Hello, and thank you for joining today's Meaningful Measures Initiative Webinar. Today representatives from the Centers for Medicare and Medicaid Services will provide an overview of the Meaningful Measures initiative, including the goals and objectives of this new framework. The presentation will be followed by a Q&A Session, where attendees will have an opportunity to ask questions. You can listen to the presentation through your computer speakers. If you cannot hear audio through your computer speakers, please contact CMSQualityTeam@Ketchum.com. Questions will be taken via the phone line and question box. We will distribute the phone number during the Q&A portion of the webinar. Subject-matter experts will address as many questions as time allows. The webinar slides, recording, and transcript will be posted on the CMS website in the coming weeks. I would now like to introduce Jean Moody-Williams, Deputy Director of the Center for Clinical Standards and Quality at CMS. Miss Moody-Williams, you may now begin.

Thank you, and hello, everyone. I greet you on behalf of the entire leadership team here at CMS. We really count this opportunity to meet with you today to discuss our new approach to achieving meaningful outcomes as a privilege. We know that on this call, we have several thousand dedicated people from across the country that really are all involved with improving care for patients every day. We have a common goal of achieving meaningful outcomes for many millions of patients and families receiving care through programs that cover lives from birth to end of life, and while we're primarily discussing CMS programs today, in fact, we understand that the reach is greater, and we've had many conversations with private payers interested in alignment of measures in the future and a number of other stakeholders, as well. We have several goals we're working through, but, primarily, we want to have a healthy population. You may also be aware that CMS has launched a "Patients Over Paperwork" initiative really to move the needle on removing regulatory obstacles that get in the way of providers spending time with patients and healthcare consumers, and while some regulations are essential, we know that to ensure patient and provider safety and program integrity, we realize there's really a fine line between being helpful and being a hindrance, and while we have all worked together for a number of years, and we've made some great strides in quality improvement over the past years -- saving thousands of lives, we've averted harm -- as with all quality-improvement efforts, it's time to do our PDSA Cycle to study or check what we've been doing before we continually do, and that's what we want to take a pause for. We've set up agency-wide processes to evaluate and streamline our regulations and our operations. We started by addressing burden in areas where we've heard most about, such as Payment Policy, Quality Measures, Documentation Requirements, Conditions of Participation, and Health Information Technology. You'll be hearing much more about all of those areas in the immediate future, but today we want to focus on our Meaningful Measures. If we could have the next slide, please. We are currently working with clinicians, hospitals, EHR vendors, and other stakeholders to make reporting, for example, from EHRs easier and less burdensome for our providers. We're working with clinical data registries to better seek approval to submit data on behalf of clinicians. We've developed an API that will significantly streamline quality data submission from EHRs, and we're testing that, and we're continuing to focus on value and quality through what we're here to talk about today -- a Meaningful Measurement framework that will allow us to move toward the most parsimonious and least burdensome Measure Set that is well understood by stakeholders and helpful in guiding our quality efforts. We've heard from a number of stakeholders that personally had the opportunity to travel around the country, to sit and

listen to commissions with patient and families, many of which perceived CMS to have too many quality measures. It's difficult to understand how these measures are related to each other and how they link to common goals. Tracking these measures does not always result in better outcomes for patients, and so in our Meaningful Measurement, we were taking a fundamentally new approach, kind of looking at where we are and taking this new approach to coordinate an implementation of meaningful quality measures and reducing burden. We're focusing it around empowerment of patients and doctors to make decisions about their care, state flexibility. We also -- It's very important for quality-improvement purposes, ensuring access and affordability, and, also, something that we've been doing quite a bit of is looking to see how can we improve the customer experience so that when you interact with CMS, we have taken into consideration how to best make it easy to be able to do the things that you need to do so that you can give the kind of care that you need, spend more time doing that rather than trying to meet our requirements. Next slide, please. So, as we begin to look at our approach to Meaningful Measures, we have a number of objectives that we're going to consider so that if it means that we are adding measures, if we're taking away measures, if we're looking for gaps, we have some way to help lend the specificity by which we do that. We want to address high-impact measures that really are going to help safeguard public health, as I said earlier. We want to be patient-centered and make sure that whatever we're measuring is meaningful to patients and outcomes-based where possible. It needs to be relevant to providers while we're minimizing burden and collecting of data, as I talked about a few minutes ago. We want to look for areas where there really is significant opportunity for improvement, and, of course, the healthcare system is changing. We're seeing lots of transformations, so we need to be able to address measures that are really going to be used for population-based payments through alternative payment models, and one of the things that is really important, aligning across programs with other payers so that they're not conflicting or competing priorities and requirements that clinicians are trying to meet. So that is really kind of high level of where we are at this point. You're going to hear from the presentation today that this is a work in progress. We want your feedback. We're gathering feedback right now for the past several weeks and weeks to come before we do anything final. So this is, again, a work in progress, and now I want to turn it over to Dr. Pierre Yong, who's the Director of our Quality Measurement Value and Incentives Group to take you down to the next level. Pierre?

