NATIONAL QUALITY FORUM

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MAP CLINICIAN WORKGROUP

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THURSDAY
DECEMBER 5, 2019

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The Workgroup met at the National Quality Forum, 5th Floor Conference Room, 1099 14th Street, N.W., Fifth Floor, Washington, D.C., at 9:00 a.m., Bruce Bagley and Robert Fields, Co-Chairs, presiding.

PRESENT:

BRUCE BAGLEY, Co-Chair
ROBERT FIELDS, Co-Chair
JOY BLAND, Magellan Health, Inc.
KEVIN BOWMAN, Anthem
HELEN BURSTIN, Council of Medical Specialty Societies
WILLIAM FLEISCHMAN, Subject Matter Expert
STEPHANIE FRY, Subject Matter Expert
WENDOLYN GOZANSKY, Kaiser Permanente
ANN GREINER, Patient-Centered Primary Care Collaborative
JOYCE KNESTRICK, American Association of Nurse Practitioners
SUSAN KNUDSON, HealthPartners*
ROBERT KRUGHOFF, Consumers= Checkbook
TRUDY MALLINSON, American Occupational Therapy Association
AMY NGUYEN HOWELL, America=s Physician Groups
DONALD NICHOLS, Genentech
SANDY POGONES, American Academy of Family Physicians

LOUISE PROBST, St. Louis Area Business Health Health Coalition
PETER ROBERTSON, Pacific Business Group on Health
DAVID SEIDENWURM, American College of Radiology
J. CHAD TEETERS, American College of Cardiology*
TRACY VADEN, Atrium Health
YANLING YU, Patient Safety Action Network

FEDERAL LIAISONS:

PETER BRISS, CDC
REENA DUSEJA, CMS
KIMBERLY RASK, Alliant Health Solutions
MICHELLE SCHREIBER, CMS

NQF STAFF:

SHANTANU AGRAWAL, MD, MPhil, President and CEO
TAROON AMIN, Consultant
KATE BUCHANAN, Senior Project Manager
JORDAN HIRSCH, Project Analyst
ELISA MUNTHALI, Senior Vice President, Quality Measurement
SAM STOLPE, Senior Director

ALSO PRESENT:

SUSANNAH BERNHEIM, Yale School of Medicine
ELIZABETH DRYE, Yale School of Medicine
JENNIFER GASPERINI, Public Participant
JEPH HERRIN, Yale School of Medicine
LISA HINES Pharmacy Quality Alliance
MOLLY MURRAY, Public Participant
JESSE ROACH, CMS
DAN ROMAN, NCQA
KORYN RUBIN, Public Participant
SOMAVA SAHA, IHI

***present by teleconference**

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P-R-O-C-E-E-D-I-N-G-S

(9:01 a.m.)

CO-CHAIR BAGLEY: Welcome, and I hope you all had a chance to get some breakfast.

I'm Bruce Bagley. I'm one of the co-chairs here. And Rob and I will be trying to -- what are we trying to do?

(Laughter.)

CO-CHAIR BAGLEY: Herd the cats or -- so we're going to have a good day.

We have some ground rules, though. There will be no hitting, no ad hominem attacks, and we're going to try to seek win-win solutions. Okay? And, actually, it should be a fun day. We've got some good presentations, and we have some things to hash out, so that we get these measures right or at least give CMS some good advice.

And CMS in the past in these meetings has been very willing to listen. They always staff this extremely well, and they are very interested in what we have to say. So it should

be a good meeting.

And is Shantanu here?

MR. AGRAWAL: I'm here.

CO-CHAIR BAGLEY: Oh, there you are.

(Laughter.)

CO-CHAIR BAGLEY: The man of the hour. I hear you have some words of greeting for us.

MR. AGRAWAL: Oh, sure. Well, welcome. I want to thank you both for your leadership of this committee, and welcome to the MAP community space. This is day three for us, so I've offered to Michelle to give her presentation this morning since I've now heard it a couple of times.

But, again, we are excited for the work, and I'll turn it back over.

CO-CHAIR BAGLEY: Okay. Great. Thanks for being here. Thanks for your hospitality and taking care of us.

I think that we have to go around the table, do an official "we have no conflicts" type of thing. Is that right?

MS. MUNTHALI: Yes, we do. So, hi, everyone. My name is Elisa Munthali. I'm the Senior Vice President for Quality Measurement. And so what we're going to do today is --

CO-CHAIR BAGLEY: Can you hear her? Okay.

MS. MUNTHALI: Yeah. And the folks in the -- on the phone can hear us as well with the green light on. They can probably hear us better than we can hear each other in this room.

But what we're going to do today is combine disclosures of interest with introductions. And so we're going to ask you in a very abbreviated way to tell us what you disclosed to us in your forms. There are two types of representatives on the committee.

There are organizational representatives -- that's the majority of the clinician workgroup -- and subject matter experts. And that includes your co-chairs; there are five of those.

We will go around the room first to

ask those that are organizational reps to disclose anything that is relevant to the committee. Let us know who you are, who you're with, and let us know if you have anything to disclose.

We are going to skip Stephanie and Will and your co-chairs, and we'll come to them later. So we'll start first with -- I think it's Joy. I can't see your nametags. Yeah, hi.

MEMBER BLAND: Hi. I'm Joy Bland. I am representing Magellan Complete Care, and I do not have any -- I'm the Vice President of Quality for that organization, and there is -- I didn't disclose any conflicts on my form.

MEMBER PROBST: I'm Louise Probst, Executive Director for the St. Louis Area Business Health Coalition, filling in for my colleague Karen Roth. And I did not have disclosures on the form.

MEMBER BRISS: I'm Peter Briss. I'm the Medical Director at the Chronic Disease Center at CDC, and I have nothing to disclose.

MEMBER BURSTIN: Helen Burstin, ADPC, the Council of Medical Specialty Societies. No disclosures.

MEMBER YU: I'm Yangling Yu with Patient Safety Action Network. I'm a board member, and I have no conflicts of interest to close.

MEMBER SEIDENWURM: I'm David Seidenwurm with the American College of Radiology and Sutter Health, and I have several conflicts of interest with this work, which are I'm a medical director for Sutter Quality and Safety, I'm a measure developer for the American College of Radiology, and I just received a grant from the Moore Foundation for measure development in diagnostic accuracy.

MEMBER MALLINSON: Hi. I'm Trudy Mallinson. I'm representing the American Occupational Therapy Association, and I'm currently on a contract with Lewin as the prime -- to develop measures for the Home and Community-Based Services Program.

MEMBER KNESTRICK: Hi. My name is Joyce Knestrick. I'm with the American Association of Nurse Practitioners, and I have nothing to disclose.

MEMBER ALEMU: Hi. My name is Girma Alemu. I am representing HRSA. I have no conflicts.

MEMBER NICHOLS: Donald Nichols with Genentech. I am a principal of our health policy and systems research team. Nothing to disclose.

MEMBER BOWMAN: Kevin Bowman with Anthem. Nothing to disclose.

MEMBER VADEN: Traci Vaden, organizational representative for Atrium Health, formerly known as Carolinas HealthCare System. I am the vice chair of quality, safety, and patient experience there. No further disclosures.

MEMBER POGONES: Sandy Pogones. I am the senior strategist for healthcare quality with the American Academy of Family Physicians. I have nothing to disclose.

MEMBER RASK: Kimberly Rask with

Alliant, for QIN-QIO and ESRD networks across the Southeast. And nothing to disclose.

MEMBER ROBERTSON: Peter Robertson with the Pacific Business Group on Health. Nothing to disclose.

MEMBER GOZANSKY: Good morning. Wendy Gozansky. I am an organizational representative for Kaiser Permanente, Vice President and Chief Quality Officer for the Colorado Permanente Medical Group and National Permanente Quality Leader. I have nothing to disclose.

MS. MUNTHALI: So on the phone, do we have Chad from the American College of Cardiology? Okay.

Susan from HealthPartners?

MEMBER KNUDSON: Yes. Good morning. This is Sue Knudson. I'm the Senior Vice President of Health Informatics, Health and Care Engagement here at HealthPartners, the Minnesota-based HealthPartners. I have nothing to disclose.

MS. MUNTHALI: Thank you very much.

So for our subject matter experts, we asked you a lot more questions than we did the organizational representatives. And we are particularly interested in paid and unpaid activities as they are related to the work in front of you.

We also wanted to remind you that you do not represent the interest of anyone who may have nominated you for the workgroup or your employers. And probably the most important reminder is, you know, just because you disclose there is nothing you have a conflict of interest, we go through this process in the interest of openness and transparency.

So I'll start off with Bruce first, and then we'll go to Robert, and then we'll go to Stephanie.

CO-CHAIR BAGLEY: Yeah. Hi. I'm Bruce Bagley. At this point in my career, I'm sort of an independent consultant. And you've heard me say this before: I come with a boatload of biases like everybody else. But I have no

conflicts.

MS. MUNTHALI: Thank you.

CO-CHAIR FIELDS: Rob Fields, Senior Vice President, CMO for Population Health at Mount Sinai, and here serving as co-chair. Originally nominated by NAACOS, but serving as co-chair in these capacities.

MS. MUNTHALI: Yes, thank you.

Stephanie?

MEMBER FRY: Stephanie Fry, representing the patient experience voice in this. Sorry, Stephanie Fry, and have supported some of the patient experience measurement pieces for some of the measures under MAP.

MS. MUNTHALI: Okay.

MEMBER FLEISCHMAN: I'm Will Fleischman. I work at Hackensack in New Jersey on quality issues. I don't have any conflicts of interest, but I will disclose that I worked for CMS until about a year ago. I worked on some measures but did not work on any measures for discussion -- up for discussion today.

MS. MUNTHALI: Thank you very much. In addition to our subject matter experts and organization reps, we do have nonvoting federal liaisons that are here today. And we also have representatives from CMS. You've heard Peter introduce himself as a federal liaison from CDC and Girma from HRSA.

And Reena and Michelle, would you please introduce yourselves?

MEMBER DUSEJA: Good morning everyone. My name is Reena Duseja. I'm the Chief Medical Officer at the Quality Measurement Value-Based Incentives Group.

MEMBER SCHREIBER: Good morning. I'm Michelle Schreiber. I'm the Director for Quality Measures and Value-Based Incentives Group, and I have nothing to disclose.

MS. MUNTHALI: So before I turn the meeting over to my colleagues to introduce themselves, I just wanted to remind you that if at any time you remember you have a conflict, we want you to speak up. You can do so in real time

or you can approach any one of us in the front, the co-chairs, or anyone on the NQF staff.

And, likewise, if you believe that one of your colleagues on the workgroup is acting in a biased manner, we want you to speak up.

So thank you.

MR. STOLPE: Hello, and welcome, everyone. I'm Sam Stolpe. I'm a Senior Director here at NQF, and it is very much my pleasure to be conducting as a staff representative.

What I'd like to do is have my colleagues introduce themselves, and then I'll walk through a couple of housekeeping items before we move directly into our agenda.

Taroon?

MR. AMIN: Taroon Amin, consultant for NQF.

MS. BUCHANAN: Hi. Kate Buchanan. I'm a Senior Contract Manager here at NQF.

MR. HIRSCH: Hi. My name is Jordan Hirsch, and I'm a Project Analyst at NQF.

MR. STOLPE: Wonderful. Okay. So our

first order of business is probably the most fun thing we're going to do all day, and it's to follow the example of your colleagues, Stephanie and Kevin, and to slightly rotate your tent cards, so that they can be viewed by our co-chairs. Thanks very much.

Now, we might get to do one more thing with our tent cards, and that is, as you know, throughout the day, we're going to be putting these up if you wish to be recognized. And at this time, please put your tent card up if you have not logged on to Poll Everywhere, because this is the next thing that you'll need to do. As you know, we will be voting all day. So if you need some assistance from staff to get you signed into Poll Everywhere, please let us know, and we'll happily send someone over to help you get logged in.

A couple of other items that I'd like to review. First, the meeting materials, if you have not accessed them, are available both through the calendar and by -- as well as on

public.qualityforum.org where you can just click on the MAP clinician link and it will give you access to all of the materials that we will be having in front of us today.

Just a couple of other essentials. Just past the reception area here is an atrium where the restrooms are. So if you need to step out, that's where they are located.

One simple reminder, please mute your cell phones. So that's both for our -- for our members and our guests.

One other thing to note for our guests, sometimes it is a little challenging to hear. So if you -- if you do have trouble hearing, please let us know and we'll try to adjust the sound.

And if you do need to have a conversation, please take it out into the hall.

One other thing to note is that inside of the meeting materials there are two measures that you'll notice have been withdrawn from the MUC list. Now, those did go through clearance,

so they are technically on the MUC list. But as they have been withdrawn, you will not find them in your meeting materials, and those are MUC2019-110 and 112, Emergency Department utilization and acute hospital utilization.

Those are the general announcements, and I'll just walk briefly through our agenda for this morning and this afternoon.

Our first order of business is to go through two presentations, the first from Dr. Schreiber, who will be walking us through the Meaningful Measures Initiative 2.0 proposed changes, and leading us through a dialogue based on your reactions to it, and to get feedback from you. So thank you for inviting those, Dr. Schreiber.

And then next we will hear from an IHI representative, Dr. Somava Saha, who will be giving a presentation on innovation in quality measurement. And then we will walk through just MAP procedures in general to remind those of you who have been around the table and to -- to bring

up to speed those of you who are here for the first time.

Then we will move into our meeting directives in earnest, and that will be to review the 10 measures that you all have diligently been looking at.

So without further ado, we can move forward into our agenda. But before we move to Michelle, yes.

CO-CHAIR BAGLEY: I forgot to welcome Kimberly Rask at the start.

MR. STOLPE: Oh. Thank you.

CO-CHAIR BAGLEY: And Kimberly is the liaison from the Rural Health Committee to look at the MAP rules.

Now, in the past, you have been a liaison, but you haven't had an official role. So we're going to ask Kimberly later to give a short presentation, and also she'll be weighing in on each one of the measures when it comes through.

All right. We're ready for Michelle.

MR. STOLPE: We are.

MEMBER SCHREIBER: You're ready? Well, thank you.

CO-CHAIR BAGLEY: Thank you for coming out, and we're looking forward to a good day today.

MEMBER SCHREIBER: Thank you. We are, too. And to the co-chairs, thank you sincerely for taking on the opportunity and challenge for co-chairing these committees.

This is our third day. Post-acute care was the first day, hospital was yesterday, and today is the clinician meeting. And so some of the folks up front have heard these presentations a few times. That's what Shantanu was referring to. I should just turn the floor to you and see if you remember the two days.

(Laughter.)

MEMBER SCHREIBER: But the most important part, really, has been the conversation and the comments and the feedback that we have been able to get from these groups, and we hope

to make today's conversation really equally a conversation, to really hear what you think about the directions that we're going to be telling you that we think are important. We are kind of wanting to check in to make sure you think those are important and we're on the right path.

We actually specifically asked Somava to come today from IHI, so we thank her for being here today, because one of the things that we're trying to do on our new framework of meaningful measurements is to think of different kinds of measures, really different kinds of measures, things that are a bit more innovative. And IHI really has one that we're very intrigued by, and we kind of wanted to get everybody's reaction to it, so thank you.

I'd like to just take a moment to pause and, first of all, thank NQF, their staff, for all of the organization and welcome them again to their new digs. It is really quite lovely. The NQF staff has been great. I'd like to thank our contractors. If there are any of

you here, just raise your hand, so people can acknowledge you.

Hey, Suzanne. I didn't see you come.

Our contractors really do a tremendous amount of work, and they are absolutely experts in these measures.

And, finally, the CMS staff, some of you are here. Some of them we've had in another room, too. Thank you. And some of them will be on the phone. Again, our CMS staff and contractors put a lot of work into measures and measure development. They are very expert in their field, and we encourage you to reach out to them at any point in time.

Your input -- I want you to understand -- really does make a difference. We get asked frequently, "You know, I come to these meetings, I provide my input, and CMS kind of does what they want anyhow." That's really not true. We take your input extremely seriously.

And last year at the MAP we actually did not move forward with several measures that

people had some objections to. We revised some measures that people had different ideas with, and we really took the ideas and brought them forward into additional measure development that we're working on.

So please understand that your comments are exceptionally important and we do get them. That being said, I do need to remind the group that although we do take your advice very seriously, decisions here aren't binding and CMS does make the final determination of what goes into the rules and what measures are used.

Our collaboration and partnership, though, is more important than ever. As part of our strategic plan, it is actually written in there that our goal is to increase our participation with stakeholder outreach with the various associations, the professional societies, with patients, to try and build consensus, alignment, patient empowerment, and reduced burden. In other words, to drive the value proposition across the country.

And we are really very excited. I hope that some of you have felt this increased engagement, have seen our reaching out, especially to stakeholders and especially societies to help reduce some of the measures in certainly our MIPS value sets, which we will touch on a bit, co-producing those with specialty societies. So this is fundamentally important to us, this collaboration.

I have been asked about the Health and Human Services Quality Summit. Some of you in this room I know have been part of it. We do not know the recommendations that will be brought forward, but there is a report that is due out this month, and it may or may not have implications for what I'll call the quality enterprise.

But we look forward to it as well, seeing what the recommendations will be. As always, though, we remain committed to partnership and transparency.

So because we've had really fewer

measures in these sessions for the last several days, and significantly fewer -- a couple of years ago there were over 100 measures that were brought to the MAP, but I say this for all three of the committees. There were over 100 measures brought to the MAP. Last year there were about 41 measures brought to the MAP, and this year, quite honestly, there are fewer than 20.

And the reason for that is that we are being very careful and more selective in measures that we are developing and bringing forward, trying to have more outcomes measures than process measures. But I want to be very clear on the record, I think there are good process measures, too, and we shouldn't just kick them to the side. This is our commitment, however, to burden reduction and to streamlining our programs and to streamlining measures and measure development.

And so the trend, really, has played out in the number of measures that we're bringing forward. That, however, has allowed us a little

time for discussion, which has been very nice.

This morning I want to take a moment to talk about meaningful measures, and many of you have heard the meaningful measures framework. But we are in the process now of developing what I'll call Meaningful Measures 2.0, and I want to talk about what some of our priorities are and get your input as to, is this a direction that you agree with, and what perhaps are gaps in what I say that you want to ensure is part of Meaningful Measures 2.0 for us, and engage you really in our direction and hopefully including everybody in developing a shared direction.

So, with that, if we could go to the slides. You know that CMS's primary goal is actually not to remove obstacles that get in the way, but it's really to ensure that patients of this country have the highest value, highest quality, and safe care possible.

But we also recognize that getting in the way of some of this has been that some of the programs and the regulations associated with it

have become burdensome, and the initiative called Patients over Paperwork is actually a commitment to not only patient-centered care and improving outcomes, but to also reduce the burden for clinicians, so that clinicians can be spending more meaningful time directly with the patients.

Next slide, please.

This is actually CMS's strategic priorities. It's a little hard to read, but you have all received it in your books. Patients are clearly at the center, and the three big drivers here are focusing on results, empowering patients, and unleashing innovation. And with that, there are 16 specific topics areas across CMS that are being worked on, all to improve patient care.

Next slide, please.

You've heard, again, about the Meaningful Measures Initiative, and its process and reason for being was to improve outcomes for patients, but really to try to come to a decision of what is most important strategically for us to

be focusing on, and what measures should we be focusing on, so that we can all be moving in a unified and shared direction.

Next slide.

And many of you have seen this, but these are some of the cross-cutting goals to address high-impact areas to make sure that we are being patient-centered and that our measures are meaningful to patients and their families; outcomes-based wherever possible, although my caveat about process -- obviously, we have to fulfill the requirement of statute; minimize the level of burden for providers; identify significant opportunities for improvement.

So many of the measures that we have been retiring are because they are topped out and there is no longer an opportunity for improvement, but that does not mean organization shouldn't still be tracking them, because we know sometimes when you take your eye off the ball it kind of declines. So even though CMS may not have them formally in a program, that doesn't

mean that they're not important and that organizations shouldn't be tracking them.

Addressing population needs -- so certainly for providers, and really for all, it is important not just to be thinking of individual patients but to be thinking in the broader sense of populations and the shared responsibility that we all have for taking care of populations, and how do we define that, and moving forward in a value-based payment world because one of the overarching goals is really to continue to move forward in value-based payments and away from future service.

And, finally, aligning programs across the continuum of care, across programs and with all payers. And I just want to pause here and note that this has been a very important initiative for us. We have been working with the VA and the DoD to try and align all of the federal measures. We have been working with AHIP, America's Health Insurance Plans, to develop a core set of quality measures that all

payers can agree on are important and to standardize those, because we recognize that one of the challenges of burden has been perhaps misalignment, so that there could be, in theory, multiple measures trying to get to the same thing, but they are slightly one-off, and yet you as an organization or a provider, you have to report them in all of those ways. And as the former chief quality officer of a large system, I knew that implicitly.

Next slide, please.

Many of you have seen this. Many of you, hopefully, have had our cards on meaningful measures. And you can see that there are really six domains with 19 specific areas of focus. And as we look to Meaningful Measures 2.0, one of the questions is, are these the right domains? Are these the right sort of specific barriers under them? Is this what we should be driving? Are there changes that should be made to this? Are there too many? Are there too few?

And so the six domains include

effective communication and coordination of care; chronic disease, so the prevention and treatment of chronic disease; healthy living, so wellness, working with communities to promote best practices of healthy living; affordability; making care safer, so patient safety; and, finally, and not -- last but definitely not least, strengthening the person and family engagement with patients and families being partners in their care.

Next slide, please.

Do you want to talk a little bit about the transitions that we've had in the measures?

MEMBER DUSEJA: Absolutely. Thanks, Michelle.

And Michelle spoke about the impact of our Meaningful Measure Initiative in terms of how it has impacted the number of measures we have presented to the MAP over the years with that decline. But, in addition, we have applied actually the Meaningful Measure Initiative into our rulemaking.

And of note, when you look at, you know, our hospital inpatient programs, for example, we have seen over a 40 percent reduction in measures. So in the inpatient quality reporting program, we have seen actually measures that initially started in 2017, and 42 measures that, you know, hospitals were required to report, and we've gone down to 23 when it comes to the fiscal year '22.

Similarly, in post-acute type care, there have been requirements statutorily required of us in terms of implementing measures that standardize across the whole post-acute care setting, but we also have seen reductions in particular around the hospice space where there has been about a 40 percent reduction of required measures in that setting.

When we go to the clinician space, you have also seen in our rulemaking a lot of effort in terms of reducing the measures that we have within our MIPS set. And if you look across the last couple of years, we've seen a 20 percent

reduction of those measures.

And part of the emphasis on this was to remove measures that we saw that were topped out, so really not an ability to judge clinicians in terms of improvement within the program, focusing on outcomes-based measures, but also, you know, really thinking about the importance of how are we driving toward value.

You know, part of the challenge of the current structure of MIPS is, you know, we have to make sure we have measures for all specialists to report on. And part of our effort has also been to partner with registries to have innovation in that space as we are thinking about, how can we push the measurement science along to have more meaningful measures within MIPS.

