CMS Quality Measure Development Plan

Technical Expert Panel Meeting Summary

(MACRA Section 102)

Meeting Dates: May 2–3, 2018

Prepared by: Health Services Advisory Group, Inc.

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Technical Expert Panel Meeting Summary

I. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) has contracted with Health Services Advisory Group, Inc. (HSAG) to develop and update the *CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)*[1] under Contract #HHSM-500-2013-130071; Task Order #HHSM-500-T0002. As part of this contract, HSAG ("the team") has convened multidisciplinary technical expert panels (TEPs) of stakeholders (e.g., patients and family caregivers, clinicians and representatives of professional societies, consumer advocates, quality measurement experts, and health information technology specialists) to develop recommendations for updating the Measure Development Plan, known as the MDP, and prepare MDP Annual Reports documenting progress related to clinician quality measure development to support MIPS and Advanced APMs.[2]

This report provides a summary of the 2018–2019 MDP TEP's first meeting, including perspectives and recommendations in prioritizing measure subtopics for future measure development. As context for the meeting proceedings, the report reviews the legislative authority for the MDP, annual progress reports, and the environmental scan and gap analysis that framed the TEP's assessments. Overviews of panel discussions contain voting results and recommendations about the importance and feasibility of selected measure subtopics, as well as potential alternatives, to address clinician quality measure gaps. A summary of post-meeting comments at the end of the report contains follow-up communications from TEP members relative to discussion topics. Reference documents in the Appendices include the approved TEP Charter, the meeting agenda, a conceptual framework for the most recent environmental scan that served as background for the TEP pre-assessment, and the TEP pre-assessment ratings of measure subtopics identified as gaps for five clinical specialties CMS added in 2017 as priorities for measure development[3]:

- Allergy/Immunology
- Emergency medicine
- Neurology

[1] Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services. CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Baltimore, MD: US Department of Health and Human Services; 2016. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf. Accessed June 6, 2018.

[2] CMS. MACRA: delivery system reform, Medicare payment reform. Baltimore, MD: US Department of Health and Human Services; 2016. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html. Accessed June 6, 2018.

[3] The MDP included mental health and substance use conditions, oncology, orthopedic surgery, palliative care, pathology, radiology as initial priority specialties; the previous TEP also considered crosscutting subtopics under the category of general medicine.

- Physical medicine and rehabilitation
- Rheumatology

Additional appendices contain the TEP's ratings of subtopics drawn from the 2018 environmental scan results for the above five specialties and a list of subtopics that the TEP tabled for later consideration as crosscutting priorities.

II. BACKGROUND

The Quality Payment Program replaces CMS legacy programs for clinician quality reporting to support a transition from a volume-based payment system to one focused on quality and value. The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) established two tracks of the Quality Payment Program and required the Secretary of Health and Human Services (HHS) to develop a quality measure development plan. The MDP guides and prioritizes the development of measures that promote improvement in patient outcomes, relieve clinicians' reporting cost and burden, and are meaningful to patients and caregivers as well as clinicians.

Under contract with CMS, HSAG conducts environmental scans and gap analyses to expand upon on the initial measure priorities and gaps identified in the MDP. The team also supports CMS in preparing annual reports on progress in developing measures for the Quality Payment Program, which include the status of newly and previously identified gaps in measurement and updates on implementing the MDP. The first such report[4] was published June 2, 2017; the second,[5] posted May 3, 2018, aligns the measure priorities outlined in the MDP with the Meaningful Measures initiative CMS launched in 2017. Meaningful Measures focuses quality measurement and improvement efforts on those core issues that are most vital to providing high-quality care and improving patient outcomes while reducing the cost and burden associated with quality measurement.

HSAG convened a TEP in 2016–2017 to provide input on the findings of the first scan and content for the first annual report. Seeking pre-publication stakeholder input on the draft 2018 Environmental Scan and Gap Analysis Report, the team solicited nominations for a second MDP Technical Expert Panel through a call for nominations posted on CMS.gov website from December 17, 2017, through January 8, 2018. HSAG staff screened and rated 114 nominations and interviewed seven patient/caregiver nominees by telephone.

Twenty-three nominees were recommended for CMS review. Notified of their selection, all accepted. Among 14 clinicians selected, seven physicians and three non-physicians represent the target specialties for measure development. One patient, one caregiver, and two members of advocacy organizations represent patient/consumer perspectives. Collectively, the TEP also has

[4] Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services. *CMS Quality Measure Development Plan: Supporting the Transition to the Quality Payment Program – 2017 Annual Report*. Baltimore, MD: Centers for Medicare & Medicaid Services; 2017. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2017-CMS-MDP-Annual-Report.pdf. Accessed June 6, 2018.

[5] Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services. *CMS Quality Measure Development Plan 2018 Annual Report.* Baltimore, MD: Centers for Medicare & Medicaid Services; 2018. https://www.cms.gov/Medicare/Quality-Payment-Program/Measure-Development/2018-MDP-annual-report.PDF. Accessed June 6, 2018.

expertise related to clinical quality measurement, health information technology, health systems, payers, accountable care organizations, and qualified clinical data registries. *Appendix A – Technical Expert Charter* contains a membership list with individual disclosures about potential conflicts of interest, none of which was deemed to disqualify a member for service on the TEP.

The team convened the first meeting of the 2018–2019 TEP on May 2–3, 2018, in Tampa, Florida (*Appendix B – TEP Agenda*). All 23 members attended in person, along with HSAG staff and the CMS project lead, Nidhi Singh Shah. A webinar enabled other CMS representatives to attend remotely. The meeting objectives were as follows:

- Discuss the role of the TEP in terms of project background and objectives; ratify the TEP Charter.
- Consider the perspectives shared by patient and caregiver TEP members.
- Present the approach to identifying prioritized specialties.
- Review the methodology and findings of the 2018 MDP environmental scan.
- Prioritize measurement gap areas and review additional subtopics for the conceptual framework.
- Describe the Quality Measure Index and review the development approach.

In preparation for the meeting, the team sought feedback from the TEP on the relative importance of measure subtopics identified as priorities or gaps for the Quality Payment Program in the five target specialties, as illustrated in *Appendix C – Preliminary Environmental Scan and Gap Analysis Conceptual Framework for TEP Pre-Assessment*. Each TEP member used an online tool to individually rate the subtopics on a Likert scale of 1 (not at all important) to 9 (extremely important) and provided comments as applicable, based on the member's expertise and stakeholder perspective. Next, the team ranked the selections for each specialty, based on the highest median ratings and the least standard deviation of the median (see *Appendix D – TEP Pre-Assessment Ratings of Measure Subtopics*). These pre-assessment rankings formed the basis for focused discussions and revised assessments at the meeting, as summarized in the following account.

III. MEETING PROCEEDINGS

Welcome and Opening Remarks

Presenters: Kyle Campbell, PharmD, HSAG; Nidhi Singh Shah, MPH, CMS

Dr. Campbell, Project Director, welcomed the participants and thanked them for attending the meeting. He reviewed the meeting objectives and agenda (*Appendix B*) and reminded panel participants that meeting materials are proprietary to the project and cannot be shared without permission from CMS. He then introduced Nidhi Singh Shah, CMS project lead.

Ms. Singh Shah welcomed members of the panel and thanked them for their participation. "All of your input, your discussions, your pre-assessment work is all valuable feedback that we at CMS will learn from and will take into account for really moving forward and advancing high-value measures, meaningful measures for clinicians, meaningful measures for patients, to support the Quality Payment Program," she said.