Thanks, Jean, and I also want to extend Jean's welcome and reiterate that. Thank you all for taking time to join us today -- 3,500 people and counting. So, as Jean mentioned before -- if you could advance to the next slide -- we have the goals of trying to really drive high-quality healthcare while focusing on what's really meaningful outcomes for patients in clinical care, which is why I think we all went into healthcare to begin with. In order to develop the Meaningful Measures framework, we really listened and reviewed a lot of existing materials that have been published in recent times. There's a lot of work that's been done by the Health Care Payment Learning and Action Network, and the next slide that we have, we have an exhibit that's from that paper. There's been a lot of work done by the National Quality Forum and their high-impact-outcomes work. There's been work that's been done recently and published by the National Academy of Medicine through the Vital Signs Metrics Report, as well as other initiatives ongoing in the field, including work done by the Core Quality Measures Collaborative, which is a collaborative of public and private payers, as well as clinician groups, as well as other providers and patient and consumer representatives

who are really trying to align measures across public and private payers, as well as work done by other federal agencies. If you move to the next slide, you'll see a graphic that's drawn from the Healthcare Payment and Learning Action Network white paper on population health metrics. If you focus on the right side of the slide, you'll see that what they've conceptualized, if you look towards the bottom, are these, what they call, Little Dots or Atomistic Performance Measures, or Level 3 Dots, and one way to think about these are the Level 3 Dots are, essentially, the individual measures that we have in any of our programs, whether it is a measure of fall rates or a measure of catheter-associated urinary-tract infections. Any of those individual measures could be viewed as a Little Dot. But as Jean mentioned before, a lot of the feedback we've been hearing is that because there's so many measures within our program, it can be often difficult to discern what are we actually trying to drive quality improvement on? What are the most meaningful areas that we and other payers and the community, such as you, need to focus on in order to improve outcomes for patients? And so that's where this idea of these Level 2 and Level 1 Dots came from -- if you will, these Big Dots, which, really, they help identify bigger issues that we can then focus on, and so I'm going to pass this over to Dr. Ted Long, who's a Senior Medical Officer here at CMS, to give you more details in the specific 18 areas that we have identified so far and hope to have discussion on that till we conclude the presentation. So, Ted?

Thank you, Pierre. Next slide, please. Okay. Without further ado, we're going to unveil now the 18 current Meaningful Measure areas that we have developed and that we would really want your feedback on. This slide here has them mapped out, and then I'm going to go into more detail in subsequent slides. To set the stage for this, to reiterate two of the points that Pierre and Jean both made, there's two key problems that we want to solve by implementing this Meaningful Measures framework. The first is that we want to use this to identify the highest-priority areas for quality measurement and quality improvement that can guide our efforts across CMS. The second is that we want to also use this as a way to improve communication with patients, clinicians, and stakeholders about what our high-priority areas are and the direction we're going. In the figure that you see in front of you, I'll walk through this, starting at the very center, and at the center, you can see the patient is always at the center for us at CMS. Around that, we have some of our CMS goals, such as state flexibility and local leadership, supporting innovative approaches, empowering patients and doctors and eliminating disparities. Going from the patient at the center, and these are some of our CMS goals immediately surrounding the patient. We have a few spokes on the wheel here. Now, each of the spokes represents a cross-cutting principle or a cross-cutting criteria, if you will, that applies to any Meaningful Measure area. In other words, these are the important concepts that we want every measure to be filtered through and to be applicable, relevant, and important to each Meaningful Measure area. These include eliminating disparities, tracking to measurable outcomes and impact, safeguarding public health, achieving cost savings, improving access for rural communities, and, importantly, burden reduction. I'm now going to go around the periphery of the slide where you see six different colors here. Subsequent slides I'm going to go into more detail for each of these six colors or Quality Categories. With that, I will start with the first one. So next slide, please. For each of the six Quality Categories, we have one slide for each, and on each, we're going to show each of the 18 Meaningful Measure areas. This is the first Quality Category -- Making Care Safer by Reducing Harm by the Delivery of Care. Under this Quality Category, we have two Meaningful Measure areas. The first is Healthcare-associated

