all for joining us today, especially the folks on our MAP Rural Health Workgroup. I feel like to a certain extent we're old trends, because we - many of us had been working together on the MAP Rural Health project for a couple of years now. So I just wanted to say welcome.

Our slide here where we're going to do just some really quickly introductions, if you go to the next slide Ameera, we do have the same NQF facet hopefully you're used to seeing and I felt me and Suzanne (unintelligible) Ameera. So - and our same two co-chairs, Ira and Aaron.

So I'm going to hand it over to Ira and Aaron to say and hello and, welcome and then we'll get into roll call and then we'll go into the meat of our discussion today. Ira?

Ira Moscovice: Hi. This is Ira Moscovice. And I've had the pleasure of being co-chair with Aaron for the MAP Rural Health Workgroup for a couple of years as Karen mentioned and I'm really excited about the opportunity we have in front of us to continue to work of the workgroup and in an usual move CMS has given multiple years of funds to continue (unintelligible) suggestion that is important to them. So I really look forward to working with the workgroup members and welcome any new members who've joined us. I'll turn it over to you Aaron.

Aaron Garman: Thanks Ira. I agree. I think this is an exciting time for rural healthcare and look forward to working with you all. It's a big project, but hopefully we can tackle it and again I look forward to the adventure. Karen, back to you.

Karen Johnson: Thank you so much Ira and Aaron. Suzanne, I think you're going to help us run through our roll call if you don't mind doing that. So what we'll do is we have on the screen, if you're watching the screen, you may recall most of our members in our MAP workgroup are organizational members. So Suzanne will call out the organization and then if you will just respond whoever is representing the organization, let us know that you're here and your name and we'll go from there. Suzanne?

Suzanne Theberge: All right, thanks Karen. So we know our co-chairs are here. Thank you, Ira and Aaron. Alliant Health Solutions?

Kimberly Rask: Good afternoon, it's Kimberly Rask.

Suzanne Theberge: Great, thank you. American Academy of Family Physicians?

(David Schutt): Hello, it's (David Schutt).

Suzanne Theberge: Thank you. American Academy of Physician Assistants?

Daniel Coll: Yes. Hello, this is Daniel Coll on the West Coast. So good morning from the American Academy of Physician Assistants.

Suzanne Theberge: Great, thank you. American College of Emergency Physicians? Okay, American Hospital Association?

Man 1: Hey Suzanne, (unintelligible) here.

Suzanne Theberge: Great, thank you. American Society of Health-System Pharmacists?

Erika Thomas: Hi. This is Erika Thomas. We're a new member and we're delighted to be here.

Suzanne Theberge: Great. Thank you so much and welcome. Cardinal Innovations? Geisinger Health? Intermountain Healthcare?

Jesse Spencer: Yes, hello. This is Jesse Spencer, thank you.

Suzanne Theberge: Great, thank you. Michigan Center for Rural Health?

Crystal Barter: Good afternoon. This is Crystal Barter.

Suzanne Theberge: Thank you. Minnesota Community Measurement?

Julie Sonier: Hi. This is Julie Sonier.

Suzanne Theberge: Thank you.

Collette Pitzen: I'm Collette Pitzen from Minnesota Community Measurement also, thank you.

Suzanne Theberge: Great, thank you. National Association of Rural Health Clinics? National Rural Health Association? National Rural Letter Carriers' Association?

Cameron Deml: Yes, good afternoon. Cameron Deml is on.

Suzanne Theberge: Great, thank you. RUPRI Center for Rural Health Policy Analysis?

Keith Mueller: Hi Keith Mueller and (Marcia Ward) are on.

Suzanne Theberge: Thank you. Rural Wisconsin Health Collaborative? And Truven Health Analytics? Okay, I'm going to go on and call our individual subject matter experts and then we can kick in on the folks who were not on there first. So Michael Fadden? John Gale? Curtis Lowery?

Curtis Lowery: Yes, I'm here.

Suzanne Theberge: Great, thank you. Melinda Murphy?

Melinda Murphy: Yes.

Suzanne Theberge: Thank you. Jessica Schumacher?

Jessica Schumacher: Hello. Yes, I'm here.

Suzanne Theberge: Great, thank you. Ana Verzone? And Holly Wolff? Okay. And then we also have Federal Government Liaison, so our non-voting members. So do we have anything from - sorry, do we have anybody from the Federal Office of Rural Health Policy?

Craig Caplan: Hi. This is Craig Caplan.

Suzanne Theberge: Great, thank you. And CMMI?

Emily Moore: Good afternoon. This is Emily Moore.

Suzanne Theberge: Great, thank you. And Indian Health Services? Okay. And did we miss anybody or did anybody join after we were calling roll or miss getting their phone off of mute?

Cynthia Pamon: Hi. This is Cynthia Pamon from the Center for Clinical Standards & Quality at CMS.

Suzanne Theberge: Great.

(Will Thompson): Hi. This is (Will Thompson) from CCFQ as well at CMS.