Ms. Singh Shah introduced two CMS leaders who provided opening remarks via video recording: Danielle Andrews, Deputy Director of the Quality Measurement and Value-Based Incentives Group, and Maria Durham, Director of the Division of Program and Measurement Support.

CMS Welcome and Update (video)

Presenter: Danielle Andrews, MHA, CMS

Ms. Andrews welcomed the members of the panel and thanked them for volunteering their time. She thanked the patient and caregiver representatives, Lindsey Wisham and Rachel Harrington, for their willingness to share their stories.

The work of the TEP is a key component to ensuring that the MDP and the MDP Annual Reports help to guide meaningful measure development for the Quality Payment Program, she said. The work of the TEP will help CMS understand what is important as new measures are chosen and developed for the program.

Ms. Andrews said Quality Payment Program policies change how Medicare pays clinicians, which will affect more than 600,000 clinicians who receive Part B payments and will improve health care across the delivery system nationwide.

"Our aims for this payment reform are to reduce burdensome regulations; provide new incentives to provide high-quality, cost-effective care; and give clinicians more time to care for their patients. CMS will continue to listen to patients and clinicians and take actionable steps toward improving health outcomes for all Americans," she said.

Meaningful Measures (video)

Presenter: Maria Durham, MBA, MS, CMS

Ms. Durham presented an overview of the Meaningful Measures framework,[6] which CMS introduced as a comprehensive approach to identify the highest priorities for quality measurement and improvement. The framework focuses on core issues that are most critical to providing high-quality care and improving individual outcomes.

The framework draws on measure work by the Health Care Payment Learning and Action Network, the National Quality Forum (NQF), and the National Academies of Medicine. It includes expert perspectives from the Agency for Healthcare Research and Quality, other federal agencies, and external stakeholders such as the Core Quality Measures Collaborative. This input provides the basis for developing criteria for measures that are meaningful to patients and actionable for providers, Ms. Durham said.

"We want to be patient-centered. We want outcomes based on high-impact measures that are relevant. We want to look for areas where there are opportunities for improvement, and we want to address measures that are value-based and, most importantly, aligned," Ms. Durham said.

She said CMS is simultaneously addressing three dimensions to Meaningful Measures: (1) conducting a thorough review of existing measures and removing measures that fall short of

[6] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html. Accessed June 6, 2018.

CMS' criteria, (2) analyzing measure sets to identify gaps, and (3) working with clinicians, providers, registries, EHR vendors, and other federal stakeholders to lower the burden of measurement systems, particularly in the area of reporting.

She thanked the members of the panel for their participation and specifically thanked the patient and caregiver representatives for their involvement.

MACRA and the Role of the TEP in the CMS Measure Development Plan

Presenter: Kendra Hanley, MS, HSAG

Ms. Hanley, HSAG team lead for the CMS Measure Development Plan, thanked Ms. Singh Shah and the other CMS leaders for their discussions of CMS priorities and the Meaningful Measures initiative. She described how the activities of the TEP relate to MACRA and the MDP. She noted that section 102 of MACRA authorized the development of the MDP and publication of annual progress reports, which together are the primary public documents that inform Congress and stakeholders about measure development for the Quality Payment Program.

Ms. Hanley said CMS is striving to empower patients and clinicians to make shared decisions about their health care, an effort supported by the Meaningful Measures objectives. She said the panel's input will ensure that external stakeholder feedback informs work that supports the MDP, including the discussions of gaps for the five specialties at this meeting, but also other reports and publications during the term of the members' service on the TEP.

TEP Introductions and Ratification of the TEP Charter

Presenters: Amy Mullins, MD, CPE, FAAFP, American Academy of Family Physicians; Michael Phelan, MD, JD, FACEP, RDMS, CQM, Cleveland Clinic Health Systems

Dr. Mullins and Dr. Phelan introduced themselves as co-chairs and conducted a roll call that confirmed all 23 members were present.

A member proposed an amendment to the draft charter to include mention of the Meaningful Measures initiative. Dr. Campbell suggested that HSAG incorporate appropriate language into the CMS objectives, and the members ratified the draft charter by consensus, contingent upon the amendment. *Appendix A – Technical Expert Panel Charter* contains this addition to the project objectives:

- Gather input to enhance the Meaningful Measures initiative about the most impactful and highest-priority quality improvement areas for all clinicians, including specialists, and what is important to patients, families, and caregivers.

Patient and Caregiver Perspectives

Carolyn Lockwood, HSAG nurse informaticist, introduced the patient and caregiver representatives.

Patient

Presenter: Lindsey Wisham, MPA

Ms. Wisham told of being diagnosed with systemic lupus while in college 19 years ago. She later was diagnosed with another chronic illness, Crohn's disease, and in following years

experienced two deep vein thromboses. In learning to navigate the health care system as a patient with multiple chronic illnesses, she developed a passion for self-advocacy. She understood that to receive coordinated care, she needed to be her own care manager. Her own paper logs, medications, and records went with her to every appointment.

When complications led to a wrong diagnosis of appendicitis, unnecessary surgery resulted in a hospital-acquired staphylococcus infection. Multiple clinicians prescribed her medications, and only she and her pharmacists caught the contraindications. These experiences reinforced her commitment to be a proactive patient.

"It was never lost on me that communication between myself and my providers was my greatest advantage," she said. "It was opportunities to participate in my care as an equal partner in making decisions that gave me the greatest sense of patient empowerment."

Ms. Wisham acknowledged vast improvements in the way information is captured but highlighted gaps in electronic health records (EHRs). She routinely accesses four patient portals where she can see all her data from multiple care providers, yet they cannot share that information among themselves across EHRs. The data are "held hostage, with no patient-directed way to transfer information. Believe me, I have tried. And physicians can't see other labs' results, notes, or medications another provider has ordered or performed," she said. "It is common practice for me to still request that results from labs and diagnostic studies be printed out of the EHR and faxed to my other physicians. … This creates a barrier to coordinated care."

Ms. Wisham emphasized that providers must have access to all the patient's information. Quality measures will be the most meaningful to patients when they provide information that allows patients to evaluate the quality of their potential outcomes, she concluded. Such measures could equip patients to make decisions impactful to their care.

Caregiver

Presenter: Rachel Harrington, BA

Ms. Harrington said she is the caregiver for her 66-year-old mother, who is functionally disabled primarily due to complications related to osteoarthritis and rheumatoid arthritis, although she also has drug allergies and other conditions.

The past few years of her mother's care have been especially challenging, Ms. Harrington said. Unplanned gastrointestinal surgery was followed by a secondary infection that was not diagnosed until it was septic, which in turn resulted in a weeklong hospitalization and two weeks of intravenous antibiotics.

Ms. Harrington said the circumstances that led to the infection and hospitalization were, "if not a direct result, very close to a direct result of specialists playing hot potato with her care"—passing her back and forth from surgeons to interventional radiology to primary care—and emergency department (ED) personnel not trusting her reporting of her condition.

When Ms. Harrington learned she would serve on the TEP, she asked her mother three questions: the biggest challenge she faced in managing her care, the biggest hurdle to receiving care, and her biggest frustration with the health care system. Her mother's responses:

- Biggest challenge: mobility because of the pain and limitations from her arthritis

- Biggest hurdle: responsibility for keeping appointments, updating records, and keeping all of the care team informed and in the loop. Ms. Harrington repeated her mother's words: "Everyone is focused on their own specialty."
- Biggest frustration: working with different people and providers who are focused on their own processes and do not "trust what I was telling them or see me as a whole person" despite the patient's considerable knowledge of health care

Ms. Harrington gave her own answers to the same questions:

- Biggest challenge: managing information about doctors, facilities, records updates, and prescriptions
- Biggest hurdle: The burden of identifying the need for care outside the average patient mold is "100 percent on us." She cited the example of home health options for physical therapy, which could make her mother's life easier but cannot be accessed without preauthorizations and prerequisites that add "just one more thing on top of the everyday management of her health."
- Biggest frustration: Care is seen as transactional, with medical services provided within a limited scope. "It goes back to her point earlier: She is a whole person. She is not the sum of the individual visits, transactions, lab tests, imaging scans that she has. But very frequently, her care does not reflect that."