Infections. Now, there's a few arrows pointing to the bubble that is this Meaningful Measure area. The arrows represent individual measures which constitute the Meaningful Measure area. They're purely illustrative examples -- not to say that this is an exhaustive list by any means of all the measures that could constitute a given Meaningful Measure area, but we want to provide a few illustrative examples for you today for your feedback, as well. For example, for the Meaningful Measure area of Healthcare-associated Infections, we have, first, Central Line-Associated Bloodstream Infections, or CLABSI. Now, for this, I'll draw your attention to the fine print, the font with a few acronyms immediately below the measure. The point that we wanted to raise by including the acronyms below here is each of those represents a different program that this measure is in, so each Meaningful Measure area includes measures that cut across multiple programs so that at the end, you can see that a Meaningful Measure area is not just program-specific or measure-specific, but captures the intent and relatedness of measures across programs. The next illustrative example of a measure here for Healthcare-associated Infections would be, for instance, our Surgical Site Infection Measure. That's a measure in our Inpatient Quality Reporting Program, or IQR Program. Other examples include Methicillin-resistant Staphylococcus Aureus Bacteremia Outcome, which is something that we use in our Long-term Care Setting Programs as an example and our CAUTI, or Catheter-associated Urinary Tract Infection Measure, which we use in a diverse array of programs from our Long-Term Care Setting to our QIO, or Quality Improvement Organization Initiative. The next Meaningful Measure area here -- so I'm moving below Healthcare-associated Infections and going to Preventable Healthcare Harm. For this Meaningful Measure area, a few more examples. First, Early Elective Delivery. This is a measure we use in our Medicaid and CHIP Program, and then, also, percent of patients or residents with pressure ulcers that are new or worsened. These measures we use across our Long-term Care-Setting Programs, our Post-Acute Care-Setting Programs, and at the very bottom of the slide, you can see a table here which has the acronym spelled out in terms of what programs each acronym signifies, and, again, I want to make the point here that each Meaningful Measure area really does cut across multiple programs so that you can see for a given measure how it fits into a given program, but how a given measure is related to other measures in the same or different programs and the relative place where each measure fits if it's the same measure in different programs. You can see it all in one place for each conceptual Meaningful Measure area. It's that Big Dot, if you will, from the former slides that represents that larger area that's easier to understand, and you can see how it can link to helping CMS to achieve our goals and keeping the patient in the center. Next slide, please. This is the second Quality Category -- Strengthening Person and Family Engagement as Partners in Their Care. For this Quality Category, we have three Meaningful Measure areas. The first is care that is personalized and aligned with patients' goals. For this, a few examples of illustrative measures, the percent of long-term-care hospital patients with an admission and discharge, functional assessment, and a care plan that addresses function. This is a measure that we use across our Post-Acute Care-Setting Programs. The next measure, which is an illustrative example here, would be our Care Plan Measure, which is used in our Quality Payment Program. The next Meaningful Measure area we have is End-of-Life Care According to Preferences. For this, a couple of examples. One measure we have is hospice visits while death is imminent. This is in our Hospice Program. Another measure would be our CAHPS Hospice Survey, also in our Hospice Program. The third Meaningful Measure area on this slide is Patient's Experience and Functional Outcomes. A few examples we have for this Meaningful Measure area are our CAHPS Survey, and, for example, the

Hemodialysis Setting, which we have in our End-Stage Renal Disease Program, and the CAHPS Survey in our Home and Community-Based Services Program that's used in our Medicaid and CHIP Program. In addition, we have our functional status measures, too, which would fall into this Meaningful Measure area. Things like functional status assessment for hip replacement -- that's measuring our Quality Payment Program. Again, at the bottom of this slide, you can see that there's a variety of different programs that these measures fall into, but each Meaningful Measure area really cuts across all of these programs to really drive the point home that each Meaningful Measure area represents that conceptual Big Dot area that identifies what we consider our highest-priority areas for quality measurement and quality improvement. Next slide, please. The third Quality Category is Promoting Effective Communication and Coordination of Care. For this, three Meaningful Measure areas. The first, Medication Management. Examples of illustrative measures for this Meaningful Measure area are Use of High-Risk Medications in the Elderly -- that's a measure in the Quality Payment Program -- Medication Reconciliation Post-Discharge -- that's in our Medicare Shared Savings Program -- and Drug-Regimen Review Conducted with Follow-Up for Identified Issues. That's across our Post-Acute Care or Long-Term Care-Setting Programs. Our second Meaningful Measure area under this Quality Category is Admissions and Readmissions to Hospitals. For this, examples include our standardized readmission ratio, which is something we have in our End-Stage Renal Disease Program, and also our planned All-Cause Readmissions Measure, which is in our Medicaid Center and our CHIP Program. We have other Readmission Measures, as well, such as for our Hospital Readmission Reduction Program, that would all constitute this larger conceptual area or Big Dot Meaningful Measure area of Admissions and Readmissions to Hospitals. Our third Meaningful Measure area under this Quality Category is Seamless Transfer Health Information. For this, an example of a current Quality measure we have would be use of an electronic health record. We use this in our Inpatient Psychiatric Facility Program, but also in the Quality Improvement Organization Initiative that we have going on at CMS. Next slide, please. For this Quality Category, Promoting Effective Prevention and Treatment of Chronic Disease, we have five Meaningful Measure areas. The first Meaningful Measure area under this Quality Category is Preventive Care. In terms of Preventive Care, we have measures looking at, for example, flu vaccinations or timeliness of prenatal care, the Medicaid Measure. Also in Preventive Care, we have other measures in other programs, such as our colonoscopy measures, for example, in the Quality Payment Program. The next Meaningful Measure area we have under this Quality Category is Management of Chronic Conditions. An example of a measure focused on Management of Chronic Conditions is osteoporosis treatment in women who had a fracture. This is a measure we have in the Quality Payment Program. Our third Meaningful Measure area under this Quality Category is Prevention, Treatment, and Management of Mental Health. For this, an example of a measure is Follow-Up Hospitalization for Mental Illness. That's a measure in our Inpatient Psychiatric Facility Program, and we want to intentionally distinguish this third Meaningful Measure area from the fourth. Both fall under the umbrella of Behavioral Health, but we want to parse out the fourth Meaningful Measure area, which is focused on Substance Use Disorder and Opioid Use Disorder. We call this the fourth Meaningful Measure area in this Quality Category Prevention and Treatment of Opioid and Substance Use Disorders. Examples of measures include our Alcohol-Use Screening Measure, again, in our Inpatient Psychiatric Facility Program, but also measures such as Use of Opioids at High Dosage. That's a measure in our Medicaid Center and our CHIP Program. The fifth Meaningful Measure area under this Quality Category is Risk-Adjusted Mortality. For this, we have a variety of Risk-Adjusted Mortality