Suzanne Theberge: Great, thank you.

Dr. Michelle Schreiber: And hi. It's Michelle Schreiber from CCSQ as well.

Suzanne Theberge: Great. Anyone else?

Kristi Martinsen: Hi. This is Kristi Martinsen with the Federal Office of Rural Health Policy.

Suzanne Theberge: Great, thank you. All right.

Man 2: (Unintelligible).

Suzanne Theberge: Great, thank you.

Woman 1: Hi. This is (unintelligible) from Ohio Medicaid.

Suzanne Theberge: Thank you. Well, thanks so much for joining us today everybody. And now we are going to turn it over to CMS for some brief opening remarks.

Dr. Michelle Schreiber: So thank you and good afternoon to everybody. It is just afternoon in Baltimore. My name is Dr. Michelle Schreiber and I am the Director of QMVIG which is the Quality Measurement and Value-Based Incentive Group part of the Clinical Standards & Quality Group here at CMS. And we are truly delighted to welcome all of you here today.

My background is a primary care physician in the City of Detroit and it is exceptionally important that we here your voice. The MAP process is the formalized process for CMS to have external stakeholder input into the measures that may go into our various value-based payment programs either for payment or for reporting. This is an annual process as most of you are aware and the input from the teams has been extremely valuable. It has helped shape CMS's determination of what measures do go into these programs and it has changed actions as well. So I want you to understand that these committees are very valuable and we appreciate the input.

To the co-chairs, thank you for the work it takes to organize these into NQF. We of course always appreciate your efforts in organizing that work. It is very important to this administration in particular really but to everybody to get the rural perspective on the measures that are under consideration, because there are specific and special challenges in the rural communities that it's important that we are always acknowledging.

This MAP Workgroup is very important giving the rural providers a voice and CMS greatly appreciates the challenges that you face and we've made very specific efforts to incorporate this particular workgroup into the formal MAP process. This ensures the rural point of view that is always considered in specific programs that CMS is undertaking.

So again, thank you so much for all of your participation and we look forward to the rest of the session and to the in-person MAP meetings.

Suzanne Theberge: Great. Thank you so much. Karen, any other opening remarks before we dive into the content or…?

Karen Johnson: No, let's dive in.

Suzanne Theberge: All right, great. Well, since some of you are new and others of you, it's been a while since we did any work like this. We thought we would provide a brief overview of MAP in the pre-rural making process today and talk through some of the work we're going to be doing in the next couple of months.

The Measure Applications Partnership is part of the Affordable Care Act which requires HHS to contract with the consensus-based entity which is NQF to "convene multi-stakeholder groups to provide input on the selection of quality measurements" for public reporting, payment and other programs.

So we - that's what we'll be doing over the next few months. What the MAP Workgroups do is inform the selection of measures to achieve improvement, transparency and value. We - these groups provide input to HHS on measure selection for a large number of programs. The workgroups also identify measure gaps so that folks who're interested in developing measures can have some idea of what is needed out in the field.

And then the workgroups also work to encourage measure alignment across the public and private sectors across settings, across different levels of analysis, different populations to ensure that care - we have better care coordination and reduce the burden of data collection for providers and facilities.

The MAP structure is made up of the MAP Coordinating Committee which is the overarching kind of lead coordinating body. And then we have four standing workgroups: the hospital workgroup, the clinician workgroup, the PAC/LTC workgroup and this one, the rural health workgroup. We also sometimes have time limited taskforces that we bring together for various needs.

As we just discussed on our roll call, MAP Workgroups do have three types of members. We have organizational representatives and that's when an organization has exceeded the table. As that organization it can be a different person each time, but generally, you know, it's organizations that are either interested in it or affected by the use of measures and the majority of MAP Workgroup members are organizations.

We also have subject matter experts and these are folks who are experts on a specific topic and we bring them to the table to really provide us with that expertise. And then finally, we have non-voting members as our federal government liaison.

So that's the kind of basic structure of MAP. And I am now going to turn it over to Karen to talk through the MAP process. Karen?

Karen Johnson: So thank you for that Suzanne. That was very helpful to get that reminder of the MAP's background. And just to warn you, the new folks as well as the folks who have been with us for a while, this is an orientation call specifically meant to provide you the background that you need and kind of the full warning that you need on the work that we're going to do around rulemaking and pre-rulemaking.

So at the MAP Rural Health Workgroup, you're going to have kind of two functions this year. And the first function is around the rulemaking and then I'll get to the next set of activities toward the end of this call.

But rulemaking is if you're first to the process of the government agencies, you have to create regulations. So you can see kind of the process here is that Congress sets the broad mandates or the legislation and the public is informed and can Congress on proposed rules and then not too long after I'm sure the rules become final.

So what happens is HHS (CMS) actually looks at all of the comments that come through and evaluates those and finalizes things. And sometimes the initial preliminary rules or proposed rules get changed based on those comments. So that's the rulemaking process.