Ms. Harrington said the shape of care is motivated by the incentive structure behind it, and quality measurement is one way of reshaping those incentives. She suggested several changes: (1) support for observation and management of longitudinal patient-reported outcomes, (2) improved EHR interoperability, and (3) a focus on crosscutting measures that increase accountability for overall patient outcomes across the care team.

General Comments and Feedback From the TEP

A TEP member, noting that both speakers are intensive users of specialist services, asked whether they each have a primary care physician or are piecing together a primary care plan with one of the specialists. The primary care component would have implications for how specialist care is measured, the TEP member observed.

The patient representative said she has a primary care physician with whom she is clear about her expectations for working with the specialists. The caregiver representative said her mother has had the same primary care physician for about 15 years, and he has been very good in following her as she has accessed more specialty care.

A TEP member commented about a "missing voice" around the table: EHR vendors who control whether data can be shared. He added, "We would appreciate ongoing CMS support in coordination with the vendors so that we can actually be successful once we get these measures done." An HSAG staff member responded that the TEP has some EHR representation and noted that over the past year and a half, CMS has been engaging vendors in electronic clinical quality measure workgroups.

A TEP member emphasized the importance to patients of collecting data on physical function at multiple points across the care continuum, then harmonizing what is being collected. She also urged the TEP to think about collaboration across specialties.

Other TEP members agreed about the importance of EHR interoperability, care coordination, and communications between a patient's clinicians. "The problem is that we're looking at it from the perspective of all these specialties," one said. "It's also receiving a referral from the primary care physician or whoever is the internist and sending the information to us for referral, and then us sending the information back to them. And a lot of these measures that are out there really don't do a great job of capturing that."

Another TEP member cited reasons for hope in projects to promote interoperability and care coordination through models such as patient-centered medical homes. He also proposed to broaden the definition of patient-centered care. "Whenever you hear that term, patient-centered, I want you to think of patients, lay caregiver-centered, because how we communicate with our patients and their lay caregivers, family, or whatever is huge," he said.

A TEP member challenged the panel to think about how quality measures need to align with patient and caregiver perspectives. The current system for quality measurement and value-based payment represents many varied stakeholder interests, "and until we begin to align those with what's important and meaningful to patients and caregivers, we're not going to make the progress that we need to make toward value," she said.

Identification of Priority Specialties

Presenter: Anita Somplasky, RN, CHTS-PW, CHTS-PC, HSAG

Ms. Somplasky noted that the Measure Development Plan identified seven clinical specialties as the initial priorities. In 2017, the team evaluated 67 clinical specialties represented in CMS administrative data and ranked them by their need for measure development. The analysis considered data from a variety of sources, including the 2015 PQRS Reporting Experience Report, as well as factors such as cost and volume of services. This work gave an idea of which specialties were making an attempt to report, who was doing well with reporting or faced challenges, and who might face payment adjustments, she said.

The team reviewed stakeholder comments on the draft MDP and proposed rulemaking and looked at whether specialty-specific measure sets were available. The team also looked at Measure Applications Partnership reports from NQF to see what measures were identified in 2016 and 2017 as priorities for development and reviewed the specialties identified in the MACRA grants forecast announcement in May 2017.[7] The team developed a weighting score for each category and applied an algorithm to calculate final scores and rank specialties.

One TEP member asked how the Measure Development Plan would incorporate the specialties previously addressed. Ms. Somplasky said those specialties remain priorities and noted their inclusion in the MACRA grants forecast. Another member asked about cardiology, which Ms. Somplasky said has several outcome measures and therefore was not identified as having gaps.

A TEP member asked for clarification on whether the determination of available specialty measure sets was limited to MIPS measures rather than including qualified clinical data registry

[7] US Department of Health and Human Services, Centers for Medicare & Medicaid Services. View grant opportunity. TBD: Medicare Access and CHIP Reauthorization Act (MACRA) funding opportunity: Measure development for the Quality Payment Program. Baltimore, MD: US Department of Health and Human Services; 2017.

(QCDR) measures. Ms. Somplasky said the team looked only at MIPS measures in the 2018 proposed rule, as an updated list of QCDRs and their measures was not yet available.

Overview of the Environmental Scan

Presenter: Cherrishe Brown-Bickerstaff, PhD, MPH, HSAG

Dr. Brown-Bickerstaff gave an overview of how the project team identified gaps in clinician-level measurement and scanned existing clinician quality measures with the goal of identifying measure development priorities for the five specialties.

She explained that the team constructed a conceptual framework for the environmental scan based on the six quality priorities and 19 topic areas of the Meaningful Measures framework. "They were very integral for the process," she said. In addition, the team obtained external stakeholder input through patient/caregiver interviews and the TEP pre-assessment.

In discussion, TEP members underscored the importance of crosscutting measures. "It's easier for reporting; it's easier to think of it from the patient and caregiver perspective instead of chopping up care into these small, teeny little buckets," a TEP member said. Another member noted that interoperability and a good flow of information would help create crosscutting measures.

While acknowledging pressure for clinicians to have relevant, specialty-specific measures to report as a basis for reimbursement, a TEP member observed "a groundswell of sentiment from this group that goes in the opposite direction of that, wanting to be as holistic as possible and patient-centered as possible in measurement."

Dr. Campbell reminded the TEP members that their charge for this meeting was to identify specialty-specific measures for the five specialties. "We did work a little bit with that in the last panel, so there was a crosscutting area, and so we have some input from stakeholders on that. But I do think that, given the breadth of this panel, we'd like to hear more, and I think there will be an opportunity to do that."

Qualified Clinical Data Registry (QCDR) Measures and Measure Gaps

Presenter: Kendra Hanley, MS, HSAG

Ms. Hanley referred to Dr. Brown-Bickerstaff's presentation, recalling that 125 of the 213 measures applicable to the conceptual framework were from QCDRs. She reminded the TEP members they had answered several questions about QCDRs as part of their pre-assessment: Asked whether they had concerns about QCDR measures filling measure gaps, 35 percent said yes, and 65 percent said no. Ms. Hanley said the panel would discuss the results, then vote whether to support development of additional measures to fill a specialty measurement gap even if a QCDR measure already covers that same subtopic. The TEP should consider whether allowing QCDR measures to fill gaps in the subtopics means those gaps are being underestimated, she said.

As context for the discussion, Ms. Hanley explained that QCDRs are among the reporting methods available to eligible clinicians in the Quality Payment Program. QCDRs can report MIPS measures finalized through the rulemaking process but also have the flexibility to report

additional measures. Ms. Hanley said CMS works closely with QCDRs to review and approve measures that registries want to submit on behalf of eligible clinicians.

Many registries are developed and run by specialty societies with vendors handling the technical aspects of data collection, she said. A physician's membership fee may include participation in a QCDR, which could also support improvement activities and other components of MIPS. Specialists often find the measures reportable through a QCDR are those most relevant to their practice, she said; however, the lack of a standard process for measure development means that the rigor of that process varies across QCDRs.