Measures that would be used to constitute this Meaningful Measure area -- an example, Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate following heart-failure hospitalization. Next slide, please. For this Quality Category, Working with Communities to Promote Best Practices of Healthy Living, we have two Meaningful Measure areas. Now, the first I want to spend a moment on. The first Meaningful Measure area in this Quality Category is Equity of Care. You may recall that we talked about a few minutes ago one of our cross-cutting principles or criteria that we apply to all Meaningful Measure areas, and, therefore, all measures, is eliminating disparities. However, we also wanted to have, based on the feedback we've received thus far, an independent Meaningful Measure area for Equity of Care, because Equity of Care can apply to specific measures -- for example, with what we're doing in our readmission measures in our Hospital Readmission Reduction Program. We're stratifying hospitals by the proportion of dual-eligible patients that they treat in the hospital setting and then scoring is based on that. So you can see the Equity of Care has specific considerations on the measure level, so we wanted to make sure to call attention to it as an independent Meaningful Measure area in addition to the cross-cutting principle or criteria of eliminating disparities, which applies across the board. Our second Meaningful Measure area under this Quality Category is Community Engagement. An example of an illustrative measure we have here is Discharge to Community Post-Acute Care, and you can see, again, the acronyms underneath here show that this is a measure that cuts across the multiple Post-Acute Care Programs that we have at CMS. Next slide, please. Our final Quality Category is Making Care Affordable. In this Quality Category, we have the last three of the current Meaningful Measure areas that we thought to lay out today. The first Meaningful Measure area under this Quality Category is Appropriate Use of Healthcare. Examples of measures that fall under Appropriate Use of Healthcare include, for example, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis. That's in the Quality Payment Program. Also, Cesarean Section. That's in the Medicaid Center and CHIP Program. Our second Meaningful Measure area to be distinguished from Appropriate Use of Healthcare is Patient-Focused Episode of Care, which can have a cost component to it. Examples of measures that would be used to constitute this Meaningful Measure area would be, for instance, Spinal-Fusion Clinical Episode-Based Payment Measure. This is in our Inpatient Quality Reporting Program. Also, our Medicare Spending for Beneficiary Measure. This measure cuts across a variety of programs, including the Post-Acute Care Setting, which we list here. Also, in this Meaningful Measure area, our Hospital Risk Standardized Payment Associated with a 30-day Episode of Care for Heart Failure. That's in our Hospital Value-Based Purchasing Program. Our final Meaningful Measure area in the sixth Quality Category area is Risk-Adjusted Total Cost of Care. This Meaningful Measure area includes measures such as our Oncology Care Model, which is in our Innovation Center, or our CMMI, Center for Medicare and Medicaid Innovation, and also things like our total per-capita costs for All Attributed Medicare Beneficiaries Measure, which originated into VM, or Value Modifier Program, and now it included the Quality Payment Program. With that, we've just gone over the 18 Meaningful Measure areas. Next slide, please. To briefly summarize and then go over next steps, we've talked today about the need to have a Meaningful Measure strategy, some of the key problems that it solves, where it originated, and we've talked about the 18 current Meaningful Measure areas themselves. Now, at this stage, the first next step that we have here really starts with what we're doing today. We want to get stakeholder input to further improve the Meaningful Measures framework, and in just a moment, we'd love to hear any feedback you might have either now or on an ongoing basis, because that's what it really takes