And then what is the pre-rulemaking process, because that's what we're in now. So if you go to the next slide, we have - see this figure here that basically it's - people develop - so this is the pre-rulemaking process for what we talked about so far which is providing input on the selections measures into federal quality programs.

So we have this people developed measures and some of these developers or the stewards or others would like to see those taken up into federal programs. So they suggest them for this list, we call it the MUC list, it's called the Measures Under Consideration or MUC and then that list kind of gets little down and so right about this time of year, late fall and those - that list of measures comes to the MAP. And the MAP through the various workgroups makes recommendations about those measures.

And the recommendations aren't - I mean they are specific to the individual programs. So you may have a measure that's being put forward that I'm just giving you an example, here the - a workgroup might think that it is a appropriate measure for one program, but not for another. So it is looked at in the content, actually the programs.

So the MAP makes the recommendations. It goes from the individual workgroups through the Coordinating Committee and then CMS considers what MAP has sent and then uses those to develop their proposed final rule which was then deployed and usually in a year or two, you know, nothing ever happens the next day, right, so something maybe taken up to be included in a federal program, but it maybe a year or two before it's actually implemented in that program. But that is kind of the pre-rulemaking process.

And the pre-rulemaking process that we are engaging in really runs from right about now with their orientation calls kind of letting people know what's going on through the month of January. And a lot of this is part of the statute in terms of the timing and the different proposed to file rules and such come out, you know, at times after January.

So if you're wondering why we have three meetings back-to-back in November, it's to tell this pre-rulemaking work actually happens in a very short timeframe, so if in case you're wondering that's what's going on.

If you go to the next slide, you can see - and Michelle has already alluded to this, the value of this pre-rulemaking affect. First of all, it make sure that HHS hears from a variety of stakeholders. And they do that probably - you know, through their public comment as well, but through the MAP process it really does allow a multi-stakeholder process and really detailed and very pointed input.

It also allows for a consensus building process. And, you know, not all stakeholders are coming, you know, to these questions of inclusion of programs, you know, from the same perspective that, you know, hearing other's perspectives and hearing from, you know, different people, there were maybe - you know, people can change their ideas or not, but it allows ideas to be put out and discussed and, you know, a consensus recommendation be put forward.

We also believe that the proposed rules are actually closer to the mark, because the provisions really - to performance measurement have actually already been vetted and vetted by the people who are actually being very much affected by these programs.

And then finally in doing this, it does take some burden off of the various stakeholders to submit official comments and that commenting timeframe that they have. So it allows them to provide input, but not necessarily unless they just want to add, you know, written comments in the commenting period.

So the - our approach as I mentioned, it's a fairly small amount of time and we have to do all this workgroup - all this work. So in October, all the different workgroups are meeting like we are today to review the approach and what each of us as workgroups are responsible for doing, so that's what we're doing in October.

In November, we are meeting again and we have - and we'll go over this towards the end of the call again, but we have three meetings, three webinars on your calendar to run now to do the work of the pre-rulemaking process. So we have three meaningful November. We have to do it in November, because the other workgroup are meeting in the first week I think of December. So we

have to do our thing, because what we're doing is we are making recommendations to the other three setting specific workgroups.

And then they will be - they're seeing in December, they will look at each measure on the MUC list and make recommendations. And then that goes out to the Coordinating Committee who meets in January. They will look at the individual things specific recommendations and makes the final recommendation that they suggest. So kind of a bit of a pyramid there in terms of approach, but again fairly at short timeframe.

And the next slide I think says pretty much the same thing, but just with a clear picture. A couple of things to note, there will be a commenting period. I think there is a couple of different ones in the November-December timeframe and then in the December-January timeframe for comments on the recommendations of the workgroups.

And then in - let's see, I think it's, yes, January to March, somewhere in that timeframe we actually have final reports and things are kind of finalized for deliveries to CMS. So that's the approach.

And I will stop there. I know that's pretty high level. Let me stop there and see if anybody has any questions first of all. And I think we have so many great CMS colleagues on the line. If I have misspoken or misrepresented anything, please take the time right now to correct anything that I have - may have misspoken at this time. So any questions or any fixing?

((Crosstalk))

Karen Johnson: Okay. CMS, go ahead.

Jesse Spencer: Sorry. This is Jesse Spencer actually just from Intermountain. I may have missed this. Is there - this particular workgroup, did you say this workgroup meets in-person in December?

Karen Johnson: No, this one does not. So we will do our work virtually through the three webinars that we have scheduled in November. We are going to - and I will get into this more towards the end. We are actually going to ask a couple of people from the rural health workgroup if they will be willing to come to D.C. and sit in on the in-person meetings in December as a liaison. So there is going to be multiple kind of opportunities for the three setting specific workgroups to hear from us as the rural health workgroup. And again I'll explain that a little bit more towards the end. But, you know, mostly done with pre-rulemaking by - before Thanksgiving actually, but the bulk of the work will be done by us before Thanksgiving. Any other questions?