As you guys are probably also aware, this year we finalized the MIPS value pathways, which is a framework that we have that is really to get more at the cohesiveness across the four categories within MIPS. So just a reminder there

are four categories, the quality category, the cost category, improvement activities, and promoting interoperability.

The MVPs are really an effort to get coordination, but also to drive toward value to a cohesive set of measures that providers will be reporting on that are related. So we get to actually have some discussion around this as well if we have time. But the way that we're thinking about this, it could be specialty driven but it also could be based on thinking about common conditions that our beneficiaries may have, for example, chronic conditions such as diabetes care, and making sure each of those categories that providers report on would be related to that overall theme of the MVP.

I also want to point out that the Learning Action Network in October actually came out with some goals for us as a health system to move forward toward. And one of the things that they had set out for Medicare was for us to really move -- was for us to move from fee for

service to APMs, advanced APMs, in that direction by 2025. So 100 percent.

So, I mean, that actually requires a lot of coordinated effort, and I will say within the agency there has been a lot of thinking around the measurement strategy. And you'll see that even with the measures that we're presenting today, thinking about what measures will help drive toward value, how do we align across care settings, so incredibly important as we're thinking about our next steps. And we're being very strategic as we bring measures to present to you on how we can continue with that effort.

I wanted to point out that, you know, CMS has over $1.5 billion in benefit payments per day. And as of note, there is over -- we know actually from statistics that over 189 percent of Americans will be aged 85 and older between now and 2050. I presented this a few weeks ago, actually, to the hospice coalition.

And I think, you know, that -- those numbers are astounding. And of those

beneficiaries, we also know from some of our studies that greater than 30 percent of our beneficiaries have greater than six comorbidities currently.

So it's incredibly important that we actually get measurement that is actually addressing these issues. And you'll see with the measures that we are presenting today it is getting at some of these concerns. So, for example, the hospital-wide readmission measure that you guys will be evaluating is also in our hospital-based program, and so we're looking for alignment.

In addition, the multiple chronic condition measure we're presenting today also is something that we plan to have within the Shared Savings Program, and we look forward to the discussion with regard to that.

The hip-knee complication measure is a measure that we have, you know, in the hospital-based program. But this gets to, you know, how do we actually measure complications,

you know, for our patients that are undergoing these procedures.

And so we think, you know, this is part of our strategy in terms of getting more patient -- you know, in addition to this, also having patient-reported outcomes as an adjunct in getting up to procedures that are common for our beneficiaries and really trying to measure the value associated with that.

So I will pause here and hand it back to Michelle to talk about future direction, the next slides.

MEMBER SCHREIBER: Thank you very much. Can I have the next slide, please?

So I wanted to share with you, as we have kind of prioritized our work, where we have prioritized it. We got feedback on, is this what you would want us to prioritize? And so these are some of our developmental priorities.

First is really driving patient-reported outcomes. Right now they are still kind of clunky. They certainly do exist. They are

not widely used. But how can we be developing even operationally better ways of doing patient-reported outcomes?

And then, really, unleashing patient-reported outcomes because we think if patients are reporting more and more and that's becoming part of sort of standard care and clinicians are seeing this and it's transparent, then it will actually kind of transform health care as consumers really have more of a voice.

The second is moving measurement to fully electronic. I have ECQMs here, but I -- I would put this on a broader context of not just ECQMs, which traditionally come directly out of an electronic medical record, but electronic data sources because we can have sources that aren't just from the electronic medical record, for example, census information or others, but measures that are fully electronic.

And I would say that at some point in the future -- and I can't tell you the future, I can't give you a date, but our goal is to have

all measures that are fully electronic, because in point of fact, there is really no other way to be able to capture the magnitude and amount of data that we have to be able to do that in a way that we can turn them around quickly and provide feedback that is meaningful, so that our feedback isn't two and three years out, and so that we can apply advanced analytics, be that AI or machine learning or what have you, that this has to be electronic.

So our commitment is at some point in time, because I can't quite put my stake in the ground and pound it, to really be moving towards electronic measures, and many of the measures that we have brought forward and are developing are fully electronic measures.

Clearly, there is a focus on appropriate use of opioids in the avoidance of harm. But, again, I think this is actually a broader category of pain management and even a broader category of mental health and substance abuse. So how is it that we are measuring that

and shining a spotlight on it better?

There has been a lot of writing on nursing home safety and nursing home harm. And so nursing home infections is something that we are looking to develop, but, really, measures around harm in post-acute care settings where those things haven't really come to the forefront as much.

I have included safety measures as part of nursing home, but really patient safety as its own category, remains extremely important because we know that despite after 20 years of, you know, to err is human, patient safety remains a major concern and it remains at the top of our priority list.

Maternal mortality, we talked about a maternal mortality metric yesterday in the hospital setting, because we also recognize that as a country we have the highest maternal mortality statistics, and that is something that should not be tolerated. And so we are turning some of our efforts to developing maternal

measures, including we're in the process of working on a combined maternal morbidity measure.

It's a little harder to do just maternal mortality. The statistics, fortunately, are very small and low. But a composite maternal morbidity measure is something that we're working on.

Sepsis -- again, I know it's a hospital one, but we are moving forward with redefining the sepsis measure as an electronic outcome measure, which we think will be important.

Coming back to safety, we are working on electronic measures around safety and opening up also the category of diagnostic error, which we think is very important, especially in an ambulatory setting where the traditional measures of safety don't completely apply in an ambulatory setting, but I do think diagnostic error definitely does.

So these are some of the areas that we are exploring at the top of our list. I would

add cost. We clearly are developing more and more cost measures. We do have a statutory mandate to have cost measures that cover, what is it, 80 percent of all -- 50 percent of all spend. We are not there yet, and so more cost measures and linking costs to quality as we drive in a value-based world.

I will say we've gotten some interesting feedback in the last couple of days about different domains or different topics of consideration. One is around workforce, employee engagement, burnout, as a topic that we should be putting higher on our priority list. And I thought that was very interesting.

Another one that we heard was access, so ensuring that people have access to care and how are we measuring access. And, of course, there is always the conversation about social determinants about, how are we measuring that? What are we doing about it? And I will say within the federal agencies there are numerous activities ongoing, both with ASPI and HRSA and

the Office of Minority Health, looking at trying to have a standardized approach for this. But as you can imagine, this is not an easy topic.

Next slide?

I spoke a lot about the electronic measures already. We are working actively for prototyping some of our quality measures. We have at least three in the pipeline now that we have developed around FHIR-based standards and using APIs for the transmission of clinical data.

We are working on incentivizing the use of interoperable electronic registries and trying to harmonize measures across registries, all in the goal of providing timely and actionable feedback to providers.

But we are actively working on the Da Vinci Project for those of you who have heard that, which is pushing forward with buyer-based standards, and we are -- we ourselves are trying to standardize around the future of electronic measures, both reporting and receiving information and analyzing information.

Next slide?

I think that's my last one. So with that, our goal is to really open this for conversation. But, I mean, I take a little liberty, if I may, and ask Somava to come forward first, because we were very excited to hear a new concept of measures coming forward from IHI, and I want to be able to include that as part of our overall discussion.

So if you don't mind me combining these two, I appreciate that. Thank you.

MR. STOLPE: Before we start, any questions for Michelle or Reena? Go ahead, please.

MEMBER YU: Yes. Microphone?

CO-CHAIR BAGLEY: The mics are in the ceiling. But just to be clear, we're not quite picking up as much as we'd like. So let's all use outside voices.

(Laughter.)

MEMBER YU: Thank you. My question is, I'm very interested in your comments about

future measure development in diagnostic errors. And do you have any insight that you could share, what type of things you are looking for and what type of format is -- were they including in PSOs or --

MEMBER SCHREIBER: I don't know the answer yet. We're in exploratory phases. But I did just want to put that on the radar screen as something that we are actively looking at.

MEMBER YU: Okay.

MEMBER SCHREIBER: So I can't give you specifics because I don't have them. I would give them to you otherwise.

MEMBER YU: All right. Thank you.

CO-CHAIR BAGLEY: Amy, I think you were next.

MEMBER NGUYEN HOWELL: Oh, yeah. So in terms of the meaningful measure priorities, I just wanted to know, could you share with us what you are seeing in the hospital setting with the safety measures, with maternal mortality, and sepsis?

MEMBER SCHREIBER: Well, we had a really interesting conversation about the maternal measure yesterday, actually. And what we are really just hoping to do is shine a spotlight on the issue of maternal mortality and ensuring that organizations are participating in initiatives and specific programs to improve those numbers, because what is it that we're seeing?

We're seeing that our maternal mortality numbers are the highest in the world, of any country. And so shining a spotlight there -- now that obviously is not a traditional Medicare measure, but Medicaid pays for 43 percent of all deliveries in the United States. And so this is really a very important issue.

In terms of the patient safety measures, many of us are familiar with the beloved PSI-90, and our plan is really to be working on developing electronic measures of harm that right now we're sending through as

individual measures.

So this committee -- the hospital committee -- has seen some for hyper and hypoglycemia, is going to start seeing others, and ultimately over time, as those get approved one by one, to have an electronic composite for harm. That, again, is something that can be turned around and you get feedback on it very quickly, and ultimately to request PSI-90.

MEMBER DUSEJA: Okay. Just for sepsis, we have SEP-1 in the hospital-based program, but we are, you know, partnering with our colleagues at the Innovation Center to think about, how do we think about sepsis across, you know, the continuum, not just in the hospital setting.

The work that we are doing as part of the hospital care around sepsis, you know, we have seen tremendous -- with our data -- impact of having the measure within hospital facilities and being able to drive down mortality over the last few years.

But we are also going to be working in terms of what measures -- measures that Michelle spoke about in terms of trying to electronically specify a sepsis outcome-based measure. And so we just actually had a call for our technical expert panel to help us think through that concept.

MEMBER SCHREIBER: I do want to say we also think that there is a tremendous opportunity to be aligning measures across the continuum of care. So the measures in the hospital and measures in post-acute care, measures in the ambulatory space and measures in ambulatory surgical centers, for example. I think we have many more opportunities for that type of alignment.

CO-CHAIR BAGLEY: Sandy?

MEMBER POGONES: Yeah. I'd like to talk a little bit about the measures in general. There is always this push/pull between identifying gaps in care such as maternal morbidity and mortality and directing resources

toward closing those gaps versus penalizing places that have the gaps.

And I think that's a real concern when it comes to morbidity and mortality. If we look at the facilities that delivery babies, we will miss a lot of the core problems of morbidity and mortality because the rural areas don't deliver anymore. So there is -- we have to keep in mind that -- and I know everyone knows this, but we don't want the negative impacts of measures just because we can measure.

And I think measures can be very useful for informational purposes rather than financial penalties, too. And I'd like to see a lot more measures that way developed to really engage communities and entire systems and geographic areas to really target resources for it.

MEMBER SCHREIBER: Thank you for that comment. It's very important. Actually, what I thought you were going to say is the tension between identifying gap areas with this sort of

pervasive thought now that there are too many measures. So what -- you know, where is the balance of the right number of measures? Because I think that's really a topic of active conversation these days.

CO-CHAIR BAGLEY: Girma?

MEMBER ALEMU: Yeah. Talking about the need for major development policies, the maternal mortality. And from the safety net perspective, from the rural perspective, I think it's important to consider social determinants of health. Those are significant issues across states, racial and ethnographic issues.

So I think it's an important issue for the safety net that they will okay the measures. One has to consider those issues. And the good thing is that, you know, maternal mortality is preventable. So we can work on in that line.

And the other issue is about appropriate use of opioids. I think it is not enough just to look at the medical perspective, it is important also to look at the social and

strata, that data. So it can be in the form of composite measures or -- and I would think a very actionable, not-complicated measure, but it can be developed. These issues can be integrated into the new -- into the future measures.

So the third point is that, again, as Dr. Schreiber mentioned, working at CMS or the in a new position can get some outcomes. It is the future. So I would say just to expand it by saying, you know, across federal agencies and collaborating with private entities, and it helps with that. So it is something, you know, it is moving forward. It is going fast. So I think if we bring people together, this statistic it will be, you know, beneficial.

Thank you.

CO-CHAIR BAGLEY: Thank you. If I might, just a comment on Sandy's question and your answer.

I think we have to acknowledge that we are kind of stuck to some degree. As Reena said, you know, we have to have a measure for

everybody, so they can participate. So that's sort of a conundrum.

When in fact -- when we end up getting a measure and it goes into clinician's heads, it's all about payment and judgment. You know, we'd like it to be all about quality. But in the end, because of how they are rolled out, how they're incented within organizations, they're about payment and quality -- payment and judgment.

So we're stuck with that, unless you can fix that.

MEMBER SCHREIBER: I'll get right on it.

(Laughter.)

CO-CHAIR BAGLEY: No. I mean, it's the reality.

MEMBER SCHREIBER: I know.

CO-CHAIR BAGLEY: It's reality. And having watched this measurement enterprise go on for 20 years, we are in a place where we're kind of stuck, and the best quality improvement is

going to come from individual organizations that are designing their own quality measures and running them through improvement cycles constantly. That's where we're going to see the quality.

We're just sort of monitoring what's going on out there. We're not driving quality with these measures. As much as I'd like to think it does, I don't think that's the case.

And so we kind of have to deal with that, work with that as best we can, but it is a reality.

MEMBER SCHREIBER: And I think that's part of the challenge, and I would open this -- I would certainly ask you, but I would open this to the entire group, maybe after we allow Somava -- because we have plenty of time for a broader discussion -- but I think you're right.

To some degree, something has failed. I don't want to say we have failed, but something has failed not to have moved the needle adequately enough from including quality, and

what would it be that would be more effective?

We could just leave it organizations who are interested, and there will be improvements that way, but that's spotty, and you're kind of relying on really almost goodwill of organizations to do that. And, quite honestly, as the biggest payer in the United States, spending over a $1 trillion, we would like to drive and feel like we have the responsibility to drive some of that.

But what is it that we're missing? And that I think is the crux of the conversation.

MEMBER DUSEJA: Can I just add, with our MVP framework, we are trying very much to marry the quality measures that provide us a reporting arm to be linked to quality improvement activities. So, similarly, we require that of our registries. So there's a lot of work that needs to be done in that space, and, you know, you have a chance to look at -- I wish we had, actually, the slide to share with the group here today.

But if you look at what we're thinking about moving forward in 2024, you know, part of what CMS wants to do, especially as we move to electronic submission of this data, is to have more rapid feedback back to providers to make, you know, timely decisions and impacting care at the bedside. So that is part of our hope as well.

CO-CHAIR FIELDS: I have a comment, actually, on the artificial intelligence initiatives you guys are taking on. Increasingly, there is awareness that while AI is wonderful, we use predictive modeling using AI at Sinai as well. There is emerging evidence, obviously, that this amplifies systemic racism and other biases into the models. And I'm curious, as probably the holder of the largest data set probably collectively in the federal government, you know, compared to most private enterprises -- you have social service data, you have all sort of other data that can be used for lots of really good things. But I imagine the

risk is that much greater, and so I'm curious how you guys started thinking about it.

I'm sure you haven't solved it because nobody has.

MEMBER SCHREIBER: And you're right. I mean, we're really just at the cusp of this. Quite honestly, a lot of the data sources are a little bit siloed and fragmented. But you're right; it is becoming clear that the underlying drivers of some of this and some of these even predicted analytic, even the risk adjustment models, have their own bias in them. And I think it's something that we're all just going to have to be on the lookout for and try to build in in advance.

I don't think that we have enough experience with that to answer the question.

MEMBER DUSEJA: And maybe I would add that Innovation Center had this AI challenge, so there was --

MEMBER MALLINSON: I'm sorry. Can you speak up, please?

MEMBER DUSEJA: Sorry. I was just mentioning that at the Innovation Centers they just launched an AI challenge and making awardees start looking at this issue. So it is something that we're at the beginning of but continue to move forward on.

CO-CHAIR BAGLEY: Okay. I think Wendy is next.

MEMBER GOZANSKY: I would just say, going back to the point you were making, that I think leveraging our consumers to actually be the folks who are driving the -- if they actually have access and then can look and say, Well, this person has better quality measures, and that they actually choose, that will help get away from sort of this all just a clinician payment side of things.

And I think we have a huge consumerization of health care, and we need to think about how we leverage that. And a lot of that is educating consumers about what the measures mean and how they choose, you know,

where to get -- you know, if I am a non-white woman, where am I going to go to deliver my kiddo? Because I know that they actually don't have these huge disparities that everyone else does. And I think we've got to think about leveraging who our audience is a little bit differently.

MEMBER YU: Thanks, Chair. I seem to -- to belabor the point -- I don't want to repeat what he said, but I think that, you know, quality improvement should include all stakeholders that we have, you know, facilities and medical groups.

The important group of government agency is to develop some policy you can put the data out for the public to see, because, like you said, people goes to where the quality care is provided. And they want to do comparisons. I think that that's the force really driving this was CMS developed policies.

CO-CHAIR BAGLEY: Joy? Oh, I'm sorry.

MEMBER SCHREIBER: If I could just comment back for a second. And I hope you -- you

know, you are seeing CMS's commitment to transparency, you know, price transparency, quality transparency. But the challenge, of course, is on the flip side making sure that those are correct. We all know the conversation around hospital stars, right? And so I think that we just have to be very careful of that.

CO-CHAIR BAGLEY: Joy?

MEMBER BLAND: Yeah. And to her point, because I was in another workgroup where we were talking about, you know, how we were going to put the scorecards up, so that -- with the health plans. But I think we also have to think about as we educate consumers is those scores are there -- are there, are them.

So as they're picking a place, you know, one plan could have -- like mental illness predominant members versus something else. So I think we've got to really focus consumers on engaging in owning their care, too, because I think that's a big issue when we talked about gaps in care and these things is they're -- that

is the measurement of that population.

So I don't necessarily think all consumers know when they look at a five-star, you know, that that's people actually engaging in their care, managing their conditions, with the help of the health plan, providers, et cetera.

And I don't know how -- I don't have the answer to it, but it has been my pet peeve for a while, you know, especially in the Medicaid population, too. So it's something to consider.

CO-CHAIR BAGLEY: Louise?

MEMBER PROBST: I would just like to put a request in for more measures that differentiate procedurally, so complications. So we measure primary care doctors every which way, and oftentimes there just aren't a lot of differences, but I sure would like to know who -- where am I going to get the lowest chance, you know, for infection or bad outcome when I have a surgical procedure. We just don't have much there under the plan, and so we're going to have to put it together. Thanks.

CO-CHAIR BAGLEY: Okay. Before we go on, I want to do a sound check. Can you guys hear back here?

PARTICIPANT: No.

PARTICIPANT: Not well.

CO-CHAIR BAGLEY: Okay. Can you hear back there?

PARTICIPANT: It's not good.

CO-CHAIR BAGLEY: All right. We're going to have to have some rules.

(Laughter.)

CO-CHAIR BAGLEY: Normally, I say stand up and speak out, but I won't make you stand up because -- unless you have to get closer to the microphone. I want you to project your voice across the room.

When you're answering a question for Rob, you need to be talking to the room, you know, that kind of thing. So talk to the room, talk to the other wall, keep your voice pressure up. And if you're not doing that, I will interrupt you, and it's not to embarrass you.

(Laughter.)

CO-CHAIR BAGLEY: Okay. And also, how about on the phone? Susan, can you hear? She's on mute. And, Chad, are you on the phone?

MEMBER TEETERS: I am, and I can hear pretty well.

CO-CHAIR BAGLEY: Okay. Good. Well, thank you. That's helpful.

(Laughter.)

So, are we ready? Okay. So let me welcome Somava Saha. It's nice to see you. And would you say a few words about what your responsibilities are at IHI --

DR. SAHA: Sure.

CO-CHAIR BAGLEY: -- before you start? Great.

DR. SAHA: I have a slide about it.

(Laughter.)

DR. SAHA: So, first of all, thank you so much for having me here. Can you all hear me?

PARTICIPANT: Yes.

DR. SAHA: Excellent So it's such a

pleasure to be here and just listening to the conversation of some of my favorite topics. How do we actually use measurement in a way that creates good in the world? How do we understand the historic disparities and inequities that can get baked into measurement, the challenge of measurement for improvement versus measurement for accountability?

I have just been sitting here enjoying the conversation, and especially the thinking around like, what is the role of patients and how does measurement actually serve patients and consumers and helps those who are taking care of patients and consumers actually come together in a way that helps that relationship, and helps provide better outcomes.

Can you all still hear me?

PARTICIPANT: Yes.

DR. SAHA: Excellent. Can I go to the next slide?

So I'm going to share with you today a little bit about what we have been up to in

100 Million Healthier Lives. In our effort to identify measures that matter, in a specific initiative called Well-Being in the Nation, I dive deeply into one particular measure that has emerged as a measure that has unexpectedly gone a little bit viral.

So I want to share with you when a measure has -- grows legs and runs away because people like it, we think it's worth at least considering what role that might play in the way in which we think about our work and organize this kind of work.

Next slide.

So who am I? I am a Vice President of the Institute for Healthcare Improvement. I have been serving as the executive lead for 100 Million Healthier Lives for the last five years, which was really borne out of IHI's recognition that, you know, 10 years into the Triple Aim we were not actually moving population health outcomes. Experience was still pretty bad, and cost wasn't any better. And so part of

what we said is there is something missing in this equation. And we knew there were many groups working on this. This wasn't going to be for IHI to solve alone.

So when you said, what would it look like to bring together an unprecedented collaboration of organizations as well as front-line healthcare systems and communities and people across sectors who might hold a piece of the puzzle? It's a network now of about 1,850 partners who reach over 500 million people in the world.

Over the last five years, what we have been doing as they have improved actually a few hundred million lives is source what were the things that were the breakthroughs, that were the frame shifts that could be catalytic and help us see and act differently. And I'll share with you some pieces of that.

My prior work is as Vice President of Cambridge Health Alliance where we led a value-based transformation going from zero to

60 percent global payments in five years, and really redesigned the way we delivered care in a way that improved population health outcomes while taking 10 percent of cost out and substantially and statistically significantly improving joy and meaning of work for the workforce.

And in the context of that, spent a ton of time looking at actually how measures could hurt. We had about 542 to report out on the ambulatory side by the time we did all of the contracting to get to all of those value-based contracts.

Of those 542, 540 of them were measures that were some variation of physical health, most -- up to 13 at a time that were duplicative of each other. Two measures for screening for behavioral health and nothing -- no other measure for behavioral health and no measures for social needs or social determinants, even though our actual analysis of patients and what was moving the outcomes of our top 10

percent was that 85 percent was being driven by social and behavioral determinants, and in the Medicare population, about 60 percent.

And that made us realize that we didn't have a measurement system that was aligned to actually drive our outcomes, that we had too many measures in some cases with duplication, and we had not enough measures.

So we needed a Goldilocks phenomenon of some kind to say, how do we get to something that's not just right but actually simplifies this, so that we can -- in our case, we narrowed it down to 18 measures, including some new measures, that helped us organize. And then think about what the driver measures were and the process measures behind those that could help us move the needle.

And that really started my thinking around this, but all of this for me as a primary care doctor who has practiced in the safety net for over 15 years has to at the end of the day be about what helps us restore our relationship with

patients in a way that's meaningful and actually -- and also moves the needle.