to get this right. In addition, in terms of next steps, we plan to work across CMS components to implement the framework, and then we will evaluate current measure sets and use the framework to additionally inform measure development moving forward. Next slide, please. With that, we wanted to say thank you for your time joining us today. We're looking forward to answering any questions you might have, and we would love to hear any feedback you have. We have our e-mail addresses specifically for Pierre and myself listed here. We would love to be in touch via e-mail, and we'd love to be in touch right now with questions and answers, so thank you. Next slide, please.

[Indistinct] It's now [Indistinct] question-and-answer portion. For those who would like to ask a question live... [Indistinct] ...dial-in is displayed. It is 1-877-388-2064, and please press star one when you dial in to join the question queue. While we're waiting for people to dial in, we will ask a couple questions that have come through the chat box. So the first question is, "Are the Meaningful Measures in addition to all the other reporting we are already doing, or are they intended to replace some programs?"

Thanks. This is Pierre. I'll take that one. I think it's a great question. We've had a couple of questions that were sort of similar to that. We had a couple questions that were, "Does this replace a particular program, like MIPS, for example, or QPP?" So we thought it would be great to address this up front. We wanted to make sure that folks understand that the programs that currently exist for Quality reporting, whether it be MIPS or the Hospital Inpatient Quality Reporting Program or the Long-term Care Hospital Quality Reporting Program, all those programs will continue to exist. What we just described in terms of a Meaningful Measures framework is really a framework we've developed trying to unlock the sources and feedback we've received to help us think through at a global level across all of our work at CMS, including not just the Quality Reporting Programs, but also our Quality Improvement Programs. What do we think are the most high-priority, high-yield measurement areas that would improve patient outcomes? So it's a way for us to then think about what kind of measures should we have in our program? What kinds of quality-improvement initiatives should we be undertaking to really drive improvement in these areas? I want to reiterate, it does not replace any of the existing Quality-Reporting Programs, nor is it intended to, and it is not necessarily our intention that each program will have to have measures corresponding to all 18 Meaningful Measurement areas. I think that needs to be made in a more program-by-program basis, but this is really meant as an overarching umbrella framework for us to think about and coordinate our work across CMS to make sure that we are sending the right signals as to what we think are the most important things for everybody to focus on. So hopefully that helps answer that question.

Okay, thank you. Next question. "How will the Meaningful Measures affect specialists, such as Oncology, for example?"

That's a great question, too. This is Ted. So, the intention of the Meaningful Measures framework is really to capture the highest-priority areas across the board what would affect all clinicians, but, most importantly, all patients. So, for example, oncologists would play a role across several of the Meaningful Measure areas, but the contention behind creating the Meaningful Measures framework is to really identify the highest-priority areas for where we want to measure quality and where we want to look at quality improvement in prioritizing those. So we would be happy to provide further examples of ways in which specialists like

oncologists would have measures that would apply into different Meaningful Measure areas. We could take that offline if that's helpful, but I hope the global answer here is also helpful because our intention is certainly to have this applied to all clinicians, therefore, most importantly, all patients.

Great. It looks like we have a few more questions that we can take via the chat box. "How are you thinking about measuring Equity of Care?"

That's a great question. So, again, Equity of Care being its own Meaningful Measure area means that we think it has application and relevancy for specific measures. I do want to reiterate one point we made earlier, though, which is that eliminating disparities is a cross-cutting principle that applies across the board for us -- very Meaningful Measure area. That said, Equity of Care is a little bit special because it gives us the opportunity to really think on a measure-by-measure level about how we could actually work towards eliminating disparities for patients that are measured by those individual measures themselves. In terms of the role of social-risk factors that we would look at here, the example I gave was that by focusing on social-risk factors like the Hospital Readmission Reduction Program, we'll now be doing in terms of the portion of patients that are dual-eligible in a given hospital and only comparing hospitals to each other that see similar proportions of those patients. We hope that that can not only help to shed some light on the effective social determinants of health, but also to look at social-risk factors in terms of Equity of Measurement. Moving forward, the idea of measuring equity itself is a concept that, for those familiar, ASPE has written about, in their Study "A," in terms of what it would take to construct a measure of equity that is, in addition to the considerations we would take for current measures that we have like we're doing for the readmission measures. That work is ongoing, and we welcome feedback on that. What I can say is that it's very important to us, and that's why we're very intentional to create its own Meaningful Measure area for it, but that would be a great example of where we would love to continue to get feedback both as applicable to how we could think about it in terms of its own Meaningful Measure area, but, also, in general, about the role of social-risk factors across the board for us at CMS. So I appreciate that question. Thank you.