Okay, let's go. And really the - what we wanted to do here was just provide some very, very brief background on the various programs that will or that kind of come under the umbrella of a setting specific workgroup and to give you a flavor of the charge of the individual workgroups.

So as we delve into this, even though there is a lot of slides, we're going to do very, very little of reading of the slides. We'll just refer to them really quickly. We added them and primarily (unintelligible) you aware of the different programs that may have measures that are being proposed for them and again, just as a reference.

But if we go to the next slide, we see that we have the charge of the Coordinating Committee and we've already kind of referred to this already. And it is the Coordinating Committee that is the official body that advises HHS on measures that are on their MUC list as well - and, you know, they

don't just do that, they do other things too. So they talk about alignment, they talk about, you know, performance measurement more broadly and just basically give strategic direction or strategic advice I should say to HHS as well as to the MAP itself.

So the Coordinating Committee, if you remember a picture, the Coordinating Committee is the top committee. So they're kind of - information flowing down from them to the individual workgroups are flowing up from the workgroups in terms of the workgroup's specific recommendations.

And the Coordinating Committee especially talks about alignment, because again the name says it all, they are coordinating. So the individual setting specific workgroups kind of work in their lanes, their settings and then the Coordinating Committee kind of takes all of that input and, you know, tries to makes a sense of it and especially again in terms of alignment and direction.

If we go to the next slide, the charge of the hospitals workgroup is to provide on measures to be implemented through the federal rulemaking process for the following program. And you see here, all the programs that come under the hospital workgroups charge and there are a lot of them and more under hospital than under the other workgroups, because there are more programs that come under hospitals.

So again, all of these here, there is a slide and that goes with each one of these programs. So if there is the next one, the Hospital Inpatient Quality Program sometimes called the IQR, so again I'm not going to go through each one of these. But I can say, the thing just to keep in mind into maybe you look at when you're a little offline is just especially knowing what the program type in. So IQR is a pay-for-reporting program and measures that are in the IQR

are also included in public reporting fund, hospital compares. So that is the type of program.

And then as you can see the slides talk more about the incentive structure and the goals of the program. So again, I'm not going to go through each of these, but I do want to make sure that everybody this background information just again we'll be thinking about. And rule, we'll be thinking about, it's a little easier for rule, because I think when it comes time for you guys to provide input, I think your input is going to be a little more broad perhaps than the measure society program specific input, but maybe not always. Because it could very well be that you guys have input about a particular measure and you may feel very strongly that it would work great for example, pay-for-reporting, but maybe not so well for pay-for-performance or P-for-P.

So that is the kind of input that I suspect that you guys will get into and then the setting specific workgroups will go even more into the details of these specific programs looking at the needs of the program and, you know, what they are looking for their requirements, what they're trying to do with the various programs.

So just going very quickly through the remainder of the hospital programs, we have the Value-Based Purchasing Program which is a P-for-P program. And next we have Hospital Readmissions Reduction Program which is a P-for-P and public reporting. The next is the Hospital Acquired Conditions Reporting Program - Reduction Program, I'm sorry, is a pay-for-reporting and public reporting.

So again, anytime it says public reporting on these hospital slides, we're talking about hospital compared to CMS, what we call one of the compared (unintelligible) as CMS.

Next one is Hospital Outpatient Quality Reporting Program. It is a pay-for-reporting and hospital public reporting program. Next is the Inpatient Psychiatric Facility Quality Reporting Program. It also is a pay-for-reporting and public reporting program. Then next we have the Ambulatory Surgery Center Quality Reporting Program, also pay-for-reporting and public reporting.

We have the PPS-Exempt Cancer Hospital Quality Reporting Program and it is a quality reporting program. And then we have the End-Stage Renal Disease Quality Incentive Program. It is a P-for-P and public reporting program. And that's the last of the hospital programs. So there is a lot of hospital programs and they really do like they cover the - a lot of the hospitals in the U.S., especially the outpatient and the cancer hospital, so a wide range of facilities that are being captured if you will by these various programs.

Now, going on to the next slide, we have the charge of the MAP Clinician Workgroup and we are very fortunate today to have my colleague Sam Stolpe here to walk us through the rest of the program. He is - Sam, why don't you tell us your assumption with MAP this year and then - because they don't (unintelligible) to them and then you can work your way through our programs.

Samuel Stolpe: Very good. Thanks Karen and hello everyone. This is Sam Stolpe speaking. I'm a Senior Director here at NQF and I'm the Staff Lead for both the Coordinating Committee and the MAP Clinician Workgroup. And it's very much my pleasure to join you today and thank you very much for your participation and for the important contributions that you will be making to the work within the workgroups and the larger effort of MAP.

So I will be covering the programs that are included inside of the MAP Clinician Workgroup charge and then we will move over to cover also the PAC/LTC settings.