During the discussion, some TEP members expressed confusion over whether they reported to a QCDR because employers report on their behalf. Many QCDR measures are similar to MIPS measures, a member said. "It's just confusing, I think, when clinicians report. They don't know what they're reporting. They don't know which method created the highest score so that they could report more successfully."

Other TEP members highlighted the cost to specialty societies to develop measures and acquire the technology for EHR reporting. "I always look at opportunity costs," one said. "If [we're] spending the money on this, we're not spending it on something else."

A TEP member raised concerns about harmonization and duplication if a MIPS measure is developed despite the existence of a similar QCDR measure. She said there is no immediate or clear pathway for a QCDR measure to become part of MIPS, and the process can take several years. She encouraged CMS to consider an easier pathway.

Another TEP member said CMS has indicated a desire for QCDRs in the specialty societies to step forward and take on measure development. However, the member said the challenge is to streamline where these measures are being created and provide guidance on how to make QCDR measures more widely accessible to providers. CMS is encouraging harmonization, she said. "I think there's just a lot of questions about how do we disperse costs, and how do we work together, and how do we start talking early on in the process so that all of that can happen correctly."

A member expressed concern that "other people can develop measures and have them count as exactly the same level of measurement in MIPS, when we've invested [in] … bringing all the stakeholders, getting consensus, doing the rigorous work, and then bringing it to NQF." She suggested tiers for quality metrics.

A TEP member acknowledged value in QCDRs giving specialists the ability to report on measures that matter to them. However, if a measure is not publicly reported or on the path to become a MIPS measure, the availability of results is limited and patients cannot base care decisions on the data.[8]

Dr. Campbell summed up the discussion: "So, I think what I've heard around the table is this idea that there should be more harmonization, more collaboration between QCDRs and measure developers and MIPS," and that QCDR measures "should be part of the conceptual framework

[8] After the meeting, HSAG researched the matter of public reporting. CMS requires each QCDR to declare either of two options by which CMS can make their quality measure data publicly available via Physician Compare: provide the information to CMS for posting or provide a link to access the data on the QCDR website.

and considered by the developer as something that already exists" with the potential to be re-specified rather than duplicated with *de novo* (new) development.

At the end of their discussion, TEP members were asked to vote on whether additional measures should be developed to fill a measurement gap for a specialty, even if a QCDR measure covers the same subtopic. The majority of voting TEP members (55 percent) voted no on the question.

Overview of the Pre-Assessment Approach

Presenter: Carolyn Lockwood, RN, MSN, HSAG

Ms. Lockwood discussed the interviews with patients and caregivers and the pre-assessment by the TEP, which included the patient and caregiver representatives.

HSAG worked with an independent consumer survey group to develop the interview process and structured questions. The survey group screened potential interviewees to ensure representation across all five specialties and geographically across the United States. Interviews were conducted with 25 patients and caregivers who reported experience in the previous year with one or more of the target specialties. Caregivers ranged from age 41 to 57; patients from 65 to 94.

The interviews assisted in identifying topics that are important to patients and caregivers and collected input about important aspects of health care and interactions with a care team. Statements from both groups were interspersed into the presentation as they related to clinical specialty care and Meaningful Measures priorities.

The purpose of the TEP pre-assessment was to evaluate 49 specialty-specific subtopics identified during the environmental scan as potential areas for new measure development (19 of which were as condition-specific or other variants of a broader subtopic). TEP members were asked to individually rate the importance of these subtopics as quality of care issues that should be measured in the Quality Payment Program, as well as whether a subtopic could be crosscutting or would require specialty-specific measure development. The subtopics were rated on a Likert scale of 1 (not at all important) to 9 (extremely important). Individual scores were compiled to determine a median score for each subtopic.

In discussing the results, Ms. Lockwood said no subtopics were identified as not important. Three were identified as moderately important, with a median score of 4, 5, or 6, while 46 subtopics were identified as important, receiving a median score of 7, 8, or 9.

TEP members also were invited to recommend additional subtopics for consideration, especially in Meaningful Measure areas where the environmental scan identified no subtopics. Pending discussion and recommendations by the full TEP, 11 of the subtopics that TEP members proposed were mapped to the Meaningful Measure areas that included subtopics rated as important, while 80 were mapped to Meaningful Measure areas for which no subtopics had been identified.

Ms. Lockwood described the procedures for TEP review of subtopics, consisting of two discussions and two votes for each specialty area. First, the members would discuss the pre-assessment ratings and whether any subtopics should be removed from the preliminary list. The members then would vote to confirm the list of subtopics. For the second discussion, the TEP would review members' suggestions for the Meaningful Measure areas that had no subtopics

identified in the environmental scan. The TEP would make modifications as warranted, then vote on whether to recommend the subtopics be added to the conceptual framework.

Discussion of the Priority Subtopics by Specialty (Day 1)

Emergency Medicine

Presenter: Kendra Hanley, MS, HSAG

Ms. Hanley shared some of the comments obtained from patient/caregiver interviews specific to care received in EDs. One had a very positive experience; another was given an information sheet but otherwise told very little about the medications given in the emergency room. Ms. Hanley said the team mapped comments to some of the 19 Meaningful Measure areas to underscore that these CMS priority areas also are important to patients.

Ms. Hanley discussed the 19 subtopics specific to emergency medicine that the TEP rated as part of the pre-assessment (*Appendix D – TEP Pre-Assessment Ratings of Measure Subtopics*, Table D-1). The subtopics, identified through the environmental scan, spanned eight Meaningful Measure areas; all but two had a median rating of 7, 8, or 9, meaning they were rated as important. The TEP recommended five additional subtopics. Before opening the discussion, Ms. Hanley asked the TEP to keep in mind whether a crosscutting measure could address the subtopic, or if specialty-specific considerations would warrant a measure specific to emergency medicine. Is the subtopic appropriate for clinician-level measurement and accountability? Are there any feasibility considerations for a given subtopic?

Ms. Hanley said the goal of the discussion was to reach consensus among the TEP that these are subtopics important to emergency medicine.

General Comments and Feedback From the TEP

In reviewing the posted subtopics, members who are ED clinicians described most of the subtopics listed as crosscutting. A TEP member asked others to consider how quality is different in an ED setting versus a standard setting of care, even if a measure is considered crosscutting. She noted that the ED is a unique setting of care that can disrupt patients' care management, mental health, or medication regimen. "Are any of those disruptions unique enough or high-risk enough to warrant a special measure in this setting to prevent it from having a further downstream impact?" she asked.

A TEP member replied: "You could consider many of these crosscutting at a broader level, but it's a very different interaction or experience for an ED doc or a neurologist, rheumatologist—however you want to say it—for a lot of these measures." Another agreed, "You're going to do different things based on that interaction."

Some TEP members said they struggled with the question of whether a subtopic should be crosscutting or specialty-specific, given that many of the subtopics could be both, depending on the clinical scenario.

Ms. Somplasky suggested that they consider a subtopic to be specialty-specific if there is "a gap that you feel exists right now, specific to the type of patients you treat in the emergency department, that is nuanced from somebody seen in allergy, somebody seen in rheumatology." She commented that in reviewing public comments from specialty societies, the team found "a

lot of pushback from specific specialties, including those around the table, that they don't feel that one size fits all."

Regarding management of chronic conditions, a TEP member questioned which chronic condition would be selected for a crosscutting measure. "Are you going to pick COPD, rheumatoid arthritis, congestive heart failure, chronic abdominal pain, all the things that we see on a chronic daily basis that come through … our ED? Is there one unifying theme, or are you more looking at a broad, general crosscutting measure on communication, on things like that?" Another TEP member replied that a measure would have to include communication both ways, from the ED back to the patient's primary doctor or referring doctor and from the doctors making the referral to the ED.