Okay, great. Now let's take any questions that have come through via the phone line.

Your first question comes from Michelle Kimura.

Hi. Am I on the conference call?

Yes, you are.

Oh. So -- [Chuckles] I'm sorry. But have you guys ever utilized an EHR? Because it seems like creating these Meaningful Measures is just purely theoretical. So, can you do me a favor and describe to me if you're a provider, you're seeing a female patient for her annual visit, but you order some tests, and it turns out she's got an STD. What is the provider and the clinical staff supposed to document in the EHR to qualify for these Meaningful Measures?

That's an important question. So, to answer your specific first part of it, just to let you know, I am a practicing primary-care physician. I see patients every week. What matters about this for practicing clinicians, to

use your example, is one of the key criteria we're using to decide which measures to us moving forward is burden. We get and hear that there's burden in terms of what we ask clinicians to do for reporting measures, but even how they use and interact with their electronic health records. We hear that loud and clear, and our goal, using the Meaningful Measures framework, is to land at a place where we have measures that have the absolute lowest level of burden for clinicians that we can achieve, and that's with your help, too, but that are still very meaningful to patients first and also to clinicians. There's a big opportunity here for us to think about the burden of measures to clinicians across the board, and the Meaningful Measures framework lets us really address that head-on by saying, "Hey, we're listening and that burden is something that we take very seriously and that we want to prioritize reducing for clinicians. I hope that helps.

Your next question comes from Joseph Kunic.

Hi. Thanks for the presentation. So I kind of wanted to make sure I'm understanding this correctly. Is this framework now going to kind of guide CMS under all those programs you listed out there as really driving to reduce duplication of similar measures across all these programs, where, right now, we have measures that are measuring the same thing, but the criteria-exclusion population might be slightly different? Under this measure, a physician may meet, but under this particular one, they fall out, and it's because of this one data element in this particular two different measures, but they're measuring the same outcome of, like, diabetes management. Is this, going forward, so any new measures coming out would kind of -- This would guide CMS across these programs to say, do these measures really align with what we're trying to achieve, and then are we making sure that we're not asking physicians to duplicate documentation to meet these measures?

Yes, this is Ted. That is absolutely a key part of the intention here. To answer your question with a little bit of an example here. If you could think of an area of measurement -- take colonoscopy, for instance. We'll use this as an example. We want to understand what the differences are between measures, how they're comparable, and get your input on that. The best way to do that is to have criteria where we say, "These are the important areas and these are the highest-priority areas," and then once measures go through those criteria, which I think a few of the points you were making, we can then see them together in the larger conceptual area where they fall. With colonoscopy would be preventive care, but the best way to de-duplicate and to make sure the measures are aligned is to look at them through the same lens in the same playing field, if you will. So we fully agree with what you just said there, and exactly the problem you want to solve with what you were saying is what we seek to do with how we are going to operationalize the Meaningful Measures framework. So, thank you, and we fully agree.

Again, if you'd like to ask a question, press star one. The next question comes from Clarice Karen.

Oh, hi. Thank you very much. So this is a big problem with us. My physician is a hospitalist, so, of course, we have no office. All of the measures are somehow connected in one form or another to an office code, so we are never able to meet any of the reporting goals. We use EMR from the hospital. We report on -- or we cover pretty much everything, but are we able to report on those items, like smoking cessation safety? We discharged the patients to follow their own primary doctor, but we're not following the patients. Can

we say that we've -- or report on the fact that we have referred them for follow-up? You know what I mean?

Yes, absolutely. So, a couple thoughts there -- and this is partly applicable and relevant to the Meaningful Measures framework, but also partly about how we sort of structure our programs, in general, in terms of how we do attribute a certain thing or measure to a clinician. In terms of the Meaningful Measures framework, yes, our intention here is to land at a place where we have more parsimonious measure sets that are more directly applicable to what's important to the care the clinicians provide, but a piece of that -- and this is sort of one of those core program functions -- is we have to make sure that we have measures for specialists, hospitalists, primary-care clinicians that makes sense for the care they provide. I'll give you an example here. In the Quality Payment Program, if you go to qpp.cms.gov, you can see there that there's actually a box you can click for hospitalists, and then the only measures that will pop up there are the measures that hospitalists can report on or can use, so... But part of what you're saying, too -- and this is where it comes back to the Meaningful Measures framework -- is once we can be on the same page that a given clinician should only be able to and should only report measures that are applicable to what they do, what happens in a case where clinicians may not have enough measures or measures that they feel really capture the most important aspects of the care they provide. That's where -- and this is sort of the very last part of the next steps there -- the Meaningful Measures framework as we're rolling it out now will help to identify what our highest-priority areas are, and we're going to think about that for what we currently have, but directly to your point, we will also be thinking about that for what we want to have. So, for example, if you feel that hospitalists need different measures or are missing certain measures -- things like that, that can be overlaid on top of -- or underneath, rather -- the Meaningful Measures framework to understand how they fit into our high-priority areas, and then that can guide what measures we would develop in the future. So I think your point is really good, and I encourage you to go to, for example, our website for the Quality Payment Program, and we'd love your input on that, but also the future direction, which we hope the Meaningful Measures framework will help to guide on our part, but also with your input, as well.