Within MAP Clinician, you will note that there are three programs. The three programs contained inside of MAP Clinician are the Merit-Based Incentive Payment System, MIPS, the Medicare Shared Savings Program, SSP and a net new program to MAP this year, the Medicare Part C & D Star Ratings program.

So moving through these one-by-one, I just wanted to give a high level overview of MIPS. MIPS came from the implementation of the 2015 MACRA Act, one of the most significant bipartisan pieces of healthcare legislation in the last 20 years completely changed the way that we are paying physicians. So this is both a public reporting and a pay-for-performance program that falls into the umbrella of what we - what has been termed the Quality Payment Program which consist of MIPS as well as alternative payment models, MIPS being the one that is considered by MAP.

Let's go to the next slide. The next program that the clinician group covers is the Medicare Shared Savings Program or SSP. Now, this is a quality payment program that has two important corollaries. An ACO which is a voluntary collection of providers that come together to provide fairly comprehensive achieved savings they're able to share them with CMS.

Anyway, next step is the Medicare Part C & D Star Ratings for what is termed Medicare Part C or a Medicare Advantage, sometimes called MAPD and the stand-alone Part D plans or PDPs. This is both a quality payment program only for Medicare Part C as well as the public reporting program for both Part C & D.

So you were to go on to medicareplanfinder.gov and type in your zip code, you would generate a list of plans that you could enroll in. And next to the plan's name will be a star rating, one to five stars and so this is the way that that's - those star ratings are manifested is through the measures that are included in those programs entering into a total summary score for each of the plans.

Next slide? So next, I'm going to move into the MAP Post-Acute Care and Long-Term Care as we say PAC/LTC Workgroup. So this is particular workgroup covers six total quality programs. The majority of which are dictated by the measures that are dictated by the Impact Act. All of these programs have a fairly comparable structure with one exception and that's the last one that you see on the slide here which is a Skilled Nursing Facility Value-Based Purchasing Program.

The others is a basic disincentive structure where a 2% reduction in payment is put forward, let's say in a paid to reporting or a penalty for not reporting rather structure.

So the first step is the Home Health Quality Reporting Program, again, penalty for failure to report. There is also the In-Patient Rehab Facility Quality Reporting Program, also penalty for failure to report. The Long-Term Care Hospital Quality Reporting Program, same structure, but failure a 2% penalty assessed if they're not reporting for the quality measures and assets.

There is the Hospice Quality Reporting Program with the same 2% penalty. The Skilled Nursing Facility Quality Reporting Program, also with the 2% penalty.

And then lastly, the Skilled Nursing Facility Value-Based Purchasing Program. Now, this one is structured just a little bit differently. So the – there's incentive awards that are made value-based payments and of fiscal year based on their performance on a hospital readmission measure.

So this is a fairly straightforward program and we often don't see any measures related to it necessarily, but it does follow under the purview of MAP where those measures can be considered.

Karen Johnson: Okay. Let's see if anybody has - I know that was like the fastest presentation of all of these programs probably that you've ever seen or maybe ever will see. But does anybody have any questions about the various programs and again we're so fortunate to have Sam who knows these programs much better than I do and I'm sure if you have questions, he can answer those.

Man 3: Karen, this is (Brock) here. Can you hear me?

Karen Johnson: Hi (Brock). I can. Welcome.

Man 3: Well, thank you. I was sorry to be late for the beginning part of the call and I enjoyed the presentation so far. Just a quick question and maybe an observation and then we can choose to discuss it later as we look at our work of this workgroup.

One of the features of rural reporting is that we have a large number, 1,340 critical access hospitals that are voluntarily participating in the quality reporting program that CMS provides and in the IQR mostly, OQR.

So I guess the question that I have is as CMS is topping out measures, many of the ones that they're topping out and doing and excluding from evaluation

are the ones that critical access hospitals, small volume facilities actually are able to perform and have meaningful reporting around those measures. So I think this is going to be an important consideration as we move ahead as that MBQIP, the Medicare Beneficiary Quality Improvement Program is using those measures in their reporting and as measures top out, it could be excluding measures that small volume facilities are able to report. So I just wanted to make that note and put that on as a ticker for our future conversations.

Karen Johnson: Thanks for that (Brock). And yes, we didn't actually talk about what CAHs do, so I'm glad you reminded us that CHSs don't have to - they don't have to report on IQR and OQR that many - possibly most I think, right?

Man 3: Over 90% do, correct, at least one measure.

Karen Johnson: Okay, great. Sam, I don't know. I don't want to put you too much on the spot that this would come under I think the purview as a setting specific program and as part of the pre-rulemaking work, are they talking - are they going to be discussing measures that might be pulled out by the President? Or are they pretty much going to be discussing only measures that might be added to the President?