And so I'll just share that I also happen to be at Harvard Medical School, so that's who I am.

Next slide.

In the last -- maybe the next slide. I think it's just waiting to protect.

So one initiative over the last several years that we have been involved with is under the National Committee on Vital and Health Statistics, which is the Federal Advisory Committee, the statutory FACA, responsible for recommending measures for population health to the Secretary for Health and Human Services.

About four years ago, recognizing that improving population health would require a multi-sector approach, NCVHS said, you know, what are measures for social determinants, for population health, that we could actually share across sectors? That it's one thing for us in health care or public health to have measures --

frankly, health care and public health doesn't have a lot of shared measures that we're necessarily using in particular.

But when we know we need to engage the business sector, the social sector, the housing and transportation, how do these entities and what is their measuring and what they have learned about what drives those outcomes, how do those things inform what we're doing?

So they developed a framework called an NCVHS framework, which is now known as the Well-Being of the Nation framework and then Asked 100 Million Lives to steward the process across both federal agencies and non-federal agencies to identify measures for population and community health that would align -- that would help us to get to multi-sector agreement and find what actually works across sectors.

Next slide.

I'm not going to go into a lot of detail about that process. I will say this was done very collaboratively with NQF, who served as

one part of the stewardship team for the Well-Being of the Nation measures. We used the NQF decision criteria and process to, first, do a landscape analysis of measures, and then to identify what measures would work.

And this was really developed to say what measures would work across sectors, and help us think about core measures that could be used across efforts, as well as leading indicators and a full flexible set of measures to learn from that, depending on what you're working on -- housing, transportation, health -- could actually serve as measures that are leading indicators for that sector with enough parsimony and validity and strength to them that they could actually be used in a way that we could compare across with branching measures that could say, how does moving, for instance -- what's the difference between seeing 10,000 people and getting them primary care, giving out brochures in a health fair for 10,000 people and housing 10,000 people, well, how do those who move the larger outcome

measures or core measures? Does that make sense? So that we can begin to learn our way into what actually drives population health improvement and equity.

Next slide.

So started with a landscape analysis, over 500 measures, and then began a Delphi process with groups of people. There were 100 organizations and communities represented, including community residents and patients, as a fundamental part of that. Each of those 500 measures, and the ones that sort of began to be prioritized, were rated based on the decision criteria through NQF that we have identified.

But in the first cycle, we actually said, here are the measures that are all of the existing measures from the landscape. What's missing? So that a single mom could say, actually, for education, this is what's missing. Or a patient could say, this is what I would really like to see. And trust our community member could say, actually, trust the police

matter.

So this is truly, when we talk about multi-sector -- I mean, truly multi-sector -- and measurement experts went and found validated measures that correlated with that, and that all then went into the prioritization and evaluation process to identify what mattered to two different groups of stakeholders, what mattered at the community level, and what mattered at the national level.

And it was actually where there was overlap between the two that we got to prioritize as well as identify what mattered and identifying core measures or leading indicators.

One thing that was very different about this is we sourced measures from different sectors, found out how to process a multi-sector expert validation at the end. We had a process of testing out measures that were emerging as really important, so that this could be theoretical but communities actually got to try them out and say, ah ha, what really worked?

And, you know, for instance, it's in that process that Kaiser Permanente had pioneered a measure about Cantril's Ladder measure. It was also in the RWJF Culture of Health Measures. And then when communities tested it out, this one -- this one was the one that I'll talk about in just a minute -- went really viral.

But that process of testing out was a really important contributor to what actually mattered. And then, finally, we aligned with a number of initiatives, from Healthy People 2030 to a number of other major measurement initiatives that were going on multiple times throughout the cycle.

Next slide.

So what emerged out of this were nine core measures related to the well-being of people, the well-being of places, and equity. And if you think it was a food fight to get to that nine measures alone, like think about out of all of that.

(Laughter.)

DR. SAHA: You know, it actually wasn't nearly as much as you thought, because there are some that actually just emerged as clarifying, and I'm going to share what those are. But the leading indicators definitely were a food fight, and then the full flexible set. There are about 54 measures across 12 domains of the full -- of the leading indicators, and then the full flexible set.

I'll talk about -- just share with you briefly about some of those. But what was interesting about the leading indicators, for instance, in health included for instance things that the CDC is piloting and has been trying out on healthy days for instance, or self-reported health.

It included things like deaths of despair that seem to really drive our drop in life expectancy, that recognizes it's not just an opioid issue. It's actually an issue of alcohol, opioids, and suicide. There is something around hopelessness, and then in the leading indicators,

things like social connection, sense of purpose and meaning, perception of everyday racism, things that are not traditional, we don't necessarily have the data availability to make it a leading indicator, where there is availability of a sub-county level in particular.

But we could actually put those in for testing, because if there was enough data in the research arena to suggest that these drive mortality or other comorbidity outcomes.

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For the well-being of -- I'm just going to go into the core measures. The well-being of people, the well-being of places and equity, that frame ended up being very useful for people. It turned out for some sectors -- health care, business, social sector, community-based organizations -- cared a lot about the people they were directly touching.

Others like public health, community development, economic development cared a lot about places. And so just acknowledging that and

making it -- helping people understand the interconnection was useful, and equity combined the two. So for the well-being of people, how people felt about their own lives using Cantril's Ladder turned out to be by far the most validated measure, along with life expectancy.

It's a leading indicator that moves over time -- we'll talk in a minute. For the well-being of places, we used the Healthy Communities Index, county health rankings, and U.S. News and World Report, actually aligned with their rankings to these Well-Being in the Nation measures.

And then child poverty was a single measure that people said, if there is one thing that tracks with the healthy community, that's actually -- is power to improve long-term population health outcomes. That's the one measure you choose.

And for equity, then, it was differences in how people felt about their own lives, years of potential life lost or gained,

and which is better as an improvement measure than just differences in life expectancy. So that's a measure of 75 minus whatever. So if you stop someone from having an opioid overdose at the age of 35, you gain 40 years. So people could begin to count up years of life gained, and that just felt motivating to people. So people loved that.

Income inequality and graduation rates turned out to be from a place-based perspective incredibly important to driving mortality and correlated with things like residential segregation for which the measure isn't as good. And then differences by demographic variables based on race, place, gender, sexual identity, et cetera.

Next slide.

So Cantril's Ladder is the one that I want to really talk about with you that Michelle really -- and the team at CMS really wanted to talk about. This actually came from the business sector. It has been tried over 10 years in that

sector and relates to the well-being of people. There is -- it has been administered about 2.7 million times.

It's two simple questions. Imagine a ladder where the bottom is your worst possible life and top is your best possible life. Where would you put yourself now? Where would you put yourself five years from now?

It turns out that this measure correlates with morbidity, mortality, and cost, as well as worker productivity, which is the business cared about -- businesses cared about worker productivity as well as employee cost, because those are the things that affected their bottom line.

But from a healthcare perspective, it actually seemed to -- every rung of the ladder, depending on the population, seems to correlate with between 1.25 and one and a half years of life gained, which is huge if you think about two simple questions that can tell you something as important as that.

It also is very useful for risk stratification. So four or below of the ladder, which correlates to suffering as a measure that Gallup has sort has piloted and tried out for a long time, that correlates to your top three and a half percent, high-risk/high-cost people. The category of 5 and 6 are struggling -- correlates with about your next 45 percent, and then the rest is -- seven or higher is essentially thriving.

And the fact that there was some measure that's as simple as this that can correlate with risk bands, meant that people could begin to use them in real time -- for instance, in emergency rooms in Delaware where they could say, "If someone has four or below, they don't pass -- like and they've come in with an opioid overdose or something else like that, like they are being locked to, like it changes how we begin to think about what the follow-up plan is for that person.

And 5 and 6 is going to get a pretty

aggressive follow-up plan, too. So it created a way of sort of real-time risk stratification as well as for payers, because that correlates with cost, can be very useful for thinking in that way.

It works across sectors, so this is super easy to use for small practices, for small community-based organizations, very low measurement collection burden. It also turns out to be the measure that the OECD picked. It was one of two measures that OECD picked for measurement for population health in terms of people-reported outcome measures.

That sort of combined to be really powerful in terms of recommending that you can take the percent of people thriving minus the percent of people suffering to create sort of at an overall organizational level or at a community level an overall life evaluation index.

There is nice data availability in terms of racial and ethnic breakdowns, gender, place, et cetera. And that is all publicly

available through Gallup and has been made publicly available on the WIN site.

And I think that's -- I'm going to -- I am happy to go into sort of how -- in the next slide how people are using this measure. So what happened is when we went back to people who are testing the measures, it turned out that they have actually already -- like they had already adopted the measure if they tested the measure.

In fact, many of them were then -- for instance, the National Councils on Aging was working to scale this to 1,000 senior centers and have begun to adapt, with Administration for Community Living, what this really looks like in an older adult population. In Baltimore, where they did 20,000 administrations of this -- again, this is with no funding from us, no mandate, no demand.

They ended up actually using it to change local policy around senior centers based on what was happening with older adults, as well as being able to use it in their local

programming. And I just offer that kind of example as part of what it means to go viral.

Next slide.

There are five different ways that we found people are using this in the field, and I'm not excluding health rankings like U.S. News and World report from this conversation. The first one isn't an improvement thing, but actually providers find it super useful to have a conversation with people.

So they were like, oh, this helps us see the whole person and have a whole person conversation. It restored the relationship because they could quickly say, "Huh. You're at a four now and you think -- what would it take to get you to a seven, you know, if that's where you want to go. You know, why aren't you a four?" It became a motivational interviewing tool for them that they just liked, and so they wanted to keep using it.

From a risk stratification perspective, they using it at the practice level

or the emergency room or other contexts to rapidly diagnose who might be at higher risk, as well as the population level, planning level in terms of what resources might need to be aligned to meet the needs of people in more real time than we sometimes are able to do.

In terms of identifying equity populations, the simple demographic breakdowns are used for that. From an evaluation perspective, people began using it to say, "Can we see improvement in this over time, and in what time period can we begin to see improvement? And how does that relate to other clinical outcomes that we care about?"

And then, finally, a number of groups have begun -- actually, across states integrate this into population level surveillance both of members -- and I think Kaiser actually did a nationwide survey to actually get these signs. And then Health Partners has done a similar type of measure as well. But then in terms of looking at population level surveillance for the specific

groups -- the Veterans Administration has been doing -- has integrated into the veterans survey, Administration for Community Living has been doing -- looking at the older adult population, as well as a number of community health needs assessments, state health needs assessments, et cetera, by public health.

Next slide.

And I'm just going to end. The other things are the leading indicators have to do with, remember, each of the domains. So there are actually measures that are nationally vetted measures for social needs and social determinants that I invite you to consider.

I think this is something that Elisa and I have been talking about how might be the line and build on efforts and what came out of, you know, how might we measure food or housing or transportation.

Next slide?

This is just an example. This is a tiny clinic back in L.A. that decided to use this

as a measure. They were through the Diabetes Prevention Program. They were trying to improve diabetes outcomes for homeless women.

And as they adapted that program, they measured clinical outcomes like an 84 -- 92 percent improvement in blood pressure, 44 percent improvement in A1C. They used the measure to actually have conversations with people about what would help them actually improve their outcomes. And out of that they ended up getting to the farmer's market as a walk-in group to use their SNAP EBT card, so that they could actually solve some whole life challenges that people were having.

But the measures that clinicians and patients cared about that actually made sense to both of them was that the percent of people suffering declined, and the percent of people thriving increased, like that was fundamentally important. It moved within six months by 30 percent, 84 percent by the end of a year. And that -- the movability of the measure when you're

doing it at dose for a population was one of the things that I think has emerged and been really important in testing in the field.

This is -- I just want to acknowledge this is testing. If we -- as we have talked about this, what we have said is, this is an opportunity for people to learn. If there is accountability around this, it should, at the first, be to collect the measure and to learn and to use it in improvement processes, so that we can actually understand how to improve people's lives, because at the end of the day, if people don't feel like their lives are getting better, we have to ask ourselves, are we actually making enough of a difference?

Next slide.

And then this is at the population level. It might be a little hard to read. But the -- in Delaware, they are using this across for all of their patient -- people with mental health and addictions to redesign their system of care. So their outcome measures are improved

well-being in terms of their own -- for people suffering from mental health and addictions.

Improved mental health and addictions outcomes -- so this is using reduced -- the leading indicator of the reduced deaths of despair as their end outcome, and then your -- another of the poor indicators of years of life gained as well as life milestone regained.

So they are using some of those leading indicators of jobs and education, et cetera, to understand what they're doing and then thinking about economic indicators of thriving, resilient communities, and then have process measures aligned to make sure, for instance, that they are engaging in stabilizing everyone.

So those might be specific to the initiative. What percent of people who are seeing with a diagnosis of mental health and addictions were screened and connected? What percent of the connections actually made it there, et cetera? So, and of those who made it there, how many were engaged in primary care and

mental health services over time?

So this isn't about getting rid of the measures we have. It's contextualizing where those fit in in the context of improving overall well-being outcomes.

And I just want to just stop there. I have lots of other examples, but I think question and answer time might be important, so --

MEMBER SCHREIBER: Well, and I just want to open to the group and ask our --

CO-CHAIR FIELDS: Please speak up and speak out.

MEMBER SCHREIBER: I'm usually not told I'm quiet. Open to really the group. You are our advisory group for clinical programs, and I've shared with you kind of the directions that we're thinking that meaningful measures prioritizes patient safety; electronic, which to me is seamless communication; patient-reported outcomes, mainly unleashing the patient voice here; and ensuring that care is concurrent with

patient goals; population wellness; possibly adding workforce to this; and affordability.

And so just to throw this out, are these things that resonate? Are we missing things? And what do you think of shifting focus to new kind of ideas like what was presented here from IHI? So thank you, really, for the opportunity for us to bring this to all of you for some discussion today.

CO-CHAIR BAGLEY: You had your card up first, Rob.

CO-CHAIR FIELDS: Yeah. So --

CO-CHAIR BAGLEY: Quick on the draw.

CO-CHAIR FIELDS: So I appreciate it. It was really compelling. I don't know if you remember, you and I met in Asheville several years ago at a -- when you gave a talk there.

It's obviously really interesting to start to get large delivery systems -- large and small -- to start thinking about not only social determinants measures that we know are large drivers but patient-reported outcomes. In this

way, I mean, I've long been a believer are collecting this.

But relative to the comments we heard earlier, the use of measures for behavioral change, culture change, evaluation -- I shouldn't say -- behavior change and culture change and maybe resource planning and guiding is very different than evaluation.

And so as much as my, like, heart and soul believes in measuring this stuff and looking at it from an observational and then planning and resource planning standpoint, and for behavior change, I get really antsy if it starts to like get over into performance evaluation based on these kinds of measures, for the basic reason that the industry is completely not ready. And they should be, right? But they are completely not ready.

So if we -- so if we do this evaluation, I would guess that a majority -- if I'm a primary care physician, a majority of primary care physicians and hospital systems, et

cetera, know very little about how to react and what to do when they get a negative result, and it feels really bad.

And the same issue about social determinant screening and the primary care practices. There's a lot of stuff. We focus a lot on assessment and screening, relatively little on the operational discipline it requires to actually close social determinants gaps.

And, once again, it doesn't do you any good to make a referral to a social worker who says, oh, go see these five CBOs. Good luck. Have a nice day. It does zero good. And worry that will end up with sort of a half-baked solution if we're not providing some of the resources or guidance about what to do.

CO-CHAIR BAGLEY: Peter, you're next.

MEMBER BRISS: So I was delighted by this. I've been around a lot of these tables over 20 years, and I used to be the senator from public health. I had a mostly clinical table, and I'd get looks that looked like I used to get

for my vehicle. They were like --

(Laughter.)

MEMBER BRISS: And so I'm delighted that -- I'm delighted that everybody is talking about this now.

I think if there was -- and I'm delighted about the progress, and it strikes me that there was a -- there was a major gap. So most of what you talked about -- and this is for clinical audiences, so it might make sense. But most of what you talked about was sort of -- sort of addressing social determinants one person at a time, right?

And so some of that -- some of that makes sense in a clinical context. I think that -- I think that as health systems get bigger, there is probably more that they could do on sort of an organizational level to react to this kind of stuff.

And so, for example, I keep saying that from an organizational perspective, sending out your chief medical -- chief medical officer,

who might carry a lot of weight in a community discussion, could do more by talking about smoke-free air laws probably than any amount of smoking cessation delivered by individual providers.

And so it would really be good to complement some of the good stuff that you have here with more genuinely population-based stuff, because I don't think we're going to -- we're going to get to addressing social determinants by trying to address one patient one at a time.

DR. SAHA: I was asked just to largely focus on Cantril's Ladder today and was speaking to the clinical audience here. But most of it isn't actually that. So the leading indicators and much of the things focused on the well-being of places and equity are actually very much the more population-level pieces. The CDC has been a wonderful partner in --

MEMBER BRISS: As it always is.

(Laughter.)

CO-CHAIR BAGLEY: Helen.

MEMBER BURSTIN: Thank you. So, thank

you for that great presentation, that was really helpful to hear. I've been following it for years, it was great to see how it's matured and where it's come.

I think I'm going to build on the comments Robert made because I think this is phenomenally interesting work. And it's interesting CMS is presenting it to the clinician worker because I think part of the disconnect is, this is brilliant, this is great work. It's really important at a community level. It's not clear how it's translatable.

PARTICIPANT: Okay.

MEMBER BURSTIN: And I think that's going to be the key. And the one thing Robert, that I had written down before you said, learn how to use it first.

Like, really learn and improve before, I think the kiss of death sometimes is to push something into a program before it's ready and then just get a negative background from clinicians who recognize it's really important,

but yet, because of the way it's used it has an unattended consequence.

So I think that would just be one point is, really great work, put it out there, begin to understand what level of analysis makes sense, how do we begin looking at a community level, population health, what does that look like. I do think these are extraordinary researches for improvement.

I will say though, back to your earlier comments, Michelle, and I was waiting, I followed instructions, waiting until after the presentation to go back to your measures of that matter, 2.0, I do think a lot of those elements are going to be really important going forward, and I can see some of those emerging at the clinical level.

So just one interesting thing is, you raised the question of access, and I just want to speak to that. We've been doing some work with the American College of Surgeons on a grant with the NIH looking at surgical disparities.

Actually, initially some work with NQF early on.

And one of the things we found is, we looked across the five phases of surgery to understand where disparities are, they're all access. It's actually getting in the door is actually where the disparities happen, not so much once you're in-house.

And I feel like we spend a lot of time only looking at where we have the lamp post. We know where there is information when somebody is already in the system.

So I would say access and disparities would be really important. And I think even for a clinician level. The ability to look across your populations is increasingly becoming something very doable.

I do think the points you raised about diagnosis is important; as you know, this is a big issue. Several of our societies have gotten awards from the Moore Foundation to develop new measures in this space.

And I hope, one last comment is, I

hope you will also look to see what's out there first before you begin developing measures. The Moore foundation has put up a bazillion dollars. I think it's $60 million in measured development in the diagnostic space. I think it's really important to begin looking at what's out there.

Similarly, I mean, for example, the comments you're making about sepsis mortality, there's a measure from New York State that is already out there and developing.

So I guess the question is, can you begin to increasingly, so this builds on something Bruce said earlier, go to where measures are used with good experience. They've been used for improvement, they have a proven track record.

You have thousands of them, I'm sure at Henry Ford, who'd begin to start a process, similar I think to what someone described it, what are people actually in the community, in health systems, in clinician offices using already that we can begin bringing forward that

we know work, rather than always assuming we have to do a de novo extra development effort, and then wait to see years and year later if they're effective.

And then lastly, I just want to speak to the decreased number of measures, and that is certainly a delight as somebody who lived at this table, when we had hundreds of measures and a hundred, we had three hundred measures of the clinic, and that was not fun and we felt like our heads were just spinning in place.

But some of that also reflects the fact that generally we're not, many clinicians are really only using the registry pathway at this point.

So important to note, there's a whole set of measures we're not talking about that actually are increasingly getting at the priorities you're talking about. And we'd like to push further in that direction.

But I think, again, the small number of measures here is helpful and pleasant. But I

think also is reflective of the fact that we're just not submitting measures to the MIPS list. And that's a bigger issue, I think, of where so much of the action now is using fire, APIs, clinicians registries and how do we begin connecting those dots to the bigger picture where claims is useful, where electronic data sources are useful, so, that's it.

CO-CHAIR BAGLEY: David.

MEMBER SEIDENWURM: Well, Helen said a lot of what I was going to say but much better. But one point I would like to make that remains is the interaction between workforce well-being and electronic quality measurement because one of the great dissatisfiers among our clinician workforce is electronic medical records, lack of improbability, lack of user friendlessness, additional cognitive burden that distracts them from patient care.

And to the extent that we rely upon electronic quality measurement that depends upon specific field entry, that will be an increase in

burden that will dissatisfy our clinician workforce and ultimately result in poor patient care. So, that is just something that we have to consider.

The other point I'd like to make is that when, in many communities, even affluent communities, but especially in safety net communities, when clinicians know what a patient needs but they can't get it for their patient, that's another problem with our workforce satisfaction. And of course our patient outcomes.

And so, it's very difficult for, in some circumstances, for clinicians to feel like they're being measured for something that they know they want to do but find it very difficult to do so. Those were all things that we need to be consider.

CO-CHAIR BAGLEY: Sandy, you had your card up, did you --

MEMBER POGONES: I put it down.

CO-CHAIR BAGLEY: Okay. Amy.

MEMBER NGUYEN HOWELL: Thank you for the wonderful presentation, it was great. And to Holly and Mark, Charles. So my question is --

CO-CHAIR BAGLEY: Can you go ahead and speak up please?

MEMBER NGUYEN HOWELL: My question is for CMS. In the work that you're planning to do with wellness and prevention, we completely applaud it at America's Physician Groups.

And the question is around aligning incentives with that. So we're talking about EPMs, we're talking about population, health management, we're talking about wellness in the physician workforce.

So, how are you planning, as you're thinking about timeline, for aligning incentive payments as we talk about value-based incentives with respect to these measures?

MEMBER SCHREIBER: I think that there is some belief that we're not going to really make a dent as large as we would like in the quality until the majority of payments are value-

based payments. And so, the answer really is to continue to move to tied combined. Either shared savings models, ACAs, whatever, but some kind of shared risk in value-based training.

And what's the time frame of that is, I mean, there was a commitment after the LAN meeting to move 100 percent of payment there by 2025. I don't know that that will happen, but that's the current commitment from the table.

MEMBER NGUYEN HOWELL: Yes. And so I guess, we would request to take advantage of this wellness opportunity to align the incentive payment --

MEMBER SCHREIBER: Yes.

MEMBER NGUYEN HOWELL: -- with the wellness measures. Especially for pop health management and as it will bleed into the payer world with --

MEMBER SCHREIBER: Right.

MEMBER NGUYEN HOWELL: Design.

CO-CHAIR BAGLEY: Stephanie, you've been patient back there.