Referring to equity of care, a TEP member commented that ED utilization is often seen as a measure of lack of access and noted an opportunity to consider the subject on its own: who is using which emergency room, how people are accessing emergency care in an equitable way. "New vistas open up from a policy perspective from not being crosscutting about how we think about access to care" and ED use, he said. Another TEP member noted the need for shared accountability by specialists whose patients have frequent acute-care encounters. She also mentioned a need for a measure about personalized discharge discussions.

A member proposed in such instances to interpret a recommended subtopic flexibly: "Yes, it's crosscutting; it has a much broader purview than ED, or allergy, or rheumatology. But … we do think there is a need to explore specific measurement criteria for the setting." Otherwise, she said, "when an RFP goes out, you're going to get one measure back that doesn't fit these cases for the ED."

Results of the TEP Discussion

- Pre-assessment subtopic gaps rated as important (median score >= 7): 17
- Emergency medicine-specific subtopics proposed by one or more TEP members for consideration in the conceptual framework: 22
- Results of TEP discussion and vote:
  - 11 of 39 subtopics prioritized for measure development
  - 14 of 39 subtopics tabled for consideration as crosscutting (see *Appendix E. Subtopics Recommended by the TEP to Be Considered as Crosscutting*)
  - 14 of 39 subtopics not recommended for inclusion in conceptual framework[9]

Table 1 details the specialty-specific subtopics prioritized after TEP voting.

[9] Most subtopics not recommended for inclusion were suggested by one or more TEP members during the pre-assessment and either withdrawn at the meeting or rejected by consensus of the TEP. Some were judged to be inappropriate for measure development; others represented existing measures or standards of clinical practice.

Table 1: Priority Measure Subtopics – Emergency Medicine

Meaningful Measures Priority/ MACRA Domain	Meaningful Measure Area	Measure Subtopic
TEP vote #1: 91% of TEP members (21 of 23) recommended prioritizing the following emergency medicine subtopics from the pre-assessment (n = 5).		
Effective Prevention and Treatment/Clinical Care	Prevention, Treatment, Management of Mental Health	• Behavioral and psych screening • Behavioral and psych screening – anxiety/ depression
Making Care Safer/Safety	Preventable Health Care Harm	• Adverse medication events
Communication and Coordination/ Care Coordination	Transfer of Health Information and Interoperability	• Timely transition of emergency department specified data elements to next level of care • EMS information included in transfer of care summary
TEP vote #2: 91% of TEP members (21 of 23) recommended adding the following emergency medicine subtopics to the conceptual framework (n = 6).		
Effective Prevention and Treatment/Clinical Care	Preventive Care	• HIV testing for at-risk populations
Person and Family Engagement/Patient and Caregiver Experience	Care Is Personalized and Aligned With Patient's Goals	• Assessment of post-discharge patient needs
	Patient's Experience of Care	• Patient and caregiver satisfaction survey • Discharge instructions including point of contact for patient/ caregiver questions
	Patient-Reported Functional Outcomes	• Patient outcome follow-up after ED visit
Affordable Care	Risk-Adjusted Total Cost of Care	• Total cost of care for high-volume diagnosis (e.g., chest pain)

Allergy/Immunology

Presenter: Ann Clancy, MBA, RN, HSAG

Ms. Clancy started her discussion with patient/caregiver perspectives. A patient said she felt good because her doctor took her goals into consideration when deciding a plan of care. A caregiver talked about the transfer of health information, saying her mother did not want her at her appointment, so the caregiver and the doctor have an agreement that they will talk afterward —communicating but also preserving some dignity for the mother.

In reviewing the literature pertinent to the specialty of allergy, Ms. Clancy said one subtopic was found that did not have a measure: communication between patient and provider, and in particular, the subtopic of communication of test results with the patient or family.

While the TEP agreed the subtopic is important, all 23 members described the subtopic as crosscutting. Two said some specialty-specific considerations may merit a separate measure. Ms. Clancy asked for clarification on this point during the TEP's discussion.

General Comments and Feedback From the TEP

One TEP member said there was confusion over how to rank but agreed the subtopics being discussed were both important and crosscutting. After brief discussion, members of the panel agreed that the measure subtopics, while important, should be moved to the crosscutting list.

When TEP members reviewed subtopics suggested for measure development, those were recommended for removal, also considered crosscutting or captured by existing measures. A TEP member suggested that the meeting summary note that the subtopics were removed because they are already captured in QCDR measures, not because they are considered unimportant. Another TEP member said not all clinicians use QCDRs and cautioned against removing a subtopic just because a corresponding measure is in a QCDR. Panel members suggested this meeting report reflect that QCDR measures exist for some of these subtopics and should be considered for MIPS.

Dr. Campbell underscored the importance of *de novo* development, saying that if a QCDR measure exists, the first priority should be to consider whether that measure can be adapted. If no measure exists, then a measure needs to be created.

A TEP member suggested that while measures might exist in the QCDR, they are not transparent in terms of family- and patient-level decision-making. She suggested that environmental scan data identify which specialties have a high proportion of measures coming from QCDRs and highlighting them for future referral.

Dr. Campbell called this a great suggestion and said this information would be added to the environmental scan and gap analysis report.

Results of the TEP Discussion

- Pre-assessment subtopic gaps rated as important (median score >= 7): 2
- Allergy/immunology-specific subtopics proposed by one or more TEP members for consideration in the conceptual framework: 37
- Results of TEP discussion and vote:
  - 19 of 39 subtopics prioritized for measure development
  - 2 of 39 subtopics tabled for consideration as crosscutting (see *Appendix E*)
  - 18 of 39 subtopics not recommended for inclusion in conceptual framework[10]

Table 2 details the specialty-specific subtopics prioritized after TEP voting.

Table 2: Priority Measure Subtopics – Allergy/Immunology

Meaningful Measures Priority/ MACRA Domain	Meaningful Measure Area	Measure Subtopic
TEP vote #1: 96% of TEP members (22 of 23) recommended prioritizing no allergy/immunology subtopics from the pre-assessment (n = 0).		

[10] Most subtopics not recommended for inclusion were suggested by one or more TEP members during the pre-assessment and either withdrawn at the meeting or rejected by consensus of the TEP. Some were judged to be inappropriate for measure development; others represented existing measures or standards of clinical practice.

Meaningful Measures Priority/ MACRA Domain	Meaningful Measure Area	Measure Subtopic
TEP vote #2: 100% of voting TEP members (22 of 22; 1 absent from vote) recommended adding the following allergy/immunology subtopics to the conceptual framework (n = 19).		
Effective Prevention and Treatment/ Clinical Care	Preventive Care	• Identification of non-medication care plan • Identification of non-medication care plan: Environmental amelioration • Identification of non-medication care plan: Behavioral intervention • Identification of non-medication care plan: Communication of triggers
	Management of Chronic Conditions	• Allergy testing and treatment
Person and Family Engagement/Patient and Caregiver Experience	Care Is Personalized and Aligned With Patient's Goals	• Patient's goals, values, and preferences incorporated in plan of care • Patient's goals, values, and preferences incorporated in plan of care: Asthma • Self-management • Self-management: Anaphylaxis • Self-management: Asthma • Self-management: Food
	Patient-Reported Functional Outcomes	• Treatment outcomes: Allergies • Treatment outcomes: Eczema
Healthy Living/ Population Health and Prevention	Equity of Care	• Asthma disparities
	Community Engagement	• Community interventions • Community interventions: Home environmental triggers
Affordable Care	Patient-Focused Episode of Care	• Telemonitoring • Electronic medication monitoring devices • Biologic medication cost to asthma and comorbidity control ratio

Recap of Day 1 and Overview of Day 2

Presenter: Kyle Campbell, PharmD, HSAG; Kendra Hanley, MS, HSAG

Dr. Campbell welcomed the TEP members and CMS guests joining via webinar. He gave a recap of the first day's discussions, saying that the panel is helping to identify priorities for new measure development in the five specialties that have been identified.