Samuel Stolpe: All right. So the statutory authority that MAP has is to review the measures under consideration. And that will be the primary focus of discussion. So we won't be as spending as much time focused on what measures to remove necessarily, but rather reacting to - the list as it's proposed. So there is some consideration that goes into MAP discussions around harmonization across measure sets and things of that nature, but we typically don't spend as much time focused on measures that will be removed so much as those that CMS is asking us to consider for potential inclusion and the merits of those measures.

It is putting me on the spot a little bit. And so I would have to think about this on a bit more.

Karen Johnson: Sorry about that.

Samuel Stolpe: Not at all. It's a totally appropriate question and (Brock), thank you for the considered comment, something for us to think about the interim between now and when we both convene the workgroups and you all meet on November 18.

Man 3: I think the sensitivity will be is and I agree having served on the hospital MAP historically, it will be nice to know the ones that are being retired or planned to be retired through a schedule, because in terms of looking at this as a whole or from a holistic point of view, we need to see the ones that are being added to see if they even pertain or have a relevancy in the rural context. And then what's being - and at least being aware of what's being deleted so that we can see what's being excluded from the process measures, most of them are process measures that rural facilities are actually reporting on and have meaningful value instilled in their improvement activities.

Samuel Stolpe: Thanks (Brock). This is Sam. You're absolutely right and spot on. So this is part of the work that we do in preparation for our workgroup meetings where we actually dive into the proposed rules and extract some of the changes that are slated to occur. It's absolutely mission critical for us to consider the existing measure set and the proposed changes in order to make a good recommendation around which measures are supposed to go in and how they would work as a whole system together to accomplish the goals since they've been articulated both by CMS and through federal statute. So thanks very much for that comment…

Man 3: You're welcome.

Samuel Stolpe: …it very much does pertain directly to how we conduct our work.

Karen Johnson: So this is Karen. And Sam that means it sounds like that you guys, the NQF folks who are staffing the other MAP projects, setting specific ones that you actually are going to have that information that we can pass on (unintelligible) understand me correctly and will we have that before our November webinars? Is that something we'll…

Samuel Stolpe: Yes. I think this makes a lot of sense for how rural will be considering it as well as the workgroup. So I don't see any reason that they will be different when we're - the task of the workgroups is to think carefully about the measure set holistically. And I suppose that for the rural group, it's a little bit more measure specific than its system specific. But what we plan to do for the workgroups is during the orientations as we're - we'll be walking through the proposed changes. And so those slide decks have already been prepared, so there is no reason that we couldn't share some of the information related to the measure sets and the proposed changes for the measure sets, especially as they pertain to the measures that you all will be talking about.

And I think it will help you have a more holistic view. And if that is what the rural group would like to see to help you accomplish the work, there is no reason that we couldn't share that inside of your meetings as well.

Karen Johnson: Okay. So this is Karen. What we'll do is as rural health team is we will get those decks and forward those to you guys, 1. We will also as part of that, we will let you know when - I don't think you have your other orientation call?

Samuel Stolpe: No, those are occurring later this week.

Karen Johnson: Later this week. So we will let you know when the other workgroups are being oriented and they'll go through those slide decks. So if anybody wants to log on to those and listen, you can do that too. So we will send you the slides. You don't have to dial in and listen. But if you want to, you can have both, the slides and the - you can listen to the conversation and view the date and times, et cetera.

Man 3: Perfect, thank you.

Ira Moscovice: Hey Karen, this is Ira. Just one comment, I think (Brock)'s comment really is a important part of the second projects you're going to talk about at the end which involves the whole low volume issue et cetera. And I think we can certainly as part of that set of activities I think look at this whole issue of measures being removed from the set that are relevant to rural. And it's how it relates to the whole low volume issue and reporting. So I think we can get that at least from the second part also.

Karen Johnson: Yes. I think you're right and thanks for that and keep me on as because we go through that I setup those calls that we can do that. We don't lose that idea. Any other questions or comments about what we've discussed so far? This has been great.

Okay, let's get specific now. What are you guys actually going to be doing in the next few weeks? And how are we going to support you in that work? Okay, so if we go to the next slide, so a charge for this portion of the work is to provide timely input on measurement issues to the other workgroups and committees to provide the little perspectives on the selection of quality measures for programming and to help address priorities of rural health issue (unintelligible) a challenge of rural case volume and updating the rule relevant for measure set.

And the pre-rulemaking is really the second bullet point, but this is the overarching charge of the rural health workgroup. So in talking about the pre-rulemaking work, if we go the next slide, we're going to ask you to review the MUCs. Again that acronym is Measures Under Consideration.

So you probably recall that we did this last year and CMS ask for our - your input on the measures under consideration. But last year, we did it only for the clinician setting and this year as we've alluded to and CMS has broadened your scope and we like your input not only on the clinician programs or measures that are being put forward for potential inclusion in clinician programs, but also as we said hospital programs and PAC/LTC programs. So fairly - contextually a pretty big expansion and we're very happy to have seen that.