MEMBER FRY: Oh, thank you. And I think the contents so far this morning has been incredible as have the comments.

And tying into a little bit of what Robert said, to kick this discussion off, I think there's a really important piece that will face CMS in terms of translation of measurement.

And Robert brought it up in terms of translation for clinicians in terms of, okay, so we get these measures and we're not doing well, what do we do with that. And I think that's really important.

I think it's also important on the patient side to look at that. For example, as CMS is looking at payment models and value and looking to Medicare beneficiaries to make good informed decisions around that, there's a huge knowledge gap when you talk to patients about cost of care, their first reaction is, well, I mean, don't skimp on my care. Like, I don't want my care to be low cost.

Not making the connection between cost

and complications and unnecessary sort of that broader spectrum that is maybe more clearly under student within a clinician setting. So I think that really strong measurement is obviously the foundation.

And then the piece where the needle I think will be moved is where you help people do that translation from the clinical side, from the patient side into, what can I now do to move that. So, I lay that at your doorstep with everything else to figure out.

(Laughter.)

CO-CHAIR BAGLEY: Louise, you're next.

MEMBER PROBST: I also really appreciate --

(Off record comments.)

CO-CHAIR BAGLEY: Speak up please.

MEMBER PROBST: Okay. Is that loud enough? No?

(Laughter.)

CO-CHAIR BAGLEY: Well, I have my hearing aids in on the right, you can --

(Laughter.)

MEMBER PROBST: I appreciate when you said that it's been tested and so it correlates to morbidity, mortality and costs. That's good news, I think, from a purchaser perspective.

There is something that's been done somewhere to this in the past, and maybe you're familiar with it, through Gallup and Health Place. And so, they've done this for some time and looked at communities and political districts and employers.

There was an effort to really engage employers in the HR departments to understand how this looked and then to provide benchmark data. I don't know whether they're still doing that.

It was pretty expensive. There were some employers that purchased it but it wasn't something, it was too expensive for them to purchase every year.

So if it was done on a broader scale, I think you would find employers, if they weren't also purchasing the benchmark data, interesting

in knowing how they're workforce looks compared to others.

DR. SAHA: So, the two questions are sort of a main outcome questions in the larger Gallup-Healthways Index. So the index is expensive.

Of course the two questions are very simple and relatively cost effective. And they remain very interested in how this relates.

And they see the work that they've done for the last ten years in developing, trying this out, it's used in the world, happiness study.

It's what New Zealand is aligning they're budgets around now. They see this as part of their public good contribution at this point to allow these measures.

CO-CHAIR BAGLEY: Ann, you're next.

MEMBER GREINER: Thank you for such an exciting presentation. And it made me excited about measures again.

(Laughter.)

MEMBER GREINER: And I do agree with Helen that there is some caution because you move something into a public program obviously there is so much work. And I'm sure that Michelle, you understand that.

MEMBER SCHREIBER: Flattering.

MEMBER GREINER: So I'm excited that you are all connected and trying to figure out how to move this work forward.

I would like to use this measure right away. We're writing a grant to try to bring primary care and community-based organizations together around the diabetes prevention program.

PCMH, 42 percent of docs are in a PCMH. They're really not very well connected to the community. We have a evidence-based program that the Y's and other community based organizations administer. So how do we bring that together.

And we've got all the clinical measures, but it would be, if this really is as it appears, so easy to administer and so focused,

I think this would be a wonderful compliment to looking at those clinical measures.

So, I'm really excited to think about something that is whole person oriented that could give information both back to the clinician and back to the patient. And that at the end of the day, yes, people are going to be excited about the clinical measures, but to think that the population could move on that ladder, because of an intervention to help people stay healthy and not actually transition to becoming diabetics is really very exciting.

CO-CHAIR BAGLEY: Okay. Sue, you're next.

MEMBER KNUDSON: Yes, thank you. And I apologize earlier, I was on the line but I accidently hit the line button instead of unmute button --

(Laughter.)

MEMBER KNUDSON: -- to respond when you called me. So I'll pay more attention to that.

Now, I wanted to comment on the IHI presentation. I appreciate the comment about how partners are doing some measurement development in the space too, but just briefly, because I want to also take up what some of the -- were saying earlier about kind of usability and how practical it would be.

So what we've done is created a, what we call a summary measure of health and well-being, the Step Three (phonetic) performance. Measuring where our constituents are at using disability adjusted life years.

So we map that to the global burden of disease ranking to see what causes burden. And interestingly it's the, it's like muscular, skeletal and psychosocial and neurological disorders.

So it's the things that carry us through life. Not necessarily those that cause mortality, which was a super interesting finding.

Our second measure is from where we're headed, which is a sustainability measure more

around optimal life skills. Like health eating, moderate alcohol use, non-tobacco, healthy thinking, sleep and preventive services up to date.

And then third is how we feel about it. Or our wellness in that is based on a literature based single question about how satisfied are you with your life.

And we've measured this for adults. We are building up for kids. But in our strategic planning, which I think goes to the sum of the commenters questions about how applicable this is, presenting some five year goals to test to whether or not we can move these measures, particularly across all three of them.

And are focusing on really healthy behaviors. And the furthest upstream component can make a difference.

So I think it would be really good for us to trap together on this. And our team will be co-presenting with Kaiser on this concept at the IHI forum.

So, it is really interesting sort of next level work about getting to really driving healthy communities. But we'll be testing some of that in using our care group and our health plans.

So I think it's important work for us to keep on the radar. And we'll definitely keep the group posted with our ability to actually do meaningful interventions.

And not to put the burden on primary care teams, but how we use more of a systems approach to do this.

CO-CHAIR BAGLEY: Kevin.

MEMBER BOWMAN: First of all, thank you for the presentation, it was excellent. And a lot of the data sounds really good.

I wanted to comment on, I think it was a comment that David made about the --

CO-CHAIR BAGLEY: Can you speak up please?

MEMBER BOWMAN: -- some of the interoperability challenges for providers. And I

think there is also a pension interoperability challenge for payers as well.

And so, at the end of the day, in order for payers and providers to collaborate and work well together, I think having access to good comprehensive data that we can get quickly, and then deal with the feedback and work with providers, that's where I think it would help tremendously.

And I think providers are having challenges and we have challenges. I think at the end of the day you can't do anything unless you can measure it and get it back, have people respond to it quickly and effectively. And not have to wait months and months.

CO-CHAIR BAGLEY: Peter.

MEMBER ROBERTSON: Michelle, I wanted to respond to your question about the meaningful measure domains.

And from a purchaser's perspective I think we every much agree with these domains. Particularly leaning towards the patient outcomes

in electronic measurements, patient's safety. Those are really priorities for us as well. So, we're going to lighten that.

I think what I'd also offer is what everything sits on top of that is bringing together the sort of community of payers to focus on aligned measurement across the payers. Not only that we have the same measures but actually specified the same way and we're not measuring them differently in the Medicare versus the commercial space.

And then again, Peter mentioned about transparency. Transparency of the results being a priority for us as well.

MEMBER SCHREIBER: Thank you. And I do, again, want to reemphasize this work that we've been doing with AHIP to sort of cross all payers with the federal measures too because we completely agree on alignment.

CO-CHAIR BAGLEY: David.

MEMBER SEIDENWURM: Yes. I'm going to amplify on Kevin's amplification because --

(Laughter.)

MEMBER SEIDENWURM: -- super important point. One of the big problems that we have in communicating quality results and performance measurement is that patients change from one payer, from one provider, to another. And often their data don't follow them.

And we see this between private payers. There is some from Kaiser when someone comes from Sutter to Kaiser, Kaiser to Sutter because they're just from Anthem to another carrier. Switches from the commercial world into the Medicare world.

And some of the metrics, for example, colorectal cancer screening, you know, is a ten year window, we start from scratch. And yet we know, you're talking about EQMs, we know in our electric record, we have records that some of these things occurred, but we have no very easy or reliable way to communicate them back to the payers.

And so, it's a really big problem.

And I think it's one that was addressed at the first MAP.

At the first MAP is this problem of interoperability and data portability. And I think we've made some progress but I think we have not made nearly enough.

CO-CHAIR BAGLEY: Kevin, last comment.

MEMBER BOWMAN: Really quick. And I agree completely. And I think there is a difference between clinical data that's billable and what's in a record that you can get access to easily. And they're not always one in the same, and it causes for the patients.

CO-CHAIR BAGLEY: All right, I have a couple of comments for myself.

One would be, first of all, I love this, this is great. It's useful, it can be broadly used. I think we have to have some caution, and this is all going to fall to primary care unit or their systems that support primary care probably would be better.

And be careful about putting the

social problem that we have onto the medical system, more than we've already done. And you've seen the slides where we've spent twice as much money as any other country on medical care.

There's another slide that people don't usually show, and that's that everybody else spends all that delta and money on social services that we don't. So we keep pushing the social service problem on the medical and then complain that it's too expensive. So that's one thing.

The other thing is, it's kind of a bigger suggestion and that is, when I looked at the questions, Cantril's Ladder, I suspect that they correlate very well with things like workplace productivity in the business world.

I think they probably correlate very well with crime and violence and school shootings, by the way. People that do this stuff are probably pretty low on the ladder would be the --

So, get these other communities to

rally around this idea and it will go much further than if you load it on medicine or on.

DR. SAHA: Can I just respond quickly? If you go to the next slide.

(Laughter.)

DR. SAHA: The whole idea of the well-being in the nation is it's not any one sector's job alone to improve these. So, Cantril's Ladder isn't something that we're coming to help care to say it's your job --

CO-CHAIR BAGLEY: Right.

DR. SAHA: -- we're actually saying to all of these groups, Cantril's Ladder, child poverty and graduation rates. Like, this is actually a fuller view of what we need to do to improve population health, and it's all of our jobs.

And what's exciting is the range if other sectors that are adopting Cantril's Ladder because they're finding it useful. So it actually creates the potential for that collaboration to say, how do we move this.

And Kaiser actually nicely did a study to say what it correlates with. And financial security and your report of your health are the two big things that it correlates with.

So there is actually real reason to think that what we do in health and healthcare matters in moving the measure. But also what we do to improve people's financial support security matters.

CO-CHAIR BAGLEY: Great.

DR. SAHA: The Surgeon General's Report that's about to come out that links these two actually speaks about that.

CO-CHAIR BAGLEY: Great.

DR. SAHA: But I totally agree and, yes.

CO-CHAIR BAGLEY: Yes.

MEMBER SEIDENWURM: I just have a quick comment.

CO-CHAIR BAGLEY: Yes, Dave.

MEMBER SEIDENWURM: On the transparency issue, I'm fully all about

transparency, both on the internal physician's side to drive improvement, right, of course as a lot of us do.

But also recognize on the consumer side it's pretty challenging. Like, there is plenty of evidence to suggest that consumers probably don't make many health care decisions based on quality, and make it based on cost and convenience.

I think that's particularly true for the poor. They make it best on, primarily on where they can get access, which is grossly limited, right, as you all know.

And I appreciate that education obviously is part of the things that put context behind transparency and quality of data, but I'm not necessarily sure that education is nearly enough to actually make, to really drive consumers to choose higher quality providers, I think we all know that. It somehow has to be reconciled.

It seems like access is the number one

thing and then everything else is sort of secondary because the quality of data, how much education we provided it's not likely, I think, to drive people to choose the best provider.

CO-CHAIR BAGLEY: Okay, this has been a great presentation and I think it's the time to move on. And I'm sure this will come up more as we talk about some of the measures.

So, Kate --

MS. BUCHANAN: Yes.

CO-CHAIR BAGLEY: Do you want to take over again?

MS. BUCHANAN: I would, yes. So we will, just prior to our break we're going to briefly re-review the preliminary analysis algorithm and the voting, and then we will have a break.

So, one moment while we pull the slides up. Okay.

So, we are going to, as I said, review the preliminary analysis. So, the preliminary analysis is intended to provide MAP members with

a succinct profile of each measure and to start us with a starting point of that discussion. So it is just --

CO-CHAIR BAGLEY: Speak up.

MS. BUCHANAN: Oh yes, I thought I was yelling so loud. Sorry.

(Laughter.)

MS. BUCHANAN: My apologies. So, the preliminary analysis is really the start of the discussion. It's just a foundation for which the workgroup can use as a resource.

And the staff use an algorithm developed from the MAP measure selection criteria and is approved annually by the coordinating committee.

So, I apologize for the small slides. These are all things that everyone has seen before. We have our seven criteria for the preliminary analysis algorithm.

The first is a premeasure. Addresses a clinical quality objective not adequately addressed by the measures in the programs yet.

The second is that the measure is evidence-based and either strongly linked to outcomes or is an outcome measure.

The third criteria is that the measure addresses a quality challenge. I'm not going to go through all of the definition outcomes, we did it during the October meeting, but if there are any questions I can clarify at the end I'm happy to do so.

So, if we move on to the next criteria. The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.

The measure can be feasibly reported. And then our last two criteria, that the measure is applicable to and appropriately specified for the program's intended care settings, levels of analysis and population.

And lastly, if a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified. So that is an overview of our

preliminary analysis algorithm.

For our voting decision categories, we have four. They are unchanged from last year. All the same, I am going to go through them because I think that that's always a point of discussion that we have. And any additional clarification is always helpful.

So when we say support for rulemaking, our definition is that MAP supports implementation with the measure as specified. And has not identified any conditions that should be met prior to implementation.

Conditional support for rulemaking means that the MAP supports implementation of the measure as specified, but has identified certain conditions or modifications that would be ideally addressed prior to implementation.

Moving on, one of the ones that we always have good discussion on is, do not support for rulemaking with potential for mitigation. And what that means is that the MAP does not support implementation of the measure as

specified.

However, MAP agrees with the importance of the measure concept and has suggested modifications required for potential support in the future. Such modification would be considered to be a material change to the measure.

Now, material change is defined as any modification to the measure specifications that significantly affect the measure results.

And then finally we have, that does not support the measure. Which is, do not support the rulemaking.

So, Bruce, do you want me to go through the voting or do you want me to do the questions now? What do you think is best?

CO-CHAIR BAGLEY: Well, let's just have a brief pause. Most of you have seen this before, either at this meeting or in the preliminary information. And it will become pretty obvious how this works once we start voting.

MS. BUCHANAN: Okay.

CO-CHAIR BAGLEY: So, all right, go ahead.

MS. BUCHANAN: Great. Speaking of voting, for voting process. So, a quorum is defined as 66 percent of voting members of the committee present, in person or by phone for the meeting to commence.

I will tell you, we have 24 voting members total on the clinician work group. Via phone or in person we have 22 in attending. So we have a quorum to begin the meeting discussion.

And so, a quorum has been established prior to voting. The process, so, it's taking roll call, which we did earlier, determining a quorum is present.

And then moving forward, a quorum will only be reassessed if a committee member asks, you know, do we still have a quorum. So that is to begin the discussion.

To actually vote in what is considered consensus, is a threshold of greater than or

equal to 60 percent of voting members. So we have 24 potential voting members are clinicians.

That means that to have 60 percent we have to have at least 15 people voting in support of one of the choices. And Staff will be working to make sure that as we go through that is established and that we are able to reach that consensus. But just as an FYI, those are the numbers we're looking for.

MEMBER SCHREIBER: Kate, I'm sorry to interrupt.

MS. BUCHANAN: Yes.

MEMBER SCHREIBER: I thought you said there are actually 22 people present?

MS. BUCHANAN: So, there are 22 people present, but because we have 24 potential voting members, our denominator is actually 24.

CO-CHAIR BAGLEY: That's not how Robert's rules work.

MS. BUCHANAN: Oh.

CO-CHAIR BAGLEY: Unless you have a different rule that changed.

MS. BUCHANAN: Okay. Then I will reassess the numbers prior to us voting.

CO-CHAIR BAGLEY: Yes. Those are two different numbers. The quorum number --

(Simultaneously speaking.)

MS. BUCHANAN: -- higher, yes.

CO-CHAIR BAGLEY: -- that would be 60 percent of those present and voting.

MS. BUCHANAN: Okay.

CO-CHAIR BAGLEY: Is that correct?

MS. BUCHANAN: Then I will reassess that number and share it with everyone.

MEMBER SCHREIBER: That's how it was done last year too.

MS. BUCHANAN: Okay, thank you. Abstentions do not count in the denominator. And every measure under consideration will submit a decision.

So, can we move on? So the voting principles, so we will open with staff providing overview of the process for establishing consensus for voting.

And then additional introduction presentations from the staff and the chair to give context in each programmatic discussion. Voting will begin.

And the in-person meeting discussion guide will organize the content as follows. So the discussion guide has been shared with everyone. It's on the NQF public site. It's also attached to all of the calendar invitations.

And measures of consideration will be divided into a series of related groups with notices of discussion and voting. And so, it's often for clinician's condition categories, but since we have fewer measures section it's actually just by -- votes.

Each measure under consideration will have been subject to a preliminary analysis based on the decision algorithm that we reviewed. And the discussion guide will note the preliminary analysis decision.

It also provides a rational and it links to all public comments received prior to

this meeting. So when we had our public commenting period from November 19 to 26, all of those public comments were in a discussion guide and they're linked.

So we have our five step process which is that, well, first we have public comments but then Staff will review the preliminary analysis for each MUC. And the lead discussants will present their findings.

We have a rural liaison with us and the rural liaison will then present information from the rural health workgroup's review of each measure.

The co-chairs will ask for clarifying questions from the workgroup, and the co-chairs will compile all workgroup questions.

And so, this is the opportunity where measure developers can respond to clarifying questions, lead discussants and questions that people have on their analyses, as well as staff can reply to any questions on the process.

So then we will vote on acceptance of

the preliminary analysis decision. And so, this is where we ask, do you agree with the preliminary analysis decision of, and it's either one of the four categories, if greater than or equal to 60 percent is yes, then that will go forward to the coordinating committee.

If it is less than 60 percent, then we will actually open up the measure for additional discussion. And so, the co-chair will open it up for additional discussion.

As we ask, due to time constraints that if someone has said something that you agree with, acknowledging that but maybe not repeat it.

And after discussion the co-chair will open the MUC for a vote. NQF staff will summarize the major themes to the workgroup's discussion. The co-chairs will determine a decision category to put forth on the vote based a potential consensus.

And if the co-chairs do not feel there is a consensus position to use to begin voting, the workergroup will then go from support,

conditional support, do not support for mitigation and then do not support.

Tallying the votes. So, in order for agreement we need greater than or equal to 60 percent. That motion will pass and will go forward to the coordinating committee.

If no decision category issue is greater than 60 percent, 60 percent to overturn the preliminary analysis, the preliminary analysis decision will stand. This will be marked by the staff and noted for coordinating committee's decision.

MR. STOLPE: Kate, may I step in for just one moment?

MS. BUCHANAN: Please.

MR. STOLPE: I just want to clarify that we are going to be using the current committee existing voting members who are present as the denominator for our consideration to get to that 60 percent. And it is 60 percent equal to or greater than.

So if we hit 60 percent exactly then

it will pass.

The other point that I wanted to make is related to the second bullet. Because the first step of our process is to consider the Staff's preliminary analysis. And if that is rejected then we'll go through the step-wise process.

If we don't arrive at consensus on one of those, we go back to the Staff's original recommendation, and that is what moves forward.

And I would like to spend a moment explaining the rationale to that. Because if it does that, then it never feels good to somebody in the room. Somebody is really not going to like that.

Each one of these decisions that we make as a workgroup is going to be passed on considered by the overarching oversight committee, our coordinating committee. And not fully re-adjudicated, but discussed, considered and voted upon to accept your recommendation.

If you do not have a recommendation

that you came to consensus on, then they will need to go through a step-wise process. So, all the richness of the discussion that you have for measures that you accept, for measures that you don't or for measures where you do not arrive at consensus, will travel with this decision category as the, to accompany, to the coordinating committee.

Unfortunately, if we do not arrive at consensus, then it will need to be adjudicated by the coordinating committee and they will consider all of your discussion when they do that.

MS. BUCHANAN: And I just want to update my numbers based on 22 voting numbers. So in order to proceed greater than or equal to 60 percent, we need 14 people voting in agreement. So those are the updated numbers. So 14.

CO-CHAIR BAGLEY: Okay.

MR. STOLPE: Can we pause for questions, I just want to make sure we're clear.

(Off record comments.)

(Laughter.)

CO-CHAIR BAGLEY: Okay.

MS. BUCHANAN: Okay, great. And then one last thing, we do want to discuss our MAP rural health workgroup charge. And so we have Kimberly Rask here as our liaison. Thank you very much, Kimberly, for joining us.

As the rural health workgroup met via the web meeting last month to provide timely input on the measure issues to other MAP workers and committees, from the rural perspective on selection quality measures in MAP, to help address priority rural health issues, including the challenge of low case volume.

And as I mentioned, Kimberly is able to join us in person.

So, just a little bit of background in what the rural health workgroup discussed. So, when they reviewed the MUCs they reviewed the relative priority/utility of MUC measures in terms of access, cost or quality issues encountered by rural residents, data collection and/or reporting challenges for rural providers,

methodological problems of calculating performance measures for small rural facilities, potential unintended consequences of inclusion in specific programs, gap areas in measurement relevant to rural residents/providers for specific programs.

And in our measure discussion guide, we have a qualitative summary of the rural health workgroup discussion of each MUC. And the voting results that quantify the workgroup's perception of suitability for the MUC for various programs. And that is all.

CO-CHAIR BAGLEY: Okay. Kimberly, did you have a few comments?

MEMBER RASK: Yes. Thank you for letting us come and speak for the group, for the larger group, to bring the input from the workgroup.

To know we spent three days, three separate sessions going through all of the measures, both for this group and the other MAPs and the discussion was really rich. It was very,

you know, a range of perspectives.

And I'm going to try to bring that to your attention where there wasn't agreement or where things were kind of broad. And what I will say overall, which you'll hear kind of their four themes, I think you'll hear from me, that came through in looking at these measures as part of the group.

One aspect of concern about a measure, because it particularly, it was the perspective of the group that it particularly disadvantaged rural providers because of their context or their environment.

A second perspective might be that a measure was particularly relevant and important for rural residents to ensure that they're receiving the similar quality of care as those who live in non-rural communities, as sometimes there's a tension between the provider perspective on whether or not they think the measure is doing what it needs to do and whether or not the beneficiary perspective feels like,

well gosh, I'd like to know that information.

The third mention or aspect is the low volume. And usually their low volume concern is just that it's just not useful for rural providers because either the service is not provided or else it's done so infrequently that a quality measure based on that would be of no benefit to assessing quality in rural situations.

And then the fourth one, which is not as common, but sometimes there were agreements or disagreements with the measure itself, independent of its rural nature. Where they're just, people didn't like the way it was specified or people really did like the way.

So, those four themes are going to kind of hear, as I bring the comments forward, and often how the final vote ended up with people's relative perspective on which input or which perspective kind of was most important for that particular measure.

CO-CHAIR BAGLEY: Thank you. We're due for a break. Any questions before the break

on procedures?

Like I said, I think you're going to find as we get into it, it's pretty straightforward. And if it's not, stop us.

(Laughter.)