He thanked the patient/caregiver representatives, who "really highlighted the challenges that you've encountered with the health care system. And we heard that, clearly, managing information, arranging for care among multiple specialties, and the need to understand the whole patient are areas that really, clearly, need improvement. So thank you for that."

Referring to QCDR measures, Dr. Campbell said a majority of panel members agreed that they should be included in the conceptual framework and that measure developers should consider them where feasible to prevent duplicative efforts. The panel also agreed on the need for a clear path and process for a QCDR measure to become a MIPS measure, he said. He noted an issue of

access to the measures because many clinicians do not use the registries and observed that patients and caregivers may not be aware QCDR measures exist.

He asked panel members to try to "cast a wider net" in considering possibilities for measure development and to realize that measures undergo a long vetting process before becoming part of the Quality Payment Program.

Ms. Hanley explained the process for discussing the subtopics for the remaining specialties: neurology, physical medicine and rehabilitation, and rheumatology.

Discussion of the Priority Subtopics by Specialty (Day 2)

Neurology

Presenter: Mary Fermazin, MD, MPA, HSAG

Dr. Fermazin discussed two patient/caregiver comments that were mapped to the Meaningful Measure area of care that is personalized and aligned with patient goals. She then discussed the gaps identified by the environmental scan and rated by the TEP in the pre-assessment. Sixteen subtopics were mapped to Meaningful Measure areas.

The Meaningful Measure area that included the highest-rated subtopics was patient-reported functional outcomes, followed in descending order by preventable health care harm, risk-adjusted mortality, community engagement, equity of care, and management of chronic conditions, Dr. Fermazin said.

She asked the panel to consider the following points while discussing the subtopics: Are these subtopics appropriate for the specialty to hold a neurologist accountable for? Are they appropriate at the clinician level? Is there a barrier to collecting data for such a measure?

General Comments and Feedback From the TEP

Panel members discussed whether the measure subtopics were crosscutting. For example, one panel member suggested that the four suggested subtopics on health-related quality of life—each referring to a specific neurological disease—be put together into one measure concept, patient-reported functional outcomes, which could result in a crosscutting measure. A second panel member agreed with the need for such a measure but said the issue would be in developing a measure that is feasible, that could be recorded in the office and later reported by the patient on a day-to-day basis, using a mobile device, for example. He said the measure also must be easy to administer.

A TEP member pointed out that patients find generic health-related quality of life questions very important and suggested it may be worth considering how clinicians can be encouraged to capture such data.

Unintended consequences of reimbursement strategy and quality measurement in general should be considered in measure development in all of these areas, a TEP member said.

TEP members noted the importance of a diagnosis, stressing that patients want their symptoms and problems taken seriously. Searching for effective care is "an incredibly frustrating and emotional process," one TEP member said, but clear communication can "mitigate a lot of frustration and difficulty." A clinician mentioned that she gives some of her patients a pretest

and post-test, as well as handouts to help them understand why she may be unable to identify a cause for their condition.

Results of the TEP Discussion

- Pre-assessment subtopic gaps rated as important (median score >= 7): 16
- Neurology-specific subtopics proposed by one or more TEP members for consideration in the conceptual framework: 20
- Results of TEP discussion and vote:
  - 10 of 36 subtopics prioritized for measure development
  - 6 of 36 subtopics tabled for consideration as crosscutting (see *Appendix E*)
  - 20 of 36 subtopics not recommended for inclusion in conceptual framework[11]

Table 3 details the specialty-specific subtopics prioritized after TEP voting.

Table 3: Priority Measure Subtopics – Neurology

Meaningful Measures Priority/ MACRA Domain	Meaningful Measure Area	Measure Subtopic
TEP vote #1: 100% of TEP members (23 of 23) recommended prioritizing the following neurology subtopics from the pre-assessment (n = 5).		
Effective Prevention and Treatment/ Clinical Care	Management of Chronic Conditions	• Referral for rehabilitation services
Person and Family Engagement/ Patient and Caregiver Experience	Care Is Personalized and Aligned With Patient's Goals	• Patient/caregiver confidence in self-management
	Patient-Reported Functional Outcomes	• Health-related quality of life: Comprehensive health-related quality of life for neurology with proxy allowed to report • Neurological functional outcomes with proxy allowed to report
Healthy Living/ Population Health and Prevention	Community Engagement	• Home and community-based services with caregiver support and education
TEP vote #2: 91% of TEP members (21 of 23) recommended adding the following neurology subtopics to the conceptual framework (n = 5)		
Communication and Coordination/ Care Coordination	Medication Management	• Patient understanding of medications • Patient understanding of medications: Neuropathy management • Patient understanding of medications: Education of risks (e.g., gabapentin)
Making Care Safer/Safety	Preventable Health Care Harm	• Accuracy of differential diagnosis
Affordable Care	Appropriate Use of Health Care	• Reduction of ED use for headache management

[11] Most subtopics not recommended for inclusion were suggested by one or more TEP members during the pre-assessment and either withdrawn at the meeting or rejected by consensus of the TEP. Some were judged to be inappropriate for measure development; others represented existing measures or standards of clinical practice.

Physical Medicine and Rehabilitation

Presenter: Carolyn Lockwood, RN, MSN, HSAG

Ms. Lockwood discussed responses from the patient/caregiver perspectives in which the comments aligned with the Meaningful Measure areas, including care that is personalized and aligned with patient goals, as well as transfer of health information and interoperability. Ms. Lockwood said a literature review for physical medicine and rehabilitation identified four subtopics with gaps in three Meaningful Measure areas. Members added three subtopics for consideration by the TEP.

General Comments and Feedback From the TEP

In discussing the suggested subtopics, TEP members again suggested removing items they thought were crosscutting. For the symptom assessment of pain, a TEP member urged nuance in considering a measure. In physical medicine, "we want to try and educate patients in terms of not focusing on pain and using other things to help them achieve a better quality of life and a better function, even if they have pain."

Several TEP members discussed pain management and quality of life. While getting a measure of pain is important, one said, so is talking about how the patient can function in the presence of pain. Following on this point, another TEP member said patients' self-management of pain could be considered, looking at what they are able to accomplish after they have left rehabilitation and are in the community. Another said the focus should be on patient goals, which takes the focus off pain. "It's not about pain. It's about function. It's about what I can do, what I can't do, what I used to be able to do."

In considering subtopics recommended by the TEP members, one member labeled transfer of health care information as crosscutting, but he underscored the importance of a proper handoff to all settings of care, from acute care to inpatient rehabilitation or from acute care to skilled nursing and from post-acute care to community providers. He said crosscutting measures need to address all points of transition of care. "That's where I find patients and caregivers really just have a lot of anxiety and angst."

TEP members discussed how professional roles differ for a physiatrist versus an occupational or physical therapist. For example, the physician might conduct family education, whereas the therapist would provide family training from the standpoint of executing a therapy program and training plan. The TEP gave separate recommendations on those related topics because, as one member stated, "those are definitely going to be two different types of measures."