So what we will do is we will have you review all of the measures under consideration. And we're actually going to systematically go through these things that are on this slide, these bullet points. And we're going to make sure that we understand your thinking and your rationale on all of these points. So for each measure, we're going to try to understand what you are thinking in terms of priority and utility of that measure in terms of access quality or cost encountered by rural residents. So being very specific about, you know, if this is going to be useful for rural residents.

We want to know if you anticipate any data correction or reporting challenges for rural providers, again, for each measure. Any methods problems on - especially and there is our favorite topic in terms of calculating the measures for the small facilities so that low case volume problem. We really want to know if the measures that are being put forward may have some of those difficulties.

And last but not least, potential unintended consequences of inclusion in specific programs. So it may be a wonderful measure, but, you know, in general or even for one program but maybe not so much for another. So we do want to get to the extent that we need to any possible problems in specific program. So all of these things will be done for each measure that is under consideration.

Now, in case you're wondering, we don't actually know what those measures are yet, statutorily those are - they have to be released by CMS by December 1 which will be actually too late for us in our work, because we have meeting scheduled for near the end of November. But CMS has said that they were going to, you know, detect statutory requirements. So we will have those measures, we'll know what they are. But today, I don't know what they are and I actually don't know how many there will be. So that's to some extent why we have three different webinars. We think that three webinars will be enough time to do the work.

And if it turns out that there is not as many as we think, there might be - we may even be able to either have shorter calls or even cancel one of them. But again, we don't know what those measures are at the end.

We're finally going back to this last bullet here, we actually thought about this and what we're going to ask you guys to do again in a systematic way is to talk about to the extent as you can gap areas in measurements relevant to rule measurements and providers (unintelligible) programs.

So, you know, maybe looking at what's in a program and if there is something that should be there that would really do beneficial for rural and if it's not, what is that. So again that is something that we'll ask you to do kind of at the

program level. So again it will be very systematic. I'm not quite sure what that will look like. We made this almost a (little checkbox) we go through and talk about everything or we may just kind of talk about each measure kind of broadening (and loom) as staff would pull out these things. I'm not quite sure yet.

But the long and short of it is, if we go to the next slide, we are going to provide that feedback to the setting specific workgroups. And we're going to do it in two ways and I alluded to this first earlier. First of all is a measure discussion guidance and Ameera just going to pull that up in a minute to show you what that looks like. But it is a - it is the materials that the setting specific workgroups look at that give us a lot of details about the programs as well as the individual measures on the MUC.

And what we will do is once you guys provide your feedback, we are going to summarize that feedback and that comes part of this discussion guide. So just qualitative summary of your discussion will become part of the discussion guide that the individual clinician and the individual setting specific workgroups see.

We're also going to do a quantitative exercise and ask you to (rope) on individual measures. And, you know, those who're going to do basically your perception of the feasibility for the variance program. So, you know, I think probably the bulk of - you know, and kind of the need of what you were going to be providing and that will be useful is the qualitative summary. But it also – it never hurts to have a quantitative summary as well, so we'll provide both in that discussion guide.

And then also as I mentioned, we're going to ask one of you to attend each of the setting specific meetings in December. So actually come to D.C., sit

around the table with everybody else on that workgroup and not just sit around the table, but we'll actually have a spot on the agenda for you to kind of be the liaison, the relay, the translator, the interpreter, whatever word you want to use to make sure that the workgroup really does hear that feedback. Because they're going to do the - getting that feedback qualitatively, quantitatively both in written form and, you know, verbal form with the liaison at the meeting.

And this is quite different than what we did last year and we did have Ira did come to the clinician meeting last year and service liaison, but he had to kind of jump in really, you know, could or felt like he should this time again it's going to be a very specific part of the agenda for each discussion. And these things - these changes to how we're providing this input really does reflect the importance that CMS is placing on this feedback that you're giving from this rural perspective. We want to be very systematic and really just get it down on paper what that input is.

So Ameera, do you have a discussion guide up? We thought it will be interesting to see the discussion guide for a couple of reasons. One is it will give you a flavor of where your input is going to go, but this is also basically the - and this is an old one, this is from last year, so don't worry about the details of this in terms of what was there. This is last year's discussion guide. Our staff here are very busily working on getting setup to do a similar discussion guide for this year. But this is what we will be providing to you so that you can understand even in more details the programs and individual measures.

You can see the first page here is the agenda for the meeting which working in a facility will be relevant for you. But if you go up here to the top Ameera

and click on measures, you see what I mean? You know what I mean up at the top, the link there, (unintelligible). Can you click on measures?

And what this does and then if you click on, just pick one of the measures, again this is last year's, but it gives you the detail measure specifications, so all of that there. If you go down further, there is a preliminary analysis. This preliminary analysis is done by NQF staff and they actually have an official algorithm that they go through, they have questions that they are responding to and so you can see kind of the rational and where NQF staff believes, you know, these things are being, you know, like here measure developed status. You know, this is fully developed, this is still in development and things like that that might be really interesting.