CO-CHAIR BAGLEY: All right, we're going to take a break. Back at 11:15 sharp.

(Whereupon, the above-entitled matter went off the record at 11:04 a.m. and resumed at 11:16 a.m.)

CO-CHAIR BAGLEY: Okay, I have 11:15. Let's get started. All right, time to be quiet and be seated. Hello? All right, thank you for that. All right, Elisa, you had something?

MS. MUNTHALI: Yes. So we had four --

CO-CHAIR BAGLEY: Speak up.

MS. MUNTHALI: We had four workgroup members that were not here when we initially did introductions and disclosures of interest, so I'm going to call on them then to make sure that, for the record, they introduce themselves, let us know who they are, and also, let us know if they

have any conflicts, anything to disclose.

CO-CHAIR BAGLEY: All right.

MS. MUNTHALI: So, we'll start with Ann Greiner. Sorry, Ann. Introduce yourself --

MEMBER GREINER: Sure. So I'm Ann Greiner, president and CEO of Group Primary Care Collaborative, formally the Patient Center Family Care Collaborative. And I have nothing to disclose.

MS. MUNTHALI: Great, thank you. Amy?

MEMBER NGUYEN HOWELL: Amy Nguyen Howell, Patient Medical America's Physician Groups, nothing to disclose.

MS. MUNTHALI: Great, thank you. I don't know if Robert came back --

CO-CHAIR BAGLEY: He's coming through the door.

MS. MUNTHALI: Hi, Robert.

CO-CHAIR BAGLEY: Robert.

MS. MUNTHALI: Hi. So, oh no, you can stay there.

(Laughter.)

MS. MUNTHALI: We're going through disclosures of interests and introduction of the folks that didn't go through in the beginning. So if you can tell us if you have anything to disclose. And your name and who your with?

MEMBER KRUGHOFF: Robert Krughoff.

MS. MUNTHALI: Perfect. Thank you. And, Chad, on the phone.

MEMBER TEETERS: Yes. This is Chad Teeters, Executive Medical Director for a Capital Health Partners with University of Rochester and I'm representing the American College of Cardiology. And no disclosures.

MS. MUNTHALI: Thank you, Chad. I'll turn it over to Bruce.

CO-CHAIR BAGLEY: Okay. Now we're going to move on to the Merit-Based Incentive Program. And we're going to start with a brief description of the program and then ask a public comment, which is our new way to do this, so that the public gets to comment before we start our discussion. Thanks.

(Off microphone comment.)

MEMBER ROBERTSON: Can I just say, there were two different links in the agenda or the calendar invitation. One of them I think is incorrect.

CO-CHAIR BAGLEY: All right. Is anybody else having problems with Google send somebody to your space to get it taken care of.

MR. STOLPE: Okay. That is a less than desirable thing --

MEMBER ROBERTSON: Yes.

MR. STOLPE: -- so I apologize for that. We'll ensure that we'll get everyone on the right link. So, if you do have any trouble with the reporting everywhere platform, please put up your tent card, we'll send staff around to help you out.

CO-CHAIR BAGLEY: And then we'll have a test vote to make sure everybody is on the right page, so to speak.

MR. STOLPE: Very good.

CO-CHAIR BAGLEY: Okay.

MR. STOLPE: All right. Let's go directly into this program description. I respect that everyone in the room has a more than a passing familiarity with the MIPS program.

But it is under QPP. One of two tracks that physicians then take. It is a paid for performance program that a lot say a certain percentage of physicians performance associated with quality measure performance, the total payments that they will be receiving for the calendar year.

As you know, there are literally dozens, north of 200, measures within the program measure set, so we don't actually have a slide to project for you to consider them all.

But in each of our PAs we've done what we thought was some due diligence associated with comparing the measure under consideration to measures within the set. So we'll refer you there if you wish to see some measures that align either with the quality domain under consideration or with the priority. The

meaningful measure priority under which the measure under consideration falls.

With that being said, Bruce --

CO-CHAIR BAGLEY: And we're going to start before any further discussion, with the public comment. So, those of you on the phone, does the phone need to be opened up for --

PARTICIPANT: Yes.

CO-CHAIR BAGLEY: Okay. So, Jordan is going to keep an eye on that.

MS. RUBIN: Public comment.

CO-CHAIR BAGLEY: Tell us who you are and who you're with.

MS. RUBIN: Koryn Rubin, American Medical Association. So I'm actually legally required to comment today because I got out of jury duty by specifically saying --

(Laughter.)

MS. RUBIN: -- I have to speak at a government sponsored meeting.

(Laughter.)

MS. RUBIN: I'm probably also the only

person that's ever chosen to attend an NQF meeting over other obligations.

(Laughter.)

MS. RUBIN: So, today you're going to be asked to review several administrative claims measures. And we've also had lots of discussion on your thought meaningful measures initiative. And the need and push to more electronic measurement.

So, it flies in the face of trying to adopt electronic means and electronic tools to now begin to add to the mixed program, additional measures based out of claims that are based on retrospective analysis that physicians do not receive information in real time in order to make care improvements within practice.

So I hope you also consider that as you look at the measure specifications that are actually based on the claims, as opposed to the electronic submission through eCQMs or registries.

And also work that is going on in the

registry space, looking at outcomes and better way to regiment. And also, patient reported outcomes.

The other thing I'd like to highlight is, it is quite frustrating when CMS brings late submission of testing information to the table. That if the AMA or some other organization wanted to bring forward measures to be considered under the MUC list, they would have had to have been submitted back in June or else CMS would have outright rejected the measure from review today.

And only did NQF staff or CMS host the additional testing information on Tuesday. And I only noticed it today as I opened up the discussion guide. Thank you.

CO-CHAIR BAGLEY: Yes. Stand up and speak up.

MS. MURRAY: Sure. I'm Molly Murray, American College of Surgeons. I'm also always loud so hopefully everyone can hear.

We just had some comments, specifically on AQ Hospital utilization measure

and felt that the hospital utilization rates are affected by a variety of factors that the measure fails to address. And we're mainly concerned with the lack of social factors that were being considered.

And then for the other specific comment was the THA and TKA measures, that was Number 28, that this would be a better opportunity to use patient reported outcome measures in lieu of that. The detailed one there.

CO-CHAIR BAGLEY: Thank you. Is there anyone on the phone?

MS. MURRAY: Can I just clarify that we did take the acute hospitalization measure off of the MUC list last year.

CO-CHAIR BAGLEY: Thank you. Yes. Any comments on, public comments on the phone? Then I guess we can proceed.

MR. STOLPE: Excellent. Okay, so, now we actually get to talk about measures. Straight into the business.

So with our first measure into consideration for MIPS is MUC2019-27, Hospital-wide, 30 Day, All-caused Unplanned Readmission Rate for the Merit-based Incentive Payment Program Eligible Clinician Groups. I just want to emphasize that. That's the clinician groups.

This measure is a fully developed measure that is based on an NQF endorsed measure. The measure itself is not endorsed, it was based on NQF-1789.

I will read the measure description. This is a respecified version of the measure risk adjusted readmission rate of unplanned readmission within 30 days of hospital discharge for any condition. NQF-1789.

Which was developed for patients 65 years and older using Medicare claims. This respecified measure attributes outcomes to mis-participating clinician groups and assesses each groups readmission rate.

The measure comprises a single summary score derived from the results of five models.

One for each of the following special leave cohorts. Medicine, surgery, gynecology, cardiorespiratory, cardiovascular and neurology.

This measure was given conditional support by the NQF Staff pending review by the scientific methods panel and the appropriate standing committee. That is the current state.

CO-CHAIR BAGLEY: Okay. And just a reminder, if you want to, I found the easiest way to follow along to go to the discussion guide, because the measure is right there in front of you, the PA is right there in front of you, the recommendation is is right there in front of you.

So, what I would like to do is start off the lead discussant for this measure. And for this measure Tracy Vaden is the lead discussant.

And then there are other co-discussants that have been assigned this measure. And we'll have you testify as optional.

So we want Tracy to lead us off. And if anyone else who has studied the measure

carefully and wants to present from that discussion group then will go after that.

Okay, thank you.

MEMBER VADEN: So, in review of the public comments for this there were four main things that were of concern. So, those were attributions, morbidity and reliability of the data. All aligned with --

(Off microphone comment.)

MEMBER VADEN: So, a bit more about that is this preexisting measure that's taken to a different level. So we -- to provider group or provider measure.

So in that, the attribution, there was concern that there was insufficient evidence yet to take it to the provider or provider group level. The second one was that in there, there is proposals that it would be attributed to, one, ambition. Would be attributed to up to three groups. Providers.

And then as far as goal alignment, certainly there was a theme. This being a goal

at a provider group level and not being a goal at a possible assistant -- level. And the feeling there was that there were not be sufficient support.

So, certainly to have those things align among those was thought to be a better idea.

Also, there was common theme of insufficiency of reliability and validity of the data itself and the overall feeling that there needs to be a little more research among what we're measuring. That that represents what we thought that we wanted measured.

But also that it was correct in the level of analysis at prior group level. And the last was 23's data as amended.

There was one proposal in there as an alternative, which was to take the existing measure at the hospital system or hospital level, and adjust that. And the thought there were to adjust for social economic determinants and -- data.

CO-CHAIR BAGLEY: Other discussants? Can I have Robert, Trudy and Don Nichols come up.

MEMBER MALLINSON: Yes, I just had some questions that I'd like to hear from, just the NQF.

That have us met some of the pre-review guidelines. Since even in the materials it's stated it's a measure of communication and coordination. And yet this is like at level of physician groups.

And I think to prevent clinical readmissions, that coordination and communication is clearly beyond physicians only, it's physicians risk -- a lot about the providers and organizations to really ensure the quality of care for the patients. And so, I'd like to hear why it was thought that it especially met that criteria.

Also, that the issue I get from practice I'd like to hear more about because what I reviewed in terms of the literature that was provided is very out of date. And so, is that

really the concept of literature that we know about this because most of the literature side was eight, ten, 12 years old.

And so, I'd like to heard a little more about that. How we know, like, what is the gap of practicing and what the ability to meet that gap in practice where two concerns that I'd like to learn more about.

CO-CHAIR BAGLEY: Don, I misspoke. Do you have any comments?

MEMBER NICHOLS: I do not.

CO-CHAIR BAGLEY: Okay. And Stephanie?

MEMBER FRY: The other thing that struck me was the rural workgroup findings. And I don't know if they planned to speak to that individually. So, I thought that was --

(Off microphone comment.)

MEMBER FRY: Oh, sorry. The other thing that in reviewing the literature was the rural workgroup findings I thought were something that was worthy of discussion in terms of how

this measure would apply in rural settings.

CO-CHAIR BAGLEY: Okay. And that's actually a good segue because after any initial discussion we'll have the rural workgroup comment. So, Kimberly, go ahead.

MEMBER RASK: Yes.

CO-CHAIR BAGLEY: And speak out.

(Laughter.)

MEMBER RASK: I'll do my outside voice.

CO-CHAIR BAGLEY: Please.

MEMBER RASK: Sure. Okay. So this was one of the measures that the rural group was least favorable about, that was the three lowest, the three out of the ten most weighted measures.

The group felt pretty consistently that this measure would disadvantage rural providers because of the lack of social determinants of health adjustments and geographic access in particular. That the lack of available services in a local rural environment may impact the measure and the clinician groups who were

practicing in rural areas would be unfairly penalized because of it. And that led to the negative assessment.

CO-CHAIR BAGLEY: Okay. Let's open it up to broad discussion. Who would like to be first? Sandy, I saw your card first.

MEMBER POGONES: Yes. I'd just like to point out that it does say this is for eligible clinician groups but it's at the TIN levels. So keep in mind that a TIN might be a solo doctor. So it's not always this group that we're talking about, it might be one doctor.

I don't believe this has a minimal number of physicians in a practice that it applies to, or it doesn't. Does it apply to only practices of 16 or more physicians or does it apply to everybody?

CO-CHAIR BAGLEY: Does anybody have that information?

MS. BERNHEIM: Do you want an answer to that?

CO-CHAIR BAGLEY: Yes, please.

MS. BERNHEIM: Great. So one clarification for this group. A measure, this measure exists in the MIPS program. Currently, what we're bringing forward is a change to the attribution.

So this measure already is a part of MIPS. It applies to TINs with 200 or greater. CMS has not stated directly when that measure, if that measure gets replaced with this, with new attribution level, what the level would be. But the preferred version of this measure in this program requires 200 patients.

MEMBER POGONES: Two hundred patients or --

MS. BERNHEIM: Two hundred per TIN.

MEMBER POGONES: Notifications per TIN. Medicare patients per TIN.

MS. BERNHEIM: Yes. Eligible for --

MEMBER POGONES: Okay. That makes a little bit of difference although it's still very possible that a TIN with a solo physician might in fact have 200 Medicare patients. So it could

apply to individual doctors.

And I think that's our concern is that, what was expressed in the past is that an individual doctor may not have the resources available to address all of these factors that come into a readmission. They don't necessarily have the social support system, the behavioral health systems or providers in place.

They may not be able to afford nurse coordinators to reach out to some of the higher risk patients. These are all pieces of the puzzle that are in place at an ACO level. But not necessarily in a physician level practice.

So I think we have to be a little bit careful about that. That's good for right now. Thank you.

CO-CHAIR BAGLEY: David, you were next?

MEMBER SEIDENWURM: Sure. I think I'm nearly alone among the clinicians in being a big fan of the re-admissions measurement. And this is extremely important metric for quality.

However, I think that we do need to bear in mind that we may have reached the limit of improvement in this area that can be accomplished without major systemic changes.

Most people would pay extra for me to talk more quietly, so --

(Laughter.)

MEMBER SEIDENWURM: So, we may have reached the limit of benefit that can be achieved by tweaking these measurements. There's a lot of literature coming out now, that's come out recently, that a lot of the improvements and changes from one year to the next have been related to stochastic variation and regression to the mean, for example.

So, although I do support this measure for inclusion at the present time, because I think it will promote systemness, and I think that because this is also measured at the hospital level, this will, not this exact one, but re-admissions on measure, it will promote systemness and it will promote coordination and

care among clinicians and hospitals. I think a 200 patient sample size is probably a legitimate number for a cutoff, if that's maintained, that even a single provider would have the ability to influence.

So I think, despite the criticisms, I think that we should probably approve this one.

CO-CHAIR BAGLEY: Was your comment --

MEMBER SEIDENWURM: Oh, one other quick comment. Perhaps in future, assuming that we can get valid sample sizes, it might be reasonable to focus in on specific diagnoses where there is more clinician impact. For example, COPD/CHF, things like that, rather than a broad based approach like this to address some of the concerns that have been raised.

CO-CHAIR BAGLEY: So, directly to his --

MEMBER DUSEJA: Yes. So I just wanted to comment on the concerns about TIN and TIN MIP. So, it is at the TIN level so it would be, you know, a group level reporting structure.

So the concern, one individual provider, they would not, it would not be applicable to that. It would have to be reported to CMS at a TIM level. In a TIN, I'm sorry.

(Off microphone comments.)

CO-CHAIR BAGLEY: Do you need clarification?

MEMBER POGONES: I do because a TIN might be one doctor. Some TINs have one doctor.

CO-CHAIR BAGLEY: That's correct. The rule says they don't use the less than 200 patients.

(Simultaneously speaking.)

MEMBER POGONES: So more than likely will not see 200 patients.

(Off mic comments)

CO-CHAIR BAGLEY: All right, Helen, you're next.

MEMBER BURSTIN: Yes. So thank you for that clarification. It was actually a little difficult to follow that this is in fact an existing measure of a change to the attribution

methodology.

Can you just briefly explain what is the change in the attribution methodology?

And again, I think we've had enough questions that I still don't understand what the number 200 refers to. Is it physicians, their practices that have been 200 admissions, 200 patients on their panel or the number of physicians and their TIN?

Seeing that laid out is going to be really important. And again, I don't know what the reliability is going to be with two, depending on what that answer is.

And I think regardless we need to be able to see what, how the reliability changes from what it might have been at the hospital level. And certainly somebody who knows 1789 more than I'd like, difficult measures to start with.

But being able to actually look at this, at the finishing group level, is really very different and we need to better understand

what the reliability is and what we're talking about and how the attribution methodology has changed.

CO-CHAIR BAGLEY: Please.

MS. BERNHEIM: First of all, I apologize, I did not introduce myself. Susannah Bernheim, I'm one of the senior directors at Yale CORE and we've been working with CMS on this measure. Hi, Helen.

CO-CHAIR BAGLEY: You're talking to the other end of the room.

MS. BERNHEIM: Yes, right. So I'm talking to Stephanie. Can you hear me, Stephanie?

Right. So to clarify, the MIPS program has a version of the hospital-wide measures, referred to ACR. It's currently in there.

What we were asked to do was to look at the attribution approach. That measure had attributed to the primary care physician in coordination with a technical expert panel.

We were encouraged by our technical experts to actually apply attribution across multiple clinicians. They felt very strongly that no individual clinician in the context of a readmission would be an appropriate attribute entity.

And so, the measure was recreated, revised. And it currently introduced a three separate clinicians and then to their, at the TIN level. I don't know how better to explain that.

One is the discharging clinician. So the person who actually is responsible for billing, for discharging that patient to the outpatient setting.

The other because that is not always the person who has really primarily cared for that physician. We define a primary inpatient physician that was done with a lot of thought, with the technical expert panel it ends up being based on the majority of charges. The person who has charged the most during their inpatient stay.

And the third is the outpatient

primary care physician in the prior year. So, different than the current attribution, it looks back 12 months prior to the admission, but uses a very similar claims based approached to determine who has been the primary care physician in the prior year. And all three of those clinicians are a part of the attribution approach based on our testimony.

CO-CHAIR BAGLEY: Helen, does that answer your question?

MEMBER BURSTIN: I think it would be helpful, and maybe I missed it, it would be helpful to actually be able to read that. And maybe it's just premature, but the actual details of that, I mean, even being able to figure out what is a discharging clinician, I'd need to understand what that definition looks like.

And again, it seems like we need to understand what this measure looks like, the reliability of it, how you do that joint, I mean, I love the fact that the attribution isn't solely on the one person who may not have had anything

to do with it, but without understanding what the shared attribution looks like, it's kind of hard to make an assessment.

MS. BERNHEIM: So, I apologize because I don't know exactly what this Committee, but this measure has now gone through the scientific committee and a committee at NQF. That's all public information. It's in the midst of the NQF approval process. So, we're happy.

I don't know how that's to share more information, but that's all finished and vetted in that NQF right now in terms of the reliability validity question.

CO-CHAIR BAGLEY: Next in line is --

MR. HERRIN: Actually, I just to clarify. The reliability information has changed since the prior --

(Off microphone comment.)

CO-CHAIR BAGLEY: Okay, Sue, you're next.

MEMBER KNUDSON: Okay. And all, that last comment was helpful for me. That NQF

information.

But I just wanted to make two comments. After saying, first, you know, I'd agree with the earlier comments, this is an important measure.

We're a unique organization and that our health partner's clinics are in at the HSM.

And then our review of this is that the measure differs from the APM measure by focusing on specialty cohorts rather than patients with multiple kinds of conditions.

The one app was whether or not there could be continued alignment. So, to have more consistent measurement definitions.

And then the second comment is that around how the summary score is derived as mentioned using five models. Which we're unable to find like transparency on what those models are.

So, you know, it was really that the team used a planned readmission algorithm, Version 4.0. So if that algorithm could be made

more transparent to groups it would really help with the improvement work on this, on this measure.

MR. STOLPE: So just one clarification point that may be helpful. So this, related to the NQF endorsement status measure.

So this was submitted to NRQ for consideration, it passed the scientific methods panel. However, the NQF CDP Standing Committee responsible for reviewing the measure, expressed support for the attribution of physician groups.

To improve the outcome however, the NQF standing committee also encourage the developer to expand SDS respected for the measure. And was generally not supportive of the measure at the individual clinician level.

So the endorsement consideration of the measure was deferred to Spring 2020 pending updated testing information for consideration.

CO-CHAIR BAGLEY: Good. If you're on the phone, please make sure your is mute.

(Off microphone comments.)

CO-CHAIR BAGLEY: Okay. Yanling, you're next.

MEMBER YU: Thank you. I just have one comment and one question to CMS.

My comment is, that to and from the patient, and a consumers perspective readmission is really, a unapplied readmission, is really important quality of care indicator. Because you can all, related to, we all patients one time another, when you have readmission unplanned, you quite often your quality of care decrease, you suffer sometime medical harm, and also, increase your cost of care.

So, I think this is an important measure for patients and consumers. And I really urge this committee to support it.

I have, then I have a question for CMS. And I am curious about the comments from this MAP rural work funding. About the social risk factors.

I think it best is a reality that should be addressed. And I'm just curious, do

you have a plan that if approved, adopted by this committee, do you have a plan to address this, to modify it a little bit?

MEMBER DUSEJA: May I address that?

CO-CHAIR BAGLEY: Yes, please.

MEMBER DUSEJA: Okay. Thank you for your comment. So, I just want to first kind of go back to the TIN issue.

This measure currently is within the program and it's requiring that for, you know, if it is attributed to the TIN level there has to be 16 plus clinicians that are actually in the TIN in order for this measure to be applicable too.

Regarding to the SDS, all of the developers talk about their testing with the measure and looking at social determinants. But as a policy perspective with this measure as it applies with the MIPS, we do have a complex adjustment that goes on top of it in terms of the performance of providers.

And that's based on the population of beneficiaries that the provider is taking care

of. We add an additional payment that's associated with it that's around the hierarchical condition category of the score as well as the eligibility.

So we do try to account for the patient mix, that they're taken care of.

MEMBER YU: I see. May I make a comment?

I did mention that, you know, I have been doing workshop around the Seattle area or talked to people about the care. And I found lots of consumers do have issues about the transition of care, the communications.

And lots of patients felt that communication is really poor in many situations. And physicians, primary care, ER doctors, I don't know even if it's included, and any specialties do have responsibility to make sure the transition and any medical information to properly, to provide to patient and care takers. So that could reduce the risk of readmission. Thank you.

CO-CHAIR BAGLEY: Will, you were next.

MEMBER FLEISCHMAN: Yes. It might be helpful to, maybe to give us a little concrete example of how the attribution will work with taking a couple of patient examples.

So, a patient admitted for a stroke, a patient admitted for a stemi, who is going to get attributed to the community?

MS. BERNHEIM: May I respond to that?

CO-CHAIR BAGLEY: Please.

MS. BERNHEIM: I mean, I can't do anything exactly without the bills, right, because it's based on the billing codes. But I can give you a sense of what we would anticipate would happen.

You know, the patient who is admitted for a stroke, depending a little bit on the kind of hospital they're in, in many settings they will have an attending physician, maybe a neurologist, who cares for them through their whole stay and is the one who discharges them.

In that case, that clinician would

come as both the primary inpatient attending and the discharging clinician. That doesn't mean they get to readmission, that just means that they are singularly identified, both as algorithms.

If they happen to be at a tertiary care center, a team with lots of career folks and the primary person caring for them is the neurologist but their colleague is discharging them on a weekend and the person who is there making the decision on Saturday morning that this person is really ready to go home, then both of those clinicians would be identified.