In looking at the Meaningful Measure area of preventive care, a TEP member said an existing measure for falls does not go far enough in screening patients; she suggested a subtopic covering interventions that might be applied to prevent falls. She said the issue is important to many patients whom her practice sees.

Results of the TEP Discussion

- Pre-assessment subtopic gaps rated as important (median score >= 7): 4
- Physical medicine and rehabilitation-specific subtopics proposed by one or more TEP members for consideration in the conceptual framework: 34
- Results of TEP discussion and vote:
  - 24 of 38 subtopics prioritized for measure development
  - 5 of 38 subtopics tabled for consideration as crosscutting (see *Appendix E*)
  - 9 of 38 subtopics not recommended for inclusion in conceptual framework[12]

Table 4 details the specialty-specific subtopics prioritized after TEP voting.

Table 4: Priority Measure Subtopics – Physical Medicine and Rehabilitation

Meaningful Measures Priority/ MACRA Domain	Meaningful Measure Area	Measure Subtopic
TEP vote #1: 96% of TEP members (22 of 23) recommended prioritizing the following physical medicine and rehabilitation subtopics from the pre-assessment (n = 7).		
Effective Prevention and Treatment/ Clinical Care	Management of Chronic Conditions	• Complex conditions • Symptom management: Pain
Person and Family Engagement/ Patient and Caregiver Experience	Care is Personalized and Aligned with Patient's Goals	• Family/caregiver education • Family/caregiver training
	Patient-Reported Functional Outcomes	• Multiple chronic conditions • Symptom assessment • Symptom assessment: Pain
TEP vote #2: 96% of TEP members (22 of 23) recommended adding the following physical medicine and rehabilitation subtopics to the conceptual framework (n = 17).		
Effective Prevention and Treatment/ Clinical Care	Preventive Care	• Diagnosis-specific primary prevention: • Diagnosis-specific primary prevention: Traumatic brain injury • Diagnosis-specific primary prevention: Ultrasounds in spinal cord injuries • Interventions to prevent falls • Patient/caregiver interventions to prevent complications related to disability
Healthy Living/ Population Health and Prevention	Equity of Care	• Cultural competency
Person and Family Engagement/ Patient and Caregiver Experience	Care Is Personalized and Aligned With Patient's Goals	• Treatment tailored to patient goals • Patient goal attainment • Patient self-efficacy/barriers to completion • Patient self-efficacy/barriers to completion: Pain in gaining function
	Patient-Reported Functional Outcomes	• Health-related quality of life: General

[12] Most subtopics not recommended for inclusion were suggested by one or more TEP members during the pre-assessment and either withdrawn at the meeting or rejected by consensus of the TEP. Some were judged to be inappropriate for measure development; others represented existing measures or standards of clinical practice.

Meaningful Measures Priority/ MACRA Domain	Meaningful Measure Area	Measure Subtopic
Affordable Care	Patient-Focused Episode of Care	• Episode of care based on specific diagnosis • Episode of care based on specific diagnosis: Amputation • Episode of care based on specific diagnosis: Spinal cord injury • Episode of care based on specific diagnosis: Spine care • Episode of care based on specific diagnosis: Stroke • Episode of care based on specific diagnosis: Traumatic brain injury

Rheumatology

Presenter: Anita Somplasky, RN, CHTS-PW, CHTS-PC, HSAG

Ms. Somplasky discussed the responses from patient and caregiver interviews, saying they centered on interoperability and transfer of health information. In addition, a patient mentioned the importance of communication with the primary care doctor.

Ms. Somplasky noted that six subtopics that the TEP rated very highly in the pre-assessment, along with two recommended by the TEP, were mapped to four Meaningful Measure areas. Rheumatoid arthritis (RA), which three articles had mentioned as a gap in measurement, was specified for three of these subtopics.

General Comments and Feedback From the TEP

Discussing the rankings, a TEP member said it is reasonable that RA is identified among the priorities because it is the most common inflammatory disease that rheumatology specialists manage. The member noted that health-related quality of life is important, even if not specific to rheumatology. The member further noted that rheumatology has measures that track components of quality of life, such as disease activity and symptoms, as well as measures that look at functional assessment.

Treatment often is initiated before a final diagnosis, especially for lupus, the member said. "If you try to fit them into a category, you're doing them a disservice, as opposed to treating the whole person." The TEP member also noted that in considering measures, the American College of Rheumatology regards early RA as separate from a chronic, stable disease state.

Early diagnosis is important to patients, and this area would be ideal for a crosscutting measure, another TEP member said. "If a patient has had a growing set of symptoms or issues arise, this would be the perfect example of a measure where you could truly look across the continuum and do a hindsight 20/20. When did that patient first present, and then when did they officially get diagnosed?"

Panel members discussed the impact of inflammatory diseases on fatigue, noting that patients put pain and fatigue at the top of their concerns. They discussed whether a measure of fatigue should be crosscutting or specific to rheumatology.

A TEP member thanked other members of the panel for discussing fatigue as a primary symptom of rheumatic disorders. While many of the measures are being considered as crosscutting, she said, assessment of fatigue is an important aspect of rheumatology care and should be identified as a measure gap for the specialty.

Another panel member mentioned the difficulty in developing outcome measures for complex conditions such as rheumatic diseases, noting the overuse and underuse of biologics, as well as the use of steroids. "The whole issue of outcome measurement in RA specifically, but in all of the rheumatic diseases that are steroid-responsive, is you're going to have to measure multiple things at once in order to triangulate to appropriate therapy, because there are some very quick and dirty ways to make people feel better that are really clinically inappropriate in the long run."

Results of the TEP Discussion

- Pre-assessment subtopic gaps rated as important (median score >= 7): 6
- Rheumatology-specific subtopics proposed by one or more TEP members for consideration in the conceptual framework: 28
- Results of TEP discussion and vote:
  - 12 of 34 subtopics prioritized for measure development
  - 18 of 34 subtopics tabled for consideration as crosscutting (see *Appendix E*)
  - 4 of 34 subtopics not recommended for inclusion in conceptual framework[13]

Table 5 details the specialty-specific subtopics prioritized after TEP voting.

Table 5: Priority Measure Subtopics – Rheumatology

Meaningful Measures Priority/ MACRA Domain	Meaningful Measure Area	Measure Subtopic
TEP vote #1: 100% of TEP members (23 of 23) recommended prioritizing the following rheumatology subtopics from the pre-assessment (n = 3).		
Effective Prevention and Treatment/ Clinical Care	Management of Chronic Conditions	• Treatment outcomes: Rheumatoid arthritis
Communication and Coordination/ Care Coordination	Medication Management	• Treat to target (appropriate dosing)
Person and Family Engagement/Patient and Caregiver Experience	Patient-Reported Functional Outcomes	• Health-related quality of life for rheumatoid arthritis
TEP vote #2: 100% of TEP members (23 of 23) recommended to add the following rheumatology subtopics to the conceptual framework (n = 9).		
Effective Prevention and Treatment/ Clinical Care	Preventive Care	• Immunizations for patients on biological therapy

[13] Most subtopics not recommended for inclusion were suggested by one or more TEP members during the pre-assessment and either withdrawn at the meeting or rejected by consensus of the TEP. Some were judged to be inappropriate for measure development; others represented existing measures or standards of clinical practice.