We'll have rational from HHS and then it looks like that's about it. So somewhere in this kind of area, we will very prominently display the feedback from the Rural Health Workgroup, so this will be there.

A couple of other things that I will show us is if you go over to programs, again the various programs, there is more information on the program, more than what we've provided to you on the slide. So you'll have that as well as part of your material (unintelligible) in preparation for our meetings in November.

Okay, let me stop there and see if you have questions. Hopefully that makes sense of what the act is. Okay, at this time we have on our agenda that we will open it up for our public and member comments. So we'll just pause here and see if anybody from the public who have dialed in has any questions or comments that you want to put forward at this time.

Okay, hearing none. It sounds like there aren't any. I'm going to hand it over to Ameera who will walk you through our next steps and then we'll check one more time after she's done if we've got any questions that - let's hear about our next steps and go from there.

Ameera Chaudhry: Thanks Karen. So very quickly, here is the timeline of upcoming activities that Karen sort of touched on throughout the call. Again, the MUC list will be released officially December 1. So hopefully we will have access to that sooner and we will be discussing them during our web meetings in November.

We also have listed the in-person meetings for the other MAP Workgroup. We also have listed our public comment periods. So definitely we will be posted on those as well.

We also have a separate task order of new work that the MAP Rural Health Workgroup will be a part of. More information about that will be shared as we get closer to our first meeting which is currently scheduled for November 25. Invitations to all these meetings will be sent out to the workgroup shortly after this call.

But just to summarize, this is a 35-month order that the workgroup will be involved in the first two tasks. The first one is what we will be starting November 25. Again, we will be sharing relevant information and more detail, but the main idea of task one is to identify high priority rule of relevant measures with minimum case requirements for future testing using the TEP recommendations that were made in our report last year. So we're looking forward to that work and looking forward to sharing more information about it in the upcoming weeks.

Other than that, we have some additional resources here for you to check out as you'd like to or if you have any questions, we also have provided our contact information and some key links that will have lot of the information that we talked about today.

So with that, if there're any more questions we'll open the line for that.

Karen Johnson: And maybe before our questions - this is Karen again, the new (unintelligible) really excited about, because it really gives us, you know, a lot of opportunity over the next three years really to provide input. We're not talking about it too much today, because we were afraid that it will be really confusing. So we really wanted to bifurcate and talk mainly today about the pre-rulemaking activities that you will be doing and then right after those are wrapped up, we'll head into our first sub-task under our new work.

And it is pretty interesting and those who are new, most of you may not be as aware of the work that TEP did last summer. We bought together, I think it was five experts around - and basically our question to them was what do we about this low case volume problem, but from a statistical view point. So it's pretty heavy stats, methods, piece of work that they did we presented it to the rural health workgroups.

We are very excited, one of our new members is Jessica Schumacher, so Jessica was on that TEP, so which we'll probably be relying on you quite a bit Jessica to help us understand. So basically what we're going to be doing in the first task is kind of taking it to the next level and that TEP provided recommendations on how to think about this low case volume problem again from the methods perspective.

And our next piece of work will be to say okay, which measures really should be kind of put in queue for doing that kind of work that was recommended by the TEP last year. So we'll be, you know, talking about the measures that are out there, the ones that are being used, the ones that we really think are kind of vulnerable to that low case volume problem. And while we're doing that, we are also - we want to make sure that we haven't or don't lose track of any, you know, emerging issues from a rural perspective that maybe you didn't talk about so much last year. Anything new that we need to make sure that we cover. So that's what's going to be on in task one. So we're pretty excited about that and that orientation call as we said is scheduled for November 25.

I'm not quite sure why we sit tentatively on our slides. That might be in (stone) now maybe when we had to actually get these slides developed, we might - I think we were still kind of working on that. But those invites will be going out along with other invites for the other meetings that we'll be doing over the course of that task.

So let me pause again for any questions. It could be questions about any of our pre-rulemaking activities or if you're curious a little bit more about our task one. Why don't we can give you a little bit more insight if you are curious or we'll just wait for November 25 and we can go from there?

All right. It sounds like nobody has questions. So thank you very much for joining us on this call. We have no need to hold you any further. We're going to give you some time back in your day. So if you have any questions, any concerns that you want to have some NQF input on, just let us know, email, call, whatever you want to do and we'll be back to you as soon as you can.

In the mean time we will be sending out materials. I'm not exactly sure when we will be sending out the materials before the 18th. Some of that does depend on when the MUC list is actually released and our step here we'll have to actually build those discussion guides once that list is released. So there will be a little bit of timing there. But we will get those out to you as soon as we possibly can to give you the maximum amount of time that we can for you to be looking at the measures and the measure steps and the - and what you'll be thinking about those. And then as we said, we come together on the 18th and start going through the list.

So thank you so much. I'm going to go ahead and adjourn our meeting and we'll talk to you in about a month, okay.

Man 1: Thanks a lot.

Ira Moscovice: Thank you.

Suzanne Theberge: Thank you.

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