And then whoever the patient's primary care physician was in the year before that admission, they would also be identified. In a case of something like that, is there an example of stemi?

MEMBER FLEISCHMAN: Yes. Let's say there's a consultant, a hospitalist and then the primary care doctor.

MS. BERNHEIM: Right. So, again, it

depends a little bit on how the claims play out, but the goal is to identify a single person who has been primarily in charge of their inpatient care.

And part of the reason we look at billing is because for major surgeries that's going to be the surgeon, for more minor procedures it will be the attending. And that's the intent.

Again, I can't promise you worked perfectly, but that's what our testing was aiming to do. And then again, the discharging clinician and the primary care physician. Does that help?

I just, I want people to understand what we're trying to do.

MEMBER FLEISCHMAN: Yes.

CO-CHAIR BAGLEY: Trudy.

MEMBER MALLINSON: I still, I think it's a helpful, it's sounds like, going back to Yanling's comment about the, concern about our communication, and I just, I wonder how much this measure will really drive communication among, I

understand David's comment, that the goal was to try and get everybody talking, but I wonder if we're putting the lever in the right place to get that communication handled.

CO-CHAIR BAGLEY: Peter, your next.

MEMBER ROBERTSON: Thank you. Sorry. I think from a purchaser's perspective this is an important area for us. The sort of process question I have is this revisiting of the testing data in the spring with XGA, by the endorsement committee, and what that actually means for the decision we're making today.

So if we support the Staff's recommendation and the endorsement committee looks at that testing data and it's unfavorable, what actually happens to this measure?

MR. STOLPE: That's a terrific question. Okay, so the conditional support is, on Staff's recommendation, is directly connected to the conditional opponents passing through this NQF endorsement process.

Now, I do need to be clear on that

point however. CMS does have the discretion to implement a conditional support at whatever point they feel like they should.

So, if we do offer conditional support, that's essentially the green light to move forward.

MEMBER ROBERTSON: Thank you.

CO-CHAIR BAGLEY: I think to amplify that, CMS has discretion has to do whatever they want no matter what we say.

(Laughter.)

CO-CHAIR BAGLEY: However, they do listen.

(Laughter.)

CO-CHAIR BAGLEY: Next, Chad on the phone.

MEMBER TEETERS: Yes, thank you. So one of the concerns that I wanted to bring up, especially in regards to procedure related categories, is the specificity of those categories. And so, I'll give an example.

So, within the cardiovascular space,

which is specifically highlighted, is a cohort, there would be concern if we lumped something as broad as say, heart valve disorders, which could encompass open heart surgical valve replacement, minimal invasive surgical valve replacement and trans-catheter bowel replacement. Each of which has a wide variation and complexity and readmission likelihood.

So, one of the considerations for this measure to, if we were to move forward, I think for improving it, would be to pay very careful attention to how broad the categories are when we're lumping them together.

CO-CHAIR BAGLEY: Okay. David, did you have additional comments?

MEMBER SEIDENWURM: Yes, just one quick questions about, are there any specialty screens in the attribution model, for example, I'm a neuroradiologist so just one example, the stroke that you brought up, if there were a hospitalist, neurologist, primary care model, you could wind up with the anomaly that a radiologist

who read a CT scan and an MRI could wind up being the preponderance of care.

And that was recognized in the stroke cost of care episode. And I wonder if that's represented, that's recognized in this.

MS. BERNHEIM: Yes. I can just give a quick, thank you, I'm glad you asked that question because it's an important clarification.

So we do limit the potential attribution to what I'll call sort of patient basing. So people who are sort of directly, clinically a care patient.

MEMBER SEIDENWURM: and I should have disclosed a conflict of interest because I suppose that was special pleading of sort.

(Laughter.)

CO-CHAIR BAGLEY: All right. I'm sorry, go ahead.

CO-CHAIR FIELDS: No, that's all right. It's actually a related question.

So that partially answers it, but you could also image, patient gets admitted, the

discharging physician is clear right, there's a named person and the PCP to the degree that primary care defines that and gets confusing, that's clear-ish. At least we have precedent for it.

On the inpatient side though you can also image, maybe not a radiologist or someone who is not necessarily directly patient-basing, but another consultant who is not actually providing the care for the discharged diagnosis that may actually get the plurality. Is there any way to correct for that?

MS. BERNHEIM: It's a great question, and, Catherine, guide me, how deep do we want to go into measure specs in this setting or not.

I'm not sure that there is. I mean, we spent a fair amount of time looking at sort of what the specialty of the clinician that gets attributed to this, was compared to what a patient was in for and sort of see how much that was happening.

And our sense is that it's not a huge

problem --

CO-CHAIR FIELDS: Okay.

MS. BERNHEIM: -- but there's not a upper discretion in there.

CO-CHAIR FIELDS: Yes, that's fair.

CO-CHAIR BAGLEY: Okay, I don't see any other comments, so at this point we're going to vote on the recommendation of staff. Which is conditional support.

And as I listened to the conversation, and by the way, the conditional support pending replacement of 1789 in the program measure set and NQF review of reliability, performance at the physician group level in the Spring of 2020. That's what's written in your discussion guide.

As I listened to most of the concerns, they would require some testing to see if they're really a problem or not.

So, does anybody have any additional conditions, other than that, before we take a vote?

Was that a fair kind of assessment

that, I mean, that most of the things we just heard would require testing. And assuming, let's say they tested it and it was terrible, you would then do something about that, right?

MEMBER DUSEJA: I think also, I think we are committed to go through the endorsement process --

CO-CHAIR BAGLEY: Yes.

MEMBER DUSEJA: -- so it will be addressed during that time frame.

CO-CHAIR BAGLEY: Okay. Everybody okay with that approach? Then we'll proceed to voting.

But we can't vote until we have a test vote.

MS. BUCHANAN: That's correct. And we also need to make sure everyone is on the correct link. So there are two requirements first.

So, I'm going to ask everyone, I sent the link at 11:20 this morning, please use that link. It should say, NQF Voting 301 should be the number at the end.

I apologize for the confusion, there were two links sent, but this is the correct link. So we're going to ask everyone to make sure that they have, it should be a blue screen, NQF Voting, and 301 should be the number at the end. The email was sent at 11:20 a.m., the MAP Clinicians Workgroup.

MEMBER BURSTIN: It's the same one as yesterday then. It's the same one you sent yesterday, because I --

MS. BUCHANAN: Yes.

MEMBER BURSTIN: -- have it up as 301 from yesterday.

MS. BUCHANAN: That's great.

MEMBER BURSTIN: Okay.

MS. BUCHANAN: Because that's one of the two links.

MEMBER BURSTIN: Okay. I got lucky.

MS. BUCHANAN: Okay.

CO-CHAIR BAGLEY: So we're going to have a test question here. Don't make it too hard.

(Laughter.)

MS. BUCHANAN: So I actually, first I think we're going to --

MR. STOLPE: Straight to it.

MS. BUCHANAN: -- straight to it because if the people can't see it on their computer we're going to have to --

MR. STOLPE: We'll do it in real time.

CO-CHAIR BAGLEY: Okay.

MS. BUCHANAN: We're flying by the seat of our pants.

CO-CHAIR BAGLEY: Well, no we're not, we're going to have a hand vote--

(Laughter.)

MS. BUCHANAN: Oh no, this will work.

MR. HIRSCH: For MUC2019-27, hospital-wide --

CO-CHAIR BAGLEY: Speak up.

MR. HIRSCH: -- 30 Day All-Cause, Unplanned Readmission Rate for the Merit Based Incentive Payment Program, Eligible Clinician Groups, do you vote to support the preliminary

analysis as the workgroup recommendation? Your options are yes or no.

And the workgroup, and the preliminary analysis was conditional support for rulemaking.

MS. BUCHANAN: Is this a test or is this it?

MR. HIRSCH: This is the real deal.

CO-CHAIR BAGLEY: This is the real deal, so vote.

MEMBER YU: Can I ask a question?

MS. BUCHANAN: Yes.

MEMBER YU: I clicked on it before you read it, does that --

MR. HIRSCH: That will be counted.

MEMBER YU: That counted, okay.

MR. HIRSCH: Yes.

MEMBER YU: I don't want to vote twice.

(Laughter.)

MS. BUCHANAN: Chad and Sue on the line, we're going to ask that you also vote. Do you have any, oh, you did? Okay, great.

MEMBER KNUDSON: Yes, I did too.

MS. BUCHANAN: Okay. We're at 22 total. We'll just have 22 total. Robert, are you able to log in to vote or --

CO-CHAIR FIELDS: Yes.

MS. BUCHANAN: If you wouldn't mind logging in.

CO-CHAIR FIELDS: Okay.

MS. BUCHANAN: Were you able to vote for this one?

CO-CHAIR FIELDS: I can vote.

MS. BUCHANAN: Okay, great.

(Off record comments.)

MS. BUCHANAN: So we are missing two votes.

CO-CHAIR BAGLEY: How many voting members are in the room? Raise your hand please.

MS. BUCHANAN: There are 21.

CO-CHAIR BAGLEY: Would you count them?

MS. BUCHANAN: Not in the room. One, two, three, four, five, six, seven, eight, nine,

ten, 11, 12, 13, 14, 15, 16, 17, and on the phone we have two, so that's 19. So we have 19.

PARTICIPANT: What about the Chairs?

MS. BUCHANAN: Oh, 21. We have 21.

MR. STOLPE: We're shy two votes. My math doesn't count.

CO-CHAIR BAGLEY: All right. And, Kevin, just sit back.

Now, if it's okay with you I'm going to ask for yes votes by raising hands.

MS. BUCHANAN: That's fine.

CO-CHAIR BAGLEY: Okay. Yes votes? We won't have to do this every time once we verify that it's working.

MS. BUCHANAN: Not in the room. One, two, three, four, five, six, seven, eight, nine, ten, 11, 12, 13, 14, 15.

CO-CHAIR BAGLEY: And no votes please?

MS. BUCHANAN: One, two, three.

CO-CHAIR BAGLEY: Four.

MS. BUCHANAN: Four.

PARTICIPANT: Kevin is voting now.

PARTICIPANT: Kevin is voting.

MS. BUCHANAN: And then Chad and Sue, can you type your votes into the chat box please?

CO-CHAIR BAGLEY: I want you all to be comfy with this, not just me.

(Laughter.)

MEMBER SEIDENWURM: While people are counting, it's interesting to discuss it so we know, and the non-discussants, I'm going to guess, I don't know what that tells us precisely.

MS. BUCHANAN: I have 21 votes. I do not have --

CO-CHAIR BAGLEY: We've got one more.

MS. BUCHANAN: So now there's 21, okay.

(Off record comments.)

CO-CHAIR BAGLEY: I think we're good.

CO-CHAIR FIELDS: One of those might have been me because I put my name in, but then I saw log in, you said to log in, so I went back and logged in.

MS. BUCHANAN: Oh, okay. No need to

log in.

CO-CHAIR FIELDS: No need to log in, all right.

MS. BUCHANAN: That's right.

CO-CHAIR FIELDS: So one of the, probably, there are two of my votes in there. The hand votes are still more reliable at this point.

MS. BUCHANAN: So we are --

(Off record comments.)

MR. HIRSCH: For MUC2019-27, Hospital-Wide, 30-Day, All-Cause Unplanned Readmission Rate for the Merit-based Incentive Payment Program, Eligible Clinician Groups, do you vote to support the preliminary analysis as the workgroup recommendation?

Seventeen votes for yes, four votes for no. The workgroup has recommended conditional support for Rulemaking for MUC2019-27.

CO-CHAIR BAGLEY: Thank you. Everybody okay with moving on if that feels okay?

All right.

All right. If it was half and half we probably wouldn't be comfortable. So, are you going to go to the next one?

MR. STOLPE: I am. All right, let's move on to our next measure. We're considering MUC2019-28. This is the Risk-standardized Complication Rate Following Elective Primary Total Hip Arthroplasty And/or Total Knee Arthroplasty.

So this measure is based on a measure inside of IQR, NQF-1550, but it also carries its own NQF number as NQF-3493. And it's endorsed under that measure.

So I'll briefly read the description of the measure to you. And it's fairly straightforward.

This measure assess each providers complication rate defined as any one of the specified complications occurring from the data index submission to up to 90 days post date of the index procedure.

NQF Staff's review of this measure placed it under support for rulemaking. And I just wanted to point out one or two things about this.

That the developer didn't note any consequences in 2017. Maintenance endorsement submission for the measure, 1550, nor in the submission for 3493. And that this measure is an outcome measure.

And inside of the MIPS program we identified approximately 30 measures related to surgery and seven directly related to TKA and THA. But none of the measures identified actually deal with complications from both. This is the current status of the measure.

CO-CHAIR BAGLEY: Okay. And the recommendation in support for rulemaking I have Wendy.

MEMBER GOZANSKY: Okay. So, I think that overall this is a very important issue. We have more and more older folks across the country who are having more and more of these procedures.

I think the issues that were brought up of concern in the room around the fact that this is a claims-based retrospective, it's not about patient outcomes around functional outcomes, is reasonable. And yet I also think that the issue is that this is about safety. And this is an elective procedure.

And so the idea of having very high safety and very high expectations for an elective procedure I think is appropriate. I also think that this speaks to sort of that team based communication approach so that you actually are looking at, it's not only what's happening in the operative period.

And I think what's important when you look at the specifications, when I first looked at this I'm like, 90 days. But it is that the complications are targeted to different dates. So the idea that it is the acute myocardial infarction within the seven, so did you do your pre-ops gratification correctly in the 30 days, did you get them on the right anticoagulant and

make sure we're not having bleeding issues. And then the longer term is around sort of the joint infection, lymph infection, those types of things.

I also think they do a very nice job for making sure that this is primary. This is not revisions or any of that sort of thing.

I think there were a good number of concerns. So what is beneficial is that there is alignment so that if this is, you are looking at not only the system issue but then you can get alignment to the actual surgeons.

And I think this speaks to sort of the surgeon as leader. And the idea that we should have alignment between the hospital system as well as the provider performing the surgery.

I think that part of the concern was around volume. And the idea that you do see an association between higher volume has lower complication rates as we would expect.

There is a statement that this was about 25 as the threshold. And I didn't actually

see that called out specifically so I think we need to, I wanted to be sure that that is in the specification. I think that is important.

The other piece that was raised as well about the idea of the patient reported outcomes, I do think that that would be supplementary, but I think that this is a more basic and important first step. I think the combination.

And then as we talked earlier about numbers of measures, do you use this as a replacement to take the pieces and parts measures away and consider that this might be the primary measure that is more of an integrated and aligned measure to use.

The other clear comment was really about the reliability. And there was concerns in the public comments that the reliability should be .8 or greater.

I kind of, .79, I'm going to round that to .8. I think that's still a substantial reliability, I'm good with that.

And I also think when you look at the variability of the 1.2 to 7.2 percent, the idea that this actually is meaningful, again, and I will remind us that it's an elective procedure.

I think the one concern that I was also thinking about is, are we going to incentivize orthopedic surgeons to avoid doing high-risk patients?

And I think that's an important issue as we have more older folks, more complications. And there are a lot of people, I mean, having a really bad hip or knee is just as impairing as Stage 4 CHF. And so, there may be people who want to take that risk.

I do think that there is risk adjustment in the measure, and so I think that that hopefully is going to account for that. But I think that would be sort of the one adverse consequence I would think about in the measure.

CO-CHAIR BAGLEY: Okay, next I'll accept comments from the co-discussants, if you'd like, Yanling, Joyce and Tracy.

MEMBER YU: Yes, I think you did a very nice summary. I just want to point out briefly.

I think, you know, patient report outcomes are very important in term of improved quality of care and safety. And I don't think it has at least primer that we can really adopt into a meaningful measure, at the time, in my opinion.

But it may, I agree that maybe use, in the future, as a supplement measure, to compliment the claim data. And claim data is free. It's a lot more easier to use at this time.

And also, I just want to say one thing about, for risk adjustment. And I think a CMS, there is one measure that also ask whether the risk have been discussed in way of the patients.

So I think for, you know, even if it is the elective of surgery, but this type of surgery typically occurred to elderly patients. So, the risk inherence in that population, so maybe somewhere should have some type of a, I

don't know how it would do it, reflect that type of communication having discussed with the patients who you elected to do that surgery. So, that's all I have. Thank you.

CO-CHAIR BAGLEY: Thank you. Joyce.

MEMBER KNESTRICK: I just wanted to say I concur with the summary. When I looked at the comments it kind of gave me pause, and so I felt that I had to go back and look at the science and evidence again. And I think that you accurate reflected what I came up with too as well.

CO-CHAIR BAGLEY: Tracy.

MEMBER VADEN: Excellent summary and definitions.

CO-CHAIR BAGLEY: Okay. Sandy, you're next.

MEMBER POGONES: It just occurred to me, are there a lot of this type of surgeries done by physicians who do less than 25 cases a year? And if there are, aren't those the ones we really want to target?

(Laughter.)

CO-CHAIR BAGLEY: Yes, I wanted to have some clarification about that as well. Tell us more about the 25 cases.

MS. BERNHEIM: So, two clarifications, right. This is based on Medicare claims for over 65 for service Medicare patients. So you need to have 25 of such patients.

So some clinicians may have just reached that 25 threshold that actually is seeing more patients, they're just not in that category. So, just to acknowledge that.

And on the question that, don't we want to measure them, this is the question that came up when we were developing this measure and with experts. And, you know, it's the tension between making sure that when we're looking at an outcome rate we have enough information to feel like the measure can be fair versus yes.

I certainly want to know if I'm going to a surgeon who does very few cases, what their complication rate is. But we fell on the side of

making sure that the measure was assessing clinicians more or less.

CO-CHAIR BAGLEY: My concern is that any number like that is arbitrary. And could you tell us how you did your arbitrary decision?

(Laughter.)

MR. HERRIN: Jeph Herrin, I'm a methodologist at Yale CORE. The 25 number is one we use for testing. And we selected that because it provided sort of a minimal amount that we thought was adequate in reliability. At 25 volume we realized the use of about 80 percent for both clinicians and groups.

It's not baked into the use of the measure, it's what we use for the testing. We thought that 25 provided adequate reliability for all the testing we did. So that's what we used.

Susannah said is 25 Medicare --

MEMBER POGONES: A little louder if you could.

MR. HERRIN: Louder, okay.

(Laughter.)

MR. HERRIN: Sorry, I'm very soft spoken. So the 25 is, we used 25 for our testing because it's the number that provided adequate reliability. Divided, about an 80 percent reliability, 79 percent reliability, for clinicians and clinician groups.

Is the number that's used at the hospital level for this measure. Hospitals report this measure if they have 25 cases. And so that's where the 25 comes from.

But it's not baked into the use of the measure. Higher thresholds could be used. But I think a lower threshold would probably not be useful.

CO-CHAIR BAGLEY: And if I might make an observation, I think here's where we get into the problem of using it for payment and judgment versus using it for quality improvement.

So, if I were managing a group of physicians with a couple of dozen orthopedic surgeons, I might still use it for internal purposes. And to combine it with what we know

about standing side-by-side with that particular surgeon to make some changes.

CO-CHAIR FIELDS: I actually want to know if the rural workgroup actually had any comments or thoughts around the volume piece in particular.

I mean, I think before I was in New York City I was in rural North Carolina, so radically different. And we had all sorts of issues with docs in rural counties that had, I mean, couldn't ever compete in terms of volume. And I just wonder if that was a concern that the workgroup brought up in terms of these measures.

And I totally get it, right. As a consumer you want people who are experienced, and that's certainly true.

The unintended consequence though, differentially targeting a measure to those that are less than 25, relative to that comment, is that you can inadvertently then reduce access on the rural side because then docs don't want to touch it.

Thoughts about that from --

MEMBER POGONES: Yes. So the rural group did talk about those issues and kind of were balancing.

There was a strong feeling that this was a really important measure for rural residents. That these were common surgeries and that they really want to know about quality and the exists of complications.

They actually thought if it was limited to the groups with at least 25 patients, then low volume rural providers would not be penalized by this program, so they felt --

CO-CHAIR FIELDS: They felt okay with it.

MEMBER POGONES: -- they felt okay with it.

CO-CHAIR FIELDS: Okay.

MEMBER POGONES: This kind of got sort of a more neutral response. It was not the least favorable measures, it was not the highest favorable measures that came out within it. And

the other one unintended consequence --

CO-CHAIR FIELDS: So it's not the same test, right?

(Laughter.)

MEMBER POGONES: The other unintended consequences they did bring up is thinking, keeping in mind, as these elected procedures increasingly move to the outpatient setting, the ability to have access to the local services to support outpatient recovery might be an issue for rural residents getting these kinds of procedures.

CO-CHAIR BAGLEY: Trudy, you were next.

MEMBER MALLINSON: So, you were asking the question, that standard of physicians do less than 25, like, what percentage of the overall, if we can answer that question?

CO-CHAIR BAGLEY: Do you know that folks?

MS. BERNHEIM: Our team certainly does. I'm looking quickly to see if we can find

it in our notes.

CO-CHAIR BAGLEY: Okay. While you --

MS. BERNHEIM: Could you--What I remember from the development time period is that you lose a substantial percentage, right.

CO-CHAIR BAGLEY: Right. Yes.

MS. BERNHEIM: And there really are low volume surgeons doing these procedures and they tend to be doing just a wide range of procedures. So it's not necessarily that they're low volume surgeons overall, it tends to be that they just have a very broad scope of practice. And so the numbers that fit into this elective set.

But we can get you that number. I don't have it at my fingertips.

CO-CHAIR FIELDS: I would wonder if you're like a trauma, like what if you're a trauma person and you don't do hip replacements all the time but you have to do one periodically. Like you're doing a, to your point, you're doing a ton of other common related orthopedic

surgeries and then every once in a while you have to do a hip replacement or something?

MS. BERNHEIM: But not an elective.

CO-CHAIR FIELDS: Right.

MS. BERNHEIM: Certain --

CO-CHAIR FIELDS: Oh --

MS. BERNHEIM: -- these are really-- We do have a --

MR. HERRIN: Yes, so among the clinicians, 52 percent did not meet the 25 Medicare case threshold. And among clinician groups, 42 percent did not meet that threshold.

CO-CHAIR BAGLEY: Does that bother you guys at CMS?

(Laughter.)

CO-CHAIR BAGLEY: I mean, what kind of mitigation are you doing?

MEMBER SCHREIBER: Yes, I think one of the --

CO-CHAIR BAGLEY: Speak to the group please.

MEMBER SCHREIBER: Yes. One of the

issues that Susannah and others have pointed out though, this is 25 Medicare fee for service patients.

So you can clearly have an orthopedic surgeon who has mainly Blue Cross patients. Or whatever insurance you would like to say.

They would certainly meet what we would think of as a high enough volume surgeon to what we would say is competent. And so, I think this was chosen so that we make sure the data is valid.

But I don't think that we can use that number to judge whether or not the --

CO-CHAIR FIELDS: Yes, it's --

MEMBER SCHREIBER: -- surgeon is a --

CO-CHAIR FIELDS: Right.

MEMBER SCHREIBER: -- high enough volume surgeon.