Meaningful Measures Priority/ MACRA Domain	Meaningful Measure Area	Measure Subtopic
Person and Family Engagement/Patient and Caregiver Experience	Patient-Reported Functional Outcomes	• Symptom assessment for fatigue • Stability of symptom severity/disease activity over time
	Care Is Personalized and Aligned With Patient's Goals	• Plan of care
Affordable Care	Appropriate Use of Health Care	• Medications • Medications: Conventional synthetic disease-modifying antirheumatic drugs • Medications: Steroids • Medications: Biologics
	Patient-Focused Episode of Care	• Biologic medication cost to rheumatoid arthritis control ratio (transparency and value)

Quality Measure Index

Presenter: Anita Somplasky, RN, CHTS-PW, CHTS-PC, HSAG

Ms. Somplasky introduced the Quality Measure Index under development at HSAG. CMS envisioned the index as a standardized and transparent measure assessment tool that would quantify the degree to which new measures support national priorities, align with Meaningful Measure quality priorities, and fulfill requirements defined by MACRA. The index could be used by CMS in measure selection and may be applicable across reporting programs and settings, as well as useful to measure developers during the development process. Ms. Somplasky reviewed progress of the Quality Measure Index project to date. She informed the TEP how the HSAG team identified components of the index through an environmental scan and received feedback from the previous MDP TEP. Now in early stages of testing, the Quality Measure Index is being refined before beta testing.

General Comments and Feedback From the TEP

Introduction of the Quality Measure Index prompted discussion and questions about index components and how the index could be used and in what settings. Several TEP members noted that a quantitative tool to assess measures would be useful. "I think this is very exciting that you're creating the Quality Measure Index. It's very much needed," a TEP member remarked. Another member agreed and said, "Having worked with a measure selection committee many times, I know that something quantitative always helps the discussion move quicker."

The TEP also asked how variables that are not applicable to a measure or for which information is not available would be handled. Ms. Somplasky and Dr. Campbell explained that expert input will be required to determine which variables reflect measure quality and how variables should be weighted. Any scoring or weighting of the variables that comprise the Quality Measure Index will need to be carefully considered in a later phase of development of the index.

Concluding Remarks and Next Steps

Presenters: Kendra Hanley, MS, HSAG; Kyle Campbell, PharmD

Ms. Hanley discussed next steps for the committee and the team supporting the event. She said the team would prepare a summary of the meeting to be posted to a TEP SharePoint site for the members' review. They would be able to access the document and make changes or comments or send an email so the team would have that information before the summary is posted to the CMS website. She said they would receive an email explaining how to register for the TEP SharePoint site.

She told panel members to email any additional comments to the team via email. Those comments are recorded in the next section under *Summary of Post-Meeting Comments*.

The team intends to consider important input from the meeting to add to the 2018 Environmental Scan and Gap Analysis Report and the 2019 Annual Report. An updated conceptual framework will incorporate the TEP's recommendations to date. The team also will review meeting notes to plan next steps, which will include TEP discussions of subtopics tabled for consideration as crosscutting.

Dr. Campbell thanked the CMS and HSAG teams for their hard work and thanked the panel members for their willingness to share their time and expertise. He said he felt the meeting achieved its goal of providing rich feedback about the individual specialties and the goals and subtopics for measurement.

IV. POST-MEETING NOTES AND RECOMMENDATIONS

The post-meeting comments and recommendations received from the TEP are summarized and grouped by subject categories. HSAG appreciates the thoughtful and valuable input from the TEP members.

Summary of Post-Meeting Comments

QCDR Measures and Measure Gaps

A TEP member recommended that QCDR measures be included in the framework but added that QCDR measures need to be more available to all providers. Another TEP member noted that the question is not black and white regarding whether additional measures should be developed to fill a measurement gap for a specialty, even if QCDR measures exist. The TEP member suggested first assessing the adequacy of QCDR measures identified as potentially filling a gap. If the QCDR measures do not meet standards, then new measures may need to be developed.

A third TEP member said that "development of new measures should not be the answer for filling a measurement gap for specialties" because doing so goes against the guiding principles of the Core Quality Measures Collaborative regarding harmonized and parsimonious measures.

The TEP's caregiver representative noted her agreement with the concept that when a measure is in a QCDR, no gap exists and duplicative efforts are not beneficial. However, the TEP member questioned whether QCDR measures are useful for patients and caregivers. She pointed out that unlike MIPS measures, QCDR measures do not have standards for development transparency or access or evaluation of physician performance. The representative noted she supports a clear, expedited pathway for integrating a QCDR measure into MIPS.

Lastly, one TEP member advised that QCDRs could be a valuable source of adapted measures for other CMS reporting programs, such as the Inpatient Quality Reporting, Outpatient Quality Reporting, and Value-Based Purchasing programs. While the focus of this TEP is the Quality Payment Program, the member stressed the importance of measure alignment across care settings, CMS programs, and levels of measurement. Leveraging the measures implemented in QCDRs is one way to accomplish this goal, the member said.

Emergency Medicine

A TEP member proposed a measure subtopic addressing a patient presenting with an adverse drug event at the ED—namely, that the ED report the incident to the patient's primary care provider. This would differ from measures that aim to prevent adverse drug events related to ED treatment. Another TEP member recommended removal of "chest pain" from the "total cost of care" subtopic to keep the subtopic general and amenable to interpretation during measure development.

The caregiver representative agreed that many concepts for ED are crosscutting (e.g., medication reconciliation, behavioral/psychiatric evaluation) but asserted that the specialty also has measurement gaps. She noted that quality and process are different in ED settings and therefore should be measured differently.

A TEP member submitted for the record a summary of the TEP's discussion about emergency medicine:

- Equity in access is a huge priority for crosscutting measures.
- Access to ED services is not a problem in the U.S. health care system; in fact, ED use can reflect poor access to clinic-based or other community care. Therefore, any crosscutting measure of access based on utilization rates should exclude emergency physicians, which would likely be topped out.
- The possibility of defining an emergency physician-specific measure regarding equity of access was discussed; however, the TEP concluded this would be complicated and is not a priority for measurement development.

Finally, a TEP member suggested adding "screening for domestic violence" as a subtopic for emergency medicine. Additionally, the high-volume examples of abdominal pain, shortness of breath, and headache were suggested for the subtopic "total cost of care for high-volume diagnosis."

Neurology

A TEP member noted that members were still uncertain about the mapping and rationale for "skill at addressing differential diagnosis" and why the subtopic is not crosscutting.

The caregiver representative emphasized that caregiver and proxy reporting is important for neurology. She noted that the caregiver's perception may differ from the patient's, and there is no way to link caregiver values to patient values when the caregiver report is captured only after the patient no longer can report.

Physical Medicine and Rehabilitation

A TEP member recommended changes to the subtopics for this specialty. "Spasticity assessment" was suggested under the subtopic of "symptom assessment." Under "diagnosis-specific primary prevention," two revisions were recommended:

- Revise "ultrasounds in spinal cord injuries" to "renal ultrasounds in spinal cord injuries."
- Revise "traumatic brain injury" to "endocrine screening in traumatic brain injury."

Rheumatology

A TEP member commented that care plans based on shared decision-making are critical for rheumatology but not specific to rheumatology. Although treatments and assessments are disease-specific, the TEP member suggested, too much granularity would have negative effects on the crosscutting goals of care coordination and shared decision-making.

The TEP member added that a broader capture of information would likely lead to more aggressive measurement targeting improvement for quality of life and functional assessment. Yet the information has not begun to be captured across care settings, providers, and disease trajectories. The TEP member recommended measure developers be encouraged to use PROMIS tools, which have great potential for crosscutting functional status and quality of life assessments, and recommended computer adaptive testing technology for this purpose. The TEP member also noted that this type of information should not be collected at office visits. To realistically reduce burden, mobile applications and real-time data collection should be used.

Quality Measure Index

A TEP member recommended that development of the Quality Measure Index include consumer voices and patient/family involvement.