Thank you. Okay, we'll go back to some of the questions that have come through the chat box. So first question is, "Are there additional measures that we have to report, and how does one report?"

Right. This is Pierre, and I'll take those questions, those came in, and there are a couple of questions in the chat box related to that. Thank you for that. So I did want to, again, reiterate that the Meaningful Measures framework really is an overarching approach that we have adopted at CMS looking at the quality-measurement and quality-improvement work we're doing at CMS to make sure that there's alignment within CMS across these programs. It does not replace any of the individual programs themselves. So the reporting and the measure requirements for any individual program are not directly impacted by this Meaningful Measures framework. The Meaningful Measures framework does not add any new measures or remove any existing measures at this point. As we are working through and applying this framework to the programs and looking closely at the measure sets themselves, we want to make sure that each program initiative and measure align with the Meaningful Measures framework. Part of that consideration includes consideration of things like burden, things like -- There was a

question around where do patient-reported outcomes fit in? So we understand that Outcomes Measures are probably many and oftentimes more valuable than Process Measures. I've taken that into consideration. Also want to make sure that we really have high-impact measures. So as we are evaluating the current measure sets within each of the individual programs applying the Meaningful Measures framework, we'll go through the regular processes in terms of soliciting public comment on potential changes to measures and requirements in order to decrease burden. So that will generally be through a rule-making vehicle where we'll have a notice of proposed rulemaking in 2018 and solicit feedback that way, and then have a final rule, which issues final policies and changes made to the programs, but through that process that will obtain additional feedback specific to each individual program.

Great. Next question. "Will the 18 Meaningful Measures be identified in the individual measures on the Web-based CMS Measures Inventory Tool, CMIT?"

This is Pierre. I'll take that one. So, thank you for this question. We love it because we just rolled out the public CMS Measures Inventory Tool. So please go check that out. It is an inventory of all the measures we use at CMS. Since the measures framework is new, we have the intention of updating the CMIT Tool to include categorization by Meaningful Measures we've had. We've just had a discussion about that internally. It isn't currently updated yet, but that is our intention, and we plan to do that as soon as we can.

Okay, great. I think we have a few more phone questions.

Your next question comes from Melinda Morrison.

Yes. Are you there?

Yes, we can hear you.

Yes. We're a podiatry office, and this has been this big, black cloud over me for four years, and just as we -- because the measures that are given, we struggle to even find enough measures that we even can qualify for, and I realize you're talking about we're a specialty office, you're taking that into consideration, but in the meantime, this has been such a costly thing for our office, and now we're trying to do mapping through the EHR so we can at least see where we are and if we're doing the right thing, and most of the questions we have to ask our patients have nothing to do with what or really the care we're trying to give the patient, and we are doing nothing but clicking and spending quality time that we should be giving to our patient in order to meet the MIPS. This has been so costly. And now you guys seem to be admitting that these are flaws that need to be fixed and corrected, but in the meantime, if we don't meet them, you're going to penalize us, and it is so frustrating. You have no -- You might have some idea of what we're going through, but I don't know why you guys just don't say, "Okay, you're a podiatrist, these are your measures. You're a hospital, these are your measures." Because you know what you're looking for and the care you want to give. So I don't understand why, for podiatrists, you can't say, "These are the measures we want you to track," and then we would know what we need to do, but every year it changes, and just as I think I have it and I understand, there's another change, and this, I know, is not my only frustration. There's other podiatrists that are going through the same thing, and, yes, we want to provide the best care we can for the patients, but we're spending so much time trying to please Medicare that we're not

giving them the care they need, and it's like your patient-portal thing. We can't force a patient to use it, and yet if they don't use it, we are penalized. We can't meet the measure. These are the things I want you guys to kind of consider. Can't you give us the measures you want us to use?