CO-CHAIR FIELDS: Right. That's a really good point.

CO-CHAIR BAGLEY: David.

MEMBER SEIDENWURM: Yes, I think to

some of the points that have been brought up, bring up the importance of registry submission, which would include all payer populations and not just be segmented. So I think that's another reason why there is differences in the registry, as you mentioned earlier.

And you've discuss that there was a big range between the desk performance and the work performance. And I think that's an important way to think of it.

But I think perhaps a more important way to think of it is that with a gap of around one percent between the 10th percentile and the 90th percentile, if someone is performing a value, quadruple the threshold volume, if they had one bad case that could shift them from the 98th to the 10th percentile.

So the ways to mitigate that would be to look at these metric in terms of stability of the clinicians in terms of their rankings from year to year and see if that, in case a real concern or not. Or perhaps they have a longer

period of look back or a longer period of analysis and that has its own problems for quality improvement.

Having said that, I think we might even probably, we should go ahead and improve it. But perhaps in the future we can work with the refinements along those lines.

CO-CHAIR BAGLEY: Kim, did you have additional comments?

MEMBER RASK: Yes. Sorry, one other message or one other discussion on the division on the rural workgroup that we felt was not as important from a role perspective, but Mike painted this as the notion of, for these measures that are based on Medicare fee for service.

As we see the transition to Medicare and Medicare advantage programs, again, the denominator, the number of people that are fee for service that can be used for these members keeps getting smaller.

In the role perspective, the perception was that there's not as much

penetration as the Medicare advantage in rural communities relative to non-rural communities. So we didn't think that impacted the measure from the rural perspective.

CO-CHAIR BAGLEY: Wendy.

MEMBER GOZANSKY: I was just going to say that I think having this as a, sort of a hospital system based measure as well, allows for the ability to say, if they have that and then have providers who have the measure that you are then able to look and see that there could be signal that your providers look great and this doesn't, then that would be the signal that there is somebody who is not doing enough volume.

And so I think there, again, that alignment gives you the potential for some counterbalance. And I would also say, and if it does drive people to do more high volume of high risk patients and we're going to have better outcomes, that could be a positive unattended consequence.

(Laughter.)

CO-CHAIR BAGLEY: Yanling.

MEMBER YU: Yes, thank you. Just a very brief clarification. On the statistics, you just quote for 45 percent of 50 percent of group, the clinician group.

Are those numbers include all ambulatory, surgery center and in hospital or just the hospital?

MS. BERNHEIM: Currently the measures are based just on procedures done at the hospital.

MR. STOLPE: Yes, in the hospital.

MEMBER YU: In the hospital, not ambulatory.

MEMBER SCHREIBER: Not at this time.

MS. BERNHEIM: Not at this time.

CO-CHAIR BAGLEY: Oh, okay. Any others?

MS. BERNHEIM: No. And I think CMS just changed some of their payment roles around this so you know, that's going to lead to the use of these procedures and applicant settings

expanding, and obviously will be considered in reevaluation of this measure in the future.

CO-CHAIR BAGLEY: Robert.

MEMBER KRUGHOFF: Is this measurement being done for just one year, is it two years, is it 30 years?

MS. BERNHEIM: It's based on case findings for three years.

MR. STOLPE: Three years.

MEMBER KRUGHOFF: Three years. Because I, I was a senior in here.

CO-CHAIR BAGLEY: Okay, I don't see any other cards up so it looks like we're ready to move to voting.

MEMBER SCHREIBER: I'm sorry, can I just make one point?

CO-CHAIR BAGLEY: Oh, you have --

MEMBER SCHREIBER: I just want to make one point to the group since we're been talking about volumes and what this can be used for. And the advantage of obviously having a complication rate is that in medical staff credential, which

is really where you would start making decisions of, do you have a high enough volume physician, you could use this if you have, now, if somebody who is an outlier here, I think that would lead to medical staff credentialing issues.

So there is yet another way of using this that gets at that question.

CO-CHAIR BAGLEY: Okay, my concern exactly, especially when it's an arbitrary number.

(Laughter.)

CO-CHAIR BAGLEY: Okay. All right, let's, are you ready to vote, Jordan?

MR. HIRSCH: For MUC2019-28, Risk-standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty for MIPS Eligible Clinicians and Eligible Clinician Groups.

Do you vote to support the preliminary analysis as the workgroup recommendation, the options are yes or no, and the preliminary analysis with support for rulemaking?

CO-CHAIR BAGLEY: Any other votes from the phone as well?

MS. BUCHANAN: And, Chad and Sue, were you able to, so we are waiting on one vote. We have 21 votes.

MEMBER TEETERS: I did vote.

MS. BUCHANAN: Okay, great.

MEMBER KNUDSON: I did.

MS. BUCHANAN: Okay, great. So, I'm just going to do a quick walk around because there is one vote that's not being captured. I just want to make sure everyone's screen have --

CO-CHAIR BAGLEY: Does everybody have 301 at the top hand?

(Off record comments.)

MS. BUCHANAN: Okay, great.

CO-CHAIR BAGLEY: All right. And the results are?

MR. HIRSCH: For MUC2019-28, Risk-standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty, MIPS Eligible Clinicians and

Eligible Clinician Groups, the Workgroup Has Voted 21 yes, one no. The Workgroup has voted for support for Rulemaking in MUC2019-28.

CO-CHAIR BAGLEY: Okay.

MS. BUCHANAN: And just --

CO-CHAIR BAGLEY: Yes, go ahead.

MS. BUCHANAN: -- one quick thing. So when you hit your vote, don't hit clear, it will be marked on so please don't clear your responses. There is no need to, we'll fresh. So that way, that's how we're losing some of the votes.

CO-CHAIR BAGLEY: Okay. Helen.

MEMBER BURSTIN: Just one general comment for our CMS colleagues. And I think measure fails, exemplifies why we need a whole payer data.

And again, I think it also exemplifies the fact that volume measures are really important. They have never been a part of our public reporting through you.

And, again, just two small points, but

again, those are measures I think, and both clinicians, to your point, I'd love to know who doesn't do 25 year also, I am referring. Clinicians and patients would find those really valuable.

An all payer has to be, in fact, if MA is out of this, this really --

CO-CHAIR BAGLEY: Okay, you've earned lunch. Even though we're not quite finished with the one agenda we're going to do lunch.

We would like you to come back at quarter of. 12:45. Even though that's a little less than half an hour, let's do it. And we'll see you then.

MR. STOLPE: All right, before we dash out, just one brief announcement. There was materials shared by Yale CORE, which are posted on the website.

But if you would like to review a hard copy, they've been kind of printed down and you're welcome to pick up a copy. I'll have one.

PARTICIPANT: Where is it on the

website?

(Off mic comment.)

PARTICIPANT: Where is it on the website?

MR. STOLPE: So this is, sorry, this is --

PARTICIPANT: We'll just pass them around.

MR. STOLPE: -- all caused unplanned admissions for patients with multiple chronic conditions.

(Whereupon, the above-entitled matter went off the record at 12:24 p.m. and resumed at 12:47 p.m.)

MR. STOLPE: All right, very good. With that being said, let's move directly into our next measure under consideration. This is MUC2019-66. Hemodialysis Vascular Access, Practitioner Level Long-Term Catheter Rate.

This measure is currently implemented in a slightly different specification inside of ESRD QIP. The measure description is the percent

of adult hemodialysis patient MUCs using a catheter continuously for three months or longer for vascular access attributable to an individual practitioner or a group practice.

The NQF recommendation for this measure is conditional support pending NQF endorsement.

We didn't have any other significant comments on that to share other than to emphasize that the measure is feasible, as evidence by its use in ESRD QIP that it draws from both claims and CROWNWeb data and that no challenges have been identified at this time.

CO-CHAIR BAGLEY: Okay, our discussants. Let me get on the right page. Chad, you're on the phone? Is Chad back with us?

(Off mic comments.)

MR. STOLPE: Chad, are you on the line?

MEMBER TEETERS: Yes, I am.

CO-CHAIR BAGLEY: Okay. Do you have initial comments on the measure?

MEMBER TEETERS: Oh, yes, I'm sorry.

MR. STOLPE: Chad --

(Simultaneous speaking.)

CO-CHAIR BAGLEY: Did you hear me, Chad?

MEMBER TEETERS: Yes, I can hear you now. Sorry.

CO-CHAIR BAGLEY: All right. Did you initial comments on the measure, as the lead discussant?

MEMBER TEETERS: Yes. The other measure?

CO-CHAIR BAGLEY: Yes.

MEMBER TEETERS: Yes, okay. So, yes. So, this measure is a percentage of adult human analysis patient months using a continuous, catheter continuous for three months or longer for faster access, attributable to individual practitioner or group practice.

Notably, the exclusions that were listed for those who haven't had a chance to look through it were peds patients apparently on

dialysis. Those that have one MCP provider listed for the month.

And then in addition, patients with catheter that had limited life expectancy under lots of care, metastatic cancer, liver disease and brain injury being called out.

This one was actually pretty unanimous in the feedback that was provided online and that most question the validity and fee statistic of this particular measure, mainly because of, the statistic was about .602 whereas the prior EMS measure provided with NQF was (telephonic interference). The facility rate showed a correlation of about .765. So that called into question the reliability of the measures.

Otherwise the other concerns that were raised largely centered around this, is from the main delegation, largely centered around the concern for other vascular access measures and other rounds of value-based payment on whether this would be conflicting or potentially redundant. And especially attributing it to the

provider level with that degree of correlation and validity that's been demonstrated.

So, with that, those are my feedback so far.

CO-CHAIR BAGLEY: Okay, any comments, additional comments from the co-discussants? David.

MEMBER SEIDENWURM: So, the noise factor of 40 percent noise rather than the usual, the accepted 30 percent noise is, I think, important.

But I think that because, I think that this is a disparity, health disparity sensitive metric. And I think we might want to have some flexibility there to improve on health disparities.

The importance of the patients with limited life expectancy is --

CO-CHAIR BAGLEY: Keep your volume up please.

MEMBER SEIDENWURM: Sure. The importance of patients with limited life

expectancy I think was mentioned.

And I think we just need to emphasize that cost, complications, morality, hospital use are all correlated with this type of care. So we really want to push things in the direction.

And then push them into the provider level. It has the same benefits and system as, that we've seen before.

So, the one thing that I would say is that we may also promote better team based care with, there are some communities in which there's a limited supply of vascular surgeons. There are now some cutaneous devices that could be used to facilitate this by interventional nephrology, interventional radiology and other specialties. Cardiology presumably.

So, I think that some of those access problem are mitigated by the new technology. So those are the comments I wanted to make.

CO-CHAIR BAGLEY: Okay. Yanling.

MEMBER YU: Yes, I just have a question for NQF. And the recommendation is for

condition support. Is that based on the fact that measure has now been submitted for reliability and visibility of validity testing? Is that wise condition?

MR. STOLPE: That is correct. So, the expectation would be that the measure would be submitted to NQF for core review. Including evidence, the importance, the scientific acceptability, feasibility and usability.

MEMBER YU: Okay. So what if this Committee support this conditioning approval, then what if the tasking did not pass those two tests, what's going to happen?

MR. STOLPE: The assumption would be that it would be inappropriate to carry use inside of the specified workgroup.

MEMBER YU: Okay. Okay, thank you.

CO-CHAIR BAGLEY: Kim, did you have any comments from the Rural Workgroup?

MEMBER RASK: Yes. From the rural workgroup discussion, they felt this was really relevant and important for rural residents

because of the prevalence of diabetes and hypertension and subsequent kidney disease.

They were concerned about an unintended consequence. If there's a higher burden of disease.

Despite the, given some of the exclusion criteria, if there is a lot of faulty morbidities where people that were really too sick and did not have a long life expectancy, what might feel pressure to have fistulas placed when there really wasn't going to be much benefit for them long-term because of their poor prognosis.

In terms of overall impression, this, again, was one of the ones that was right in the middle. Not a strong against and not a strong four.

CO-CHAIR BAGLEY: Additional comments? Will.

MEMBER FLEISCHMAN: I'm trying to think I'm not a nephrologist. And I'm guessing this is essentially targeting nephrologists, and

maybe some primary care doctors who will seek, who are primarily caring for patients like this.

From a clinician's perspective, what control do you have, other than saying to the patient you should really get an AV fistula, what control do you have over the patients actually getting that?

You can't force a vascular surgeon to do the procedure. You can refer them to one. Is the idea that we're simply pushing people to refer people for AV fistulas?

Because you really have limited control over ensuring that this actually happens. As opposed to having this at a system level.

MR. ROACH: Can I respond to that?

CO-CHAIR BAGLEY: Please.

MR. ROACH: Okay. Hi, I'm Jesse Roach, I am the ESRD measure lead, I'm a nephrologist.

So, I think that when you set up vascular access, I think the clinician actually does have a large degree of control. So first

off, there is the referral, but then there is also followup and coordination.

There need to be a number of studies done before that need to be ordered. And in pushing the person to get it actually has been shown to help, and to help get it done.

I think we've also seen, since this is in the QIP, since it's been instituted and since we have instituted the Fistula First program, and has held the facilities accountable, that there has been a steady decrease in the number of catheters and an increase in the number of fistulas. So it is definitely something that the facilities and the physicians can control.

And then along with that decrease there's been a significant decrease in mortality as well, which we think a lot of it has to do with this Fistula First.

CO-CHAIR BAGLEY: Helen.

MEMBER BURSTIN: Just a brief question. And I'm glad you're here. So, what's the, from your perspective, what's the added

benefit of taking an existing QIP measure and bringing it to the clinician level? I want to understand how you think that is useful from a patient perspective?

MR. ROACH: So, I think that it, one, allows nephrologists to, I think it allows nephrologists to be, I'm trying to think of the right term, recognized for, or to establish their value of doing this for the patient. I think it's an extra step to encourage physicians to work for this instead of just facilities.

We've had facilities tell us that the physicians are separate actors and that they are not necessarily working in concert all of the time.

And then also on top of that I think that there is still a gap. There's about ten percent of patients that have, that still continue to have fistulas, I mean, catheters for over three months. And I think that this would work to continue to decrease that.

MEMBER BURSTIN: And I think the

safety issue is a given, I'm just trying to understand how that added effect matters. But thank you for that.

CO-CHAIR BAGLEY: Okay, other comments or questions? Will.

MEMBER FLEISCHMAN: One follow-up item. So how is, I didn't see the measure specs. This is specifically targeting only nephrologists or --

MR. ROACH: So, I imagine if you had multiple, if you're a primary care provided and had more than, I think it's ten patients that were on dialysis, you could do that. I think this is geared almost exclusively towards nephrologists but there is potential for primary care docs if they were sort of active primary care doc with these people.

But most of the time the person that's arranging all of this and billing it is going to be a nephrologist.

MEMBER FLEISCHMAN: All right.

CO-CHAIR BAGLEY: Okay, Chad, do you

have any comment on the phone?

MEMBER TEETERS: Yes, I just have another question, I guess, for the CMS folks. So one concern I would raise, and I don't know, maybe it should be a concern.

But with the plan to release mandatory bundles to 50 percent of the nephrology groups in the next, in January, and then with the advent of the elective KCF, and I think KCC bundles soon to follow, isn't there a concern that by putting us in the mix down there that we're kind double jeoparding the groups who will be participating in these other programs?

MR. ROACH: So, well, it's a little hard to say right now because those are still under development. They just have, they've just been proposed right now and so the final iterations of those isn't quite known.

I do think that the fistula part for the QIP will be there. I think for the ETC, the first one that you mentioned, that will just, that's just going to be trying to push patients

towards transplant and home dialysis modalities. I don't think that this will necessarily affect that.

With the KCC models, which are the Kidney Care Choices models for nephrology practices, it's, I can't answer that fully just because we don't know what those models are going to look like right now when they're done.

MEMBER FLEISCHMAN: All right. Okay, thank you.

CO-CHAIR BAGLEY: Thank you. Any other comments or are you ready to go for a vote? I don't see any cards up; are we ready?

MR. HIRSCH: For MUC 2019-66 Hemodialysis Vascular Access, Practitioner Level Long-Term Catheter Rate, do you vote to support the preliminary analysis as the workgroup recommendation with the preliminary analysis being conditional support for rulemaking? Your options are yes or no.

MS. BUCHANAN: So, we need two more votes, if people could just, oh, we need one more

vote. Just make a selection and not clear it.

CO-CHAIR BAGLEY: We got it.

(Off mic comments.)

MR. HIRSCH: For MUC 2019-66 Hemodialysis Vascular Access, Practitioner Level Long-Term Catheter Rate, do you vote to support the preliminary analysis as the workgroup recommendation, there were 19 votes for yes, three votes for no. The workgroup recommends MUC2019-66 for conditional support for rulemaking.

CO-CHAIR BAGLEY: Okay. Congratulations on your efficiency. Next.

(Laughter.)

MR. STOLPE: Very good. So we actually have some efficiency built into the next two measures as they are the same.

So one will be applied to MIPS. Once we finish with this one, that will conclude our discussion of MIPS measures and we'll transition directly to the single SSP measures that we'll be reviewing this cycle. Which is the same measure.

Now, after I give a brief introduction of this measure I'm going to hand it over to the measure developer. Inside of your meeting materials there's a supplementary memo that outlines a couple of things that we thought would be particularly pertinent for you to consider.

I'm to invite Jordan to screencast the final portion.

(Off mic comment.)

MR. STOLPE: Yes, that's fine. Please do so now.

The final portion of that memo that outlines both the importance and the scientific acceptability of the measure that we felt like this group would particular benefit from considering it a highly projected during the course of the discussion. And I'll turn it over to Elizabeth once we get through this initial part.

So, the measure that we're discussing now is measure, MUC2019-37. And that is the Clinician Group Risk-Standardized Hospital

Admission Rates for Patients with Multiple Chronic Conditions.

Now, just to briefly highlight the measure description, this is the annual risk standardized rate of acute, unplanned hospital admissions among Medicare fee-for-service patients age 65 years and older with multiple chronic conditions. The Staff recommendation for this measure is conditional support pending NQF endorsement.

We wanted to point out a couple of things related to it, mainly that MIPS currently has 30 measures in the priority area of communication in care coordination, including all costs for readmission, unplanned hospital readmission within 30 days of principle procedure and unplanned re-operation within the 30 day postoperative period. However, there are no measures for admissions of patients with multiple chronic conditions.

And the evidence review, we would traditionally have found the evidence not

sufficient for this. However, when we looked at a comparable NQF endorsed measure, NQF-2888, which was last, sorry, excuse me, reviewed in 2016, there were a number of things that tied this together that made it make sense a bit more.

And we found sufficient evidence that this was actually the case. This measure doesn't do the work.

So, that concludes our findings so I'll hand it over to the measure developer to walk through the importance and the scientific acceptability, which you'll see projected on the screens behind you for those of you that are facing the other way.

MS. DRYE: Hi, Elizabeth Drye from Yale. I'm six of seven kids so I'm just going to shout because that's --

(Laughter.)

MS. DRYE: So, tell me I'm too loud. So, just to clarify how these measures are the same and what -- how they are coming at you, one after the other, before we go over what's on the

board.

So this one we're going to talk about first. It's for them merit-based incentive payment system program.

There is a measure for multiple chronic, of admissions for multiple chronic condition patients that's already in use in the ACO program. And so when we get to the share savings program we're going to be talking about a new version, a revised version of that measure that is completely aligned with this new MIPS admission measure.

So the, Sam, the stuff on the board from that memo is for the ACO measure. So you can, we're not there yet, at the ACO measure, but I just, I always want to say that again.

So, CMS had an ACO, has an ACO program, an admission measure for patients with multiple chronic conditions. We developed one for the merit-based incentive payment system. Because the merit-based incentive payment system is different, it has individual clinicians and

small groups, it's shaped differently. And particularly the outcome is a lot narrower, the kinds of admissions we count.

And then recently CMS just decided, let's stay aligned. And so, the ACO measures coming back at you, it's already approved NQF measure, but it's coming back to this Committee with a narrow outcome and aligned to be the same as the new measure that we're showing you right now.

So that's why you're getting both in the MAP because the ACO measure is changed, and particularly the outcome is narrower than the one that already went through NQF and is in the program.

The ACO program has the entire Shared Savings Program to switch over and use this new realigned measure. So, let me just pause there, so you know before we start, these two measures, their questions about what you're going to see sequentially, because that's probably is a bit confusing.

CO-CHAIR FIELDS: I guess so, I do have a clarifying question but it is actually, are we going to discuss them en masse then if I have a question that's specifically related to SFP, just wait?

CO-CHAIR BAGLEY: We have to wait.

CO-CHAIR FIELDS: Okay. All right, then I'll defer.

MS. DRYE: Okay, other questions about, okay, just before --

CO-CHAIR BAGLEY: So, same measure, using two different programs, we actually have to discuss them and vote on them separately. Just in case you forgot about that.

MS. DRYE: Okay, so I'll just really briefly highlight what you're seeing. You've seen the, you know, you have a discussant on the MIPS version of this measure which was fully defined and in the public domain and had gone through public comment.

So, the outcome is acute unplanned admissions, but narrow to drop out of what is the

current ACO measure, things that ambulatory care providers don't have the ability to influence. Like admissions for complications of surgeries, accidents or injuries or the patient went directly from a skilled nursing facility --

(Teleconference music plays.)

(Laughter.)

(Off mic comments.)

CO-CHAIR BAGLEY: All right.

MS. DRYE: Okay. So, in just describing the outcome and how it's narrower than what has been being used in the Medicare savings program today, there are, we take out of the ACO, we don't count as an admission in this measure, complications of surgeries because we are measuring primary care providers and other relevant clinicians who take care of chronic disease patients and not surgeons, patients who get admitted directly from a skilled nursing facility, patients who are admitted within ten days of being in the hospital. And this just goes to thinking about, and we had another

measure where we talked about this, you know, which providers are influencing that very directly post-hospitalization period here.

We're trying to be conservative in the sense that we don't want to hold ambulatory care providers accountable for more types of admissions than they can really influence.

Or if patients are in the Medicare hospice benefits. Benefit when they get admitted. Or if they hadn't seen the provider prior to the admission.

So, the MIPS programs, like the Shared Savings Program, there is a measurement near January to December, and if the patient gets admitted and they never saw the provider to whom they're attributed, then we don't count that admission in the outcome.

The structure of this measure, and the next one, it's different than the readmission measure. And this that the outcome is, or the rate, is admissions per 100 person years of sort of the patient availability to be admitted.

So it's not an either/or, you can be, the time the patient is in primary care and the outpatient setting is counted and the number of admissions over that year are counted.

So, if they're admitted to a still nursing facility for a long time, that's not put in the denominator. So we adjust the denominator just for when a patient is in the primary care setting.

Questions about that? Either the way we structured the outcome or what's in the outcome or you do you want me to just go through the whole thing?

CO-CHAIR BAGLEY: I think we'll just hold until we have the lead discussants talk about it.

MS. DRYE: Okay, so we just stop there.

CO-CHAIR BAGLEY: So, Amy, would you kick it off please?

MEMBER NGUYEN HOWELL: Sure, thank you for that. I've had a lot of questions.