Yeah, this is Ted. I appreciate that question and your comments because that's exactly why we're doing this. So we're doing the Meaningful Measures framework so that we could be at a place where we do have more clarity around which measures are most important, which ones are applicable to different types of clinicians, and I think two key things that we would love your help with would be first, from a podiatry standpoint, sharing with us your thoughts about what you think the most important quality signals are for podiatry and if we're capturing those signals in the 18 Meaningful Measures areas that we've put forth. That is definitely our intention, and I think one of the main things we are hoping would come out of this webinar is to really get as much feedback as we can get and to let everybody know that we are very open and we very much want to know if you think we're getting close with this or if we need to make big changes. That's exactly the type of feedback we're looking for. So I think the first thing I wanted to say is, let us know if you think this is getting close to what you think is most important for -- I'm using your specific example here -- podiatry. The second thing is the issue of burden that you were describing, where you said that your experience has been that quality measurement can detract from the time clinicians, podiatrists can spend with patients. We definitely hear that, and we want to have a comprehensive way of approaching how we can reduce burden for clinicians, and, again, that's what the Meaningful Measures framework is. We hear you loud and clear that burden is an issue that we want to address. This is our way of addressing it -- to have more parsimonious measure sets with measures where burden, if the measures are kept, is taken clearly into account as a key criteria -- that's one thing we talked about today -- and that this is our opportunity to really look at that and really address that. So thank you for your question.

Your next question comes from the line of Cheryl Metzka.

Yes. Hello. I'm sorry. In the time that I was waiting to ask my question, several people have come out with some of the same things I'm going to say.

Sure.

We're an orthopedic specialty group, and just going through what you've told us today, it seems so general in terms, and I think we, as practitioners, are looking for specifics. We, too, have had a terrible time finding measures that we can report on. If you're an internal-medicine doctor, you kind of generally take care of the patient through all facets of their medicine, but when you're an orthopedic surgeon, and more than that, when you specialize in only hand surgery, or you specialize in only total joint surgery, these do become a big, big burden. We try to do things like Tobacco, Alcohol Cessation. We do their BMIs -- all these things, but still when we're trying to meet, say, eight Quality Measures, and we find one that's maybe Urinary Incontinence, we have nothing to do with that. So we go to our EHR, and we said, "What can we do?," and they said, "Well, pick another one off the list." You're going through this long list -- mental-health issues, urinary issues, heart issues. None of that applies. So just like she was saying of the podiatrist, I just want to key in on that, too. It's been a horrible burden. I've been working at this for a couple of years, too, and we just have a terrible time trying to find measures so that

we don't get penalized. We want to help you, we want to do what you want us to do, but it's just very, very difficult.

Yeah, and I think a little more of a response on that, too -- very much appreciate the point you're making there. Those are important points. I think part of the Meaningful Measures framework is to think about the measures we currently have and land at a place where we have more parsimonious, less burdensome measures, but that's not directly addressing the point you're bringing up. The point you're bringing up is really a second intent of the Meaningful Measures framework, which is to think about, okay, here's what we have, what do we need to have? Where do we want to go? What do we need to develop? And I think that's an area where we'd love to get your feedback, too. So, pointedly, from the Meaningful Measures framework standpoint, we want to make sure -- and this is an area where we'd love feedback -- that the Meaningful Measure areas that we have capture the important areas of care that are delivered by clinicians of all types. Then we can think about, across different specialties, where we need to focus on developing further measures. So that is definitely one of the things that we want to use this for -- in other words, one of the key problems that we want to solve, but I just wanted to highlight that it is, I think, important to distinguish evaluating our current Measure Sets in terms of landing at a place where we can have more parsimonious and high-priority measures and the issue of what measures we want to develop moving forward. We'd love your feedback on both of those, but the Meaningful Measures framework really seeks to solve both of those problems, but I did want to agree with you that I think they are separate.

Thanks so much. I know we only have just three minutes left, so a few people have submitted chat-box questions, asking how they can provide feedback -- if there's a location or website, how they will be able to provide feedback on the Meaningful Measures?

Yeah. Thank you for that. So in terms of the best way to provide feedback for us, we really want to hear your feedback. So Pierre and I have listed our personal e-mails on the, I think, second-to-last slide. So please do feel free to be in touch with us. We also will, soon, if you'd like to wait and gather your thoughts a little bit more, be posting an inbox or an e-mail address specific to this body of work. So if you want to bear with us a little bit, we will make sure -- I assume we have everybody who's on this call's e-mail address to share with everybody on this call, and, more broadly, the e-mail address to use for that. So I appreciate that question, and hopefully that will be a helpful thing in the very near future, as well.

Okay, I think that is all the time we have for today. Just a reminder for anyone who did not see this message previously, but today's presentation and a recording and transcripts will be posted on the CMS website in the coming weeks. We will share a list of communications providing you with a direct link for that. Thank you all for joining.

Thank you very much.

Thank you for participating in today's conference call. You may now disconnect.