Clarifying questions.

So, I applaud CMS for really wanting to bring this up, it's definitely needed in terms of our chronic care, condition and management in comp health and value-based care. I love the fact that it's an outcome measure, so we really like the direction that this is going.

And with the research, and I was a little confused about the MIPS and the ACO because there was different discussions, but I liked the alignment. But just to review for the folks in the room, there was issues around attribution and risk adjustment. So I'm sure you'll be able to clarify that. So I look forward to hearing about that.

But I think the attribution point was consistent with the other comments that have been talked about at the clinician individual level. Especially AMA's comment.

Earlier, Koryn, your comment at that level versus at the provider group physician organization level. So we, I think from what

I've read, it is preferred at the PO level.

And I just want to reiterate kind of the LANs, our gold standard in terms of patient attribution. We've done a lot of work on how the patient's choice should always be the gold standard.

So, I wanted to reiterate that and make sure and confirm that that was consistent with this measure.

And then the risk adjustment, I'm just glancing over this memo so I'm hoping, if you could clarify regards to the frailty index and the risk adjustment, that that is, that would be really enlightening and hoping to clarify that. Because it will help, not just frailty but also talk about the social and behavioral determinants and how that's related to this in terms of the revised methodology.

And glad to hear that it's not a duplication of ACO-38 because that's always good to know. And thank you for the clarification about the narrower outcome. Especially excluding

hospice from that definition, from the denominator.

Oh, and if you can clarify the minimal, minimum reliability as well.

(Off mic comments.)

MS. DRYE: Okay. So, just to recap, I think, you asked about attribution, risk adjustment for frailty, but we'll talk about social risk factors as well, and then reliability. Those are your three --

MEMBER NGUYEN HOWELL: Yes.

MS. DRYE: Okay.

MEMBER NGUYEN HOWELL: Thank you.

MS. DRYE: And I'm going to contrast this to the ACO program a little bit. This is the one place they differ is attribution.

So, this was a great measure to think about attribution with. I built on the principles of, you know, the NQF's attribution work with I was part of in our team. We really tried to think about how do we get, how do we accomplish the purpose of the measure within the

context of this program?

The thinking on attribution from our technical expert panel and in our group was really to drive accountability towards one provider for this particular measure, to start to address or have one to address the fragmentation of care and accountability and fee-for-service patients in the Medicare program.

So, we attribute to one provider. We favor the primary care provider. We use a visit based approach, so it's who's seeing the patient the most in the measurement year.

And if there is not, if there is a specialist, however, who is seeing the patient more, and that could be, we narrow the group of people who -- couldn't be a pediatrist, who couldn't be a radiologist, this measure is not designed for them.

We limit the group of types of providers that the measure can be attributed to. To those that plausibly are caring for chronic disease patients. So that includes, obviously,

internist, but cardiologist, pulmonologist, nephrologist, neurologist, endocrinologist.

And I'll just say one other thing, it's a little detail about this measure, which we want, we got comments and public comment on the measure from clinical oncologists and we wanted to think about how to handle patients who have cancer that's active. That's in an acute phase.

And what we do in attribution is we include hematologists-oncologists, and if they're really seeing a patient frequently we make an attribution of that patient, which means they don't get attributed to an internist, for example.

But the measure doesn't, they just get pulled out of the measure. The score isn't generated or done for hematologist-oncologist because this measure really isn't designed for that.

So, we tried through attribution to find the dominant provider, limit it to the relevant specialist and pull out patients that

were really in a unique phase that we couldn't potentially deal with through risk adjustment, for example. Questions about that?

It's -- there is an algorithm in our technical report, which is in the public domain, but I don't know that guys have seen it, but gives the flow.

CO-CHAIR FIELDS: So, a simplified form is related but not equal to the ACO attribution?

MS. DRYE: So, ACO is different, and I'm going to have the ACO team jump in.

CO-CHAIR FIELDS: So I'm really --

MS. DRYE: So let me just play on difference and then you guys can talk. Is that MIPS is, and this goes to the NQF framework for attribution.

This attribution strategy is designed for this measure in the MIPS program, just as the hospital-wide readmission was its own, you know, we considered.

ACO uses one attribution strategy to

assign all patients to the ACOs, and then the measures that apply. So it's a different starting point.

So, yes, it's not the same because the inclusions, exclusions are all aligned but the ACOs just get all their patients assigned in one step --

CO-CHAIR FIELDS: Sure.

MS. DRYE: -- and then the measures get run --

CO-CHAIR FIELDS: But there are similarities. I'm just assuming, in terms of the plurality of care issue with assigning the PCP designated specialty codes as --

MS. DRYE: Now, we use --

CO-CHAIR FIELDS: -- their priority.

MS. DRYE: We use evaluation and management codes --

MS. BUSH: Right.

MS. DRYE: -- when looking at -- do you want to talk more to that?

MS. BUSH: I'm just going to say, we

begin with primary care providers and I think --

MS. DRYE: Yes, we do.

MS. BUSH: -- there is more, more Shared Savings Programs. Initially they get attributed to the ACO itself and then to the measures that apply to the ACO --

CO-CHAIR FIELDS: Right.

MS. BUSH: -- based on the provision of primary care.

So, primary care received from a primary care provider type is first, and if the beneficiary didn't receive any primary care from the provider type, provider care provider type, it's based on plurality of primary care by itself.

CO-CHAIR FIELDS: And you start with the plurality, or do you also start with primary care?

MS. DRYE: We favor primary care providers.

CO-CHAIR FIELDS: Okay.

MS. DRYE: But there is a dominant

specialist, we'll move the patient over.

CO-CHAIR FIELDS: So if they saw a PCP three times and an endocrinologist five times they'd be --

MS. DRYE: They go to the endocrinologist, exactly. That's a good example.

Most people get assigned to a primary care provider.

CO-CHAIR FIELDS: Okay.

CO-CHAIR BAGLEY: Kimberly.

MS. BUSH: I'm sorry, I'm Kim Spalding Bush from CMS. I was supposed to introduce myself, I apologize. And I run the division that administers the quality program for SSP.

CO-CHAIR BAGLEY: And excuse me, Kevin, hold on just a second. I think I'd like to, was it directly to this point or can --

MEMBER BOWMAN: Yes, to one of, the example that was given for the oncologists. So, extension for that example, what you're saying is patients being treated actively for cancer, you would hold the oncologist accountable, not

necessarily PCP or any admissions or any outcomes of the treatment that's going on, is that kind of what you're saying?

MS. DRYE: This measure, the matter is not designed to score oncologists.

MEMBER BOWMAN: Got you.

MS. DRYE: So, they would just, they're just not affected by the measure at all. It only is designed to score, to give a measure score to the primary care doctors and the specialists I mentioned, endocrinologists, pulmonologists, cardiologists. They don't get a score.

We assign the patient there to pull the patient off of everybody else's panel because they're really being cared by, for, primarily by an oncologist for an acute process that's dominated.

MEMBER BOWMAN: So they're taken out.

MS. DRYE: Taken out, exactly. Through the --

(Simultaneous speaking.)

MEMBER BOWMAN: Okay.

CO-CHAIR BAGLEY: Before we go on I'd like to allow the other co-discussants to weigh in. Peter and Sandy and Louise.

MEMBER ROBERTSON: So, I think generally supportive of the measure, I had questions about contributions, so thank you for those clarifications.

And just to compare, the data that's presented here though is specific to the ACO version of the metric, not clinician level performance as it --

MS. DRYE: Right.

MEMBER ROBERTSON: -- will be in MIPS.

MS. DRYE: So, we --

MEMBER ROBERTSON: That testing information is to come?

MS. DRYE: No. So the MIPS measure, in the merit-based incentive payment system, I'm just going to say it because there's too many acronyms, ACO, MSSP. All that testing was in what was submitted to the MAP already.

We did the ACO testing very recently. And this is why some of the results that you would want to see, like the reliability testing and the measure score distribution just went up online Tuesday because CMS made a decision, and I think you guys jump in, but very recently we had the whole data rerun on the measures and run all the testing to fully align that ACO measure and move it through the MAP process completely along with the MIPS measures.

So we had to rerun and generate the numbers with the new outcome definition with the same inclusion exclusion. It's the same risk adjustment including the frailty and the social risk factors.

So, they then rerun all the results and it's way too close. We're owning this because it just isn't getting too early but these measures are very similar and the numbers are there now.

So, what, you want to cease the number, we were going to walk through them on the

screen too because I know everybody can't look online while you're traveling, et cetera.

CO-CHAIR BAGLEY: Sandy, comments?

MEMBER POGONES: Yes. I was also very interested in admission rates. And we really do appreciate the work that's been done on the measure.

We do have some concerns, particularly because when you look at this on an individual level, it's one thing to have the entire hospital community and provider community, multiple different types of other multiple stakeholders involved in addressing some of the social determinants and addressing some of the issues that are required to prevent hospitalization.

We know a lot of that comes back to the social determinants. And when you are an individual provider, you don't always have the resources there with those things.

The research is pretty good that improved care coordination and programs that are focused on care management can lead to reductions

in admissions. But it also involves multiple partners working together.

And when we start looking at a sole provider in the community, there are not multiple partners there. So that's our problem with looking at the individual physician one-to-one, that it holds this single physician responsible for an awful lot of things that may not be under their control.

Behavioral health services in rural communities, you've already heard that that's a huge problem for hospital admissions. A lot of it points back to the behavioral health. But those services aren't always available in rural health in America.

And the social services, the housing, those types of issues, the poverty, boy, it would be nice if as the clinician you could impact that. But it goes back to what was said earlier, there is nothing more frustrating to be a physician, knowing what's wrong but not being able to do anything about it.

And I think a measure like this can really reflect that. Really highly.

When you have a group of ACOs, an ACO that has all of these other stakeholders working together, you definitely have an advantage there. Individually I think there could be some really issues there.

We also agreed that ACOs, they know it's attributed to their individual clinicians. We didn't find out until 18 months later who was actually under their care and who they were supposed to be response for, for this admission. So the upfront attribution is really important.

We had a little issue with the reliability. And correct me if I'm wrong, but we believe that reliability achieved for the -- at the individual clinician level was .5. Is that correct?

MS. DRYE: I'm so sorry, I was asking a question.

Yes. So for this, the MIPS measure, the -- so, when you look a measure of reliability

at the physician level, meaning every physician has at least .5 that we calculated, in the data set we have, we did this testing, which was 2015.

Which is really actually using the way physicians were organized to report for the value modifier program. I just want to say as an aside, this measure is going to go to NQF in the next, in the summer, and we'll use 2018 data.

So this should look different than it does now. But basically using how physicians were organized to report for a value modifier, we needed at least 28 inpatients in the measure to get a reliability of .5.

If you wanted two requirement -- a higher minimum reliability because there is no right way to do this, it's usually a tradeoff as you know, then it would be 64 patients per provider.

So, you have to have a fair number of multiple chronic condition patients with, the conditions you need to qualify for the measures are very common.

MEMBER POGONES: Yes.

MS. DRYE: So you won't hit every individual provider who will have 65, and that many 65 and older patients, if we go to .7, which is a pretty strict reliability, it equals 81 percent of the patients. So you cover most of the patients but you're going to miss a chunk of the providers.

MEMBER POGONES: And we would like to see that reliability, go to at least .7 by summer.

MS. DRYE: Okay.

MEMBER POGONES: We don't think .5 is high enough. Mostly what we look at, we promote .7 reliability. And I think that will also relieve some of the pressure on physicians in smaller communities that don't have the support to make all this happen.

And not only financially, but they don't have the structures in place and they can't get it because they're, just because of where they're at and how they're financed. So, I think

that would be really important to us.

There's also this constant struggle we have with your hand measured at potentially at, but never seeing your own data, or never seeing a wide range of data that applies to physicians to be able to look at it and say, oh, this measure does some crazy things. And really can't identify that until you really see your data.

And I think that's one of the struggles we have with base validity, is that there's some many algorithms and it's so complicated that we don't have any idea. That's transparency. We don't know what's going to happen.

And I think we need to, I think we need to know that. And I think physicians need to see what happens to their data before they're paid. So, we would like to see that. Thank you.

CO-CHAIR BAGLEY: Louise?

MEMBER PROBST: I just want to take up on the comment of how positive I think the measure is.

PARTICIPANT: Speak louder.

MEMBER PROBST: Okay. This is really an important measure, I think, for people. I think the staff has told us over 80 percent of the people over 65 meet this criteria of two chronic conditions.

And it's really about communications, educating patients, self-care. You know, talking with the team. It's really about the care coordination and communications. Which is so important.

And it just seems to be where our health system needs to go. And so, I have a little concern about the hematologist, so I appreciate you clearing up the attribution issues.

But things like the very, very important measure from a consumer and public perspective, so I just want to lend my support. It does promote, as someone else said, systemness.

CO-CHAIR BAGLEY: Okay. Amy, if

you'll hold on just a second.

MEMBER NGUYEN HOWELL: Sure.

CO-CHAIR BAGLEY: Kim, would you, on the rural.

MEMBER RASK: From the rural group, echoing what we've just been hearing here, our feeling is that this is a really important measure for rural residents. These are chronic conditions to modern multi-morbidity in health communities.

And then concern on the provider side, depending on, to what extent availability and local resources, to mitigate social determinates, and health available in rural communities. And so, technically it balanced out.

The group had sort of an intermediate comfort level with the, at the provider level MIPS measure and were highly supportive of the MSSP measure.

CO-CHAIR BAGLEY: Okay. Amy.

MEMBER NGUYEN HOWELL: Oh, I get it. So, speaking from a nurse position, we totally

agree about the ACO measure. We won't go against that.

And I really concur with CMD and the rural team and the AMA during one of the few times we actually agreed --

(Laughter.)

MEMBER NGUYEN HOWELL: We get this all the time, I'm an AMA member.

And it goes down to that individual clinician level. Because what is the goal of MIPS? The goal of MIPS is to encourage the individual practice practitioners, providers, physicians in our country to move along the continuum to APMs, correct.

And maybe that's, at least that's my understanding of where we're trying to go. And so, we shouldn't, we should encourage them, and perhaps put this as maybe informational for the first couple of years, gather some more data.

I fully support increasing the minimum reliability to at least .7. Because it does cover your 80 percent of Americans with chronic

conditions so it meets that criteria.

But I think if we, I fully applaud CMS's goal to align these measures. I think it's, we definitely need to do that.

At least -- but for this one, it might have unintended consequences that may discourage individual physicians, practitioners to move into APMs with this measure. Because it can penalize them in a way that wasn't intended.

So, I think as a solution to maybe do it information, gather some data. So, I'm curious, you said you do have data for both MIPS and ACOs in terms of reliability, were they consistent? I know you're going to walk through --

MS. DRYE: Yes. I mean, the ACO-1 is on, I think, did you put it on the board there?

MR. STOLPE: It is.

MS. DRYE: Yes. So, if you look at, ACO is easier to get a higher reliability because ACOs are big. And so you need, actually it's about 100 patients to get to a minimum of .5 and

over 200 patients to get to .7. But that's basically everybody who can get there.

It's 99 percent of the patients on the ACOs, would have a reliability of .7 or better. Because they're just not, you know, they're big compared to individuals.

So, reliability is easy now. I didn't answer your question though. I don't know if you still want me to answer about frailty and some of those factors or move on.

MEMBER NGUYEN HOWELL: Yes. So, if the reliability for ACOs is easy, then is that inconsistent with the reliability when we look at MIPS?

MS. DRYE: So, I'm going to guess here. I mean, reliability is influenced by the outcome rate, the sample size and the variation, right? That within and between variation.

MIPS, there is a lot of variation. The problem is, in any outcome measure, whether it's -- or this one, we need enough cases. This is a one year observation period.

And so we just can't get down to like ten or 15 cases. If we were willing to accept a reliability rate of .5, we can get down to 26 cases in MIPS.

Which I think a lot of providers, more providers will read in the 2018 data than they did in the 2015 data just because, again, we were looking at how providers were grouped for reporting under value modifiers.

But we will run that, when we take the measure to NQF for endorsement, we will recalculate the reliability in the 2018 data, which will then be a MIPS, when MIPS is already implemented and we'll be able to see that.

It's not that you can't get reliable in the bigger groups or in physicians, we see a lot of elder patients, it's just there are a lot of individual clinicians who just don't have as big of a case load. And we really can't assess their quality with the outcome of admission and reliability.

MEMBER NGUYEN HOWELL: Yes.

Certainly. Absolutely. Yes. I just I think this is a really important measure.

It's great that we're discussing this, I just don't see it at the MIPS level because it, to Sandy's point, you need that care team, you need the resources, you need that care coordination piece to be successful in order to set yourself up success for APMs, right, for the ACOs.

So if we're trying to just measure everyone the same that's in SSP on this particular measure, I just think it's too premature for the MIPS program.

MS. DRYE: I don't have these, I can probably pull them up, but I just want to note that in the MIPS program some of the provider groups are very, very big, so they're not that different in size in the ACOs. So one advantage of keeping it in the MIPS program, and then CMS would propose this specific reliability level in the minimal sample side, because if you don't go into MIPS you're not going to be covering those

groups that are actually big and have capacity.

So, the program is, gives you a sort of, as you know, ACOs are all big, but MIPS is a mix of very big groups, medium size groups, virtual groups and individuals.

MEMBER NGUYEN HOWELL: Yes. So, I agree with that. If it's MIPS measuring at the PO level I agree with that.

Based on the same argument and structure as the ACO, it's just at that individual clinician level we just might be doing our country a disservice by trying to measure apples and oranges at this point in time with the different, the varying degrees of resources that we have in our country, the geographic, the other social determinants.

But I'd be happy to hear about your, the risk adjustment. The frailty and social media roles. If we have time.

MS. DRYE: Yes. I was just, I didn't mention earlier, and I just wanted to add one other reasons, this measure differs from the

previous ones we discussed in that we adjust for factor -- frailty factors.

This is a sort of move I would say building on sort of the work other people have done and others, to cull out readily accessible adjusters that align with social risk factors.

So, we have walking aids, wheelchairs, hospital beds, lifts, oxygen, supply or the original reason for enrollment in Medicare. If it was disability or ESRD. Those are individual risk variables in the risk adjustment.

And then we also adjust the field, for two -- we were thinking at this area level indicators of deprivation or social economic burden among the provider, patients providers are seeing, which is the ARC SES index, which is an area level index down to the nine zip code level.

And then also we use specialist density here, as somebody mentioned earlier in discussion, on other measure, you want -- might want to refer from a specialist, but this is what we heard from rural clinicians who gave input

that you might not have really any specialist access. And so, we adjust for the density specialists. Those are two area level indicators.

This MIPS measure adjusts for, and then when we align the ACO measure, we brought those adjusters into that. Into that model as well.

CO-CHAIR BAGLEY: Trudy.

MEMBER MALLINSON: I just wanted to follow-up on a clarification about the size of MIPS. Like the size of the groups versus the size of the ACOs.

And just to keep in mind that the ACOs are broader, are likely to have gotten many more services, many more different kinds of practitioners all collaborating, members of the team collaborating, producing outcome.

And even though MIPS isn't solely physicians, it's mostly physicians. And I think that's partly the difference there, right. It's only a physician responsible for, it is a much

broader set of problems. And I'm just not sure that we're there yet.

And I think -- sorry, I can't remember -- Sandy was saying that you were sort of speaking to that earlier and I just want to, back when we were just talking about sizes, and it's not just about the numbers, it's about the comprehensiveness of professionals who will participate and just trying to solve, and do that work for the patients.

CO-CHAIR BAGLEY: Okay, thank you for that. I don't see, oh, Ann, go ahead.

MEMBER GREINER: So, there will be discussion about, you know the systems that it takes to manage people with chronic conditions. And first of all, I would like to support something like this.

I am concerned about this at the individual clinician level because, and I know it's beyond primary care, but primary care is a lot of what is being, you know, will be managing these patients.

We don't have good systems for primary care. We don't invest in primary care. And so we don't have the team that can really take care of the patients.

So, I would like to hold the individual clinicians responsible. I don't think they have the systems there to do that well. Even patients that are in medical homes. You know, they're under power.

They're teammates, they're not full-fledged teams because of what we invest. $0.05 to $0.07 on the dollar in primary care in terms of total cost.

Could this measure be modified to get clinician groups where there actually is scale and more ability to bring in other parts of the team to manage chronic conditions as opposed to clinician groups and individual clinicians? That might make it more palatable in this event.

CO-CHAIR BAGLEY: Robert.

CO-CHAIR FIELDS: I think what you're hearing generally is that, and I suspect that

MSSP discussion will be a lot easier. It's part of what your, and just to speak to some of the, what's on the measure, no one is arguing that. We care.

Everyone believes in the measure. The tricky part is, at least when you are running large networks you skip to an outcome measure at a level of where we skip a lot of process measures that could actually get us there, that are probably way more valid at an individual level, for instance.

You know, expanding on what is, there's a process measure around that communication. There was a mention of totally one piece of achieving on this measure is adequate communication with the inpatient system, or whatever delivery system, let's measure that or encourage that in a different way than what had been done thus far because honestly -- it hasn't worked, the communication is lousy still.

So let's measure that because that's actually something we can get some behavior

change around on the primary care doctors that I think that skip to such a complicated, and we all know that the driver is there, communication is like one, probably one hundredth of the driver of this measure.

And there's all sorts of social determinants and stuff, there's housing stuff, I can't afford my meds, and I got for seven days when I got discharged, I can't afford them when I go home. That sort of stuff that there is no way the PCPs can do it, as we've already heard.

So, I would just suggest that as substitute at the individual level, especially when you're talking about payment to an individual doc, if it's not affecting the greater system, it's affecting the solo docs, in particular, are going to get hurt by this, very aggressively, I think.

Especially in rural areas about the high density of Medicare and Medicaid. I think it's a mistake.

Just point blank, I think it's a

mistake to do this at the doctor level for that reason, despite the fact that it's a hugely important measure and would suggest, as a solution, to think about an additional boosting of process measure that would get to that outcome.

CO-CHAIR BAGLEY: Stephanie.

MEMBER FRY: I was just, I was thinking one step further along of, if you're hurting the docs in terms of payment, is there some unintended consequence or possibility for unintended consequences around if you know there are not the services fully to support that patient, to not engage with that patient at all to minimize your personal risk of taking responsibility for that outcome. That's of greater concern.

CO-CHAIR BAGLEY: David.

MEMBER SEIDENWURM: One question. When a patient --

CO-CHAIR BAGLEY: One conversation --

MEMBER SEIDENWURM: -- collect a --

when a patient elects a primary care provider, does that trump the other attribution in this metric or is that only germane in the ACO population?

MS. DRYE: I'm going to apologize again because I was consulting with an ACMS colleague. Could you just ask that again?

(Simultaneous speaking.)

CO-CHAIR FIELDS: If a patient selects a PCP, via the voluntary alignment methodology, does that trump any of the attribution in this? Was that the right question?

MS. DRYE: Well, I would, going forward we can apply that, it's not ready. It wasn't technically ready when we put it in place.

But that would be the intent, right. We just didn't have the, we don't have it in the development data. I don't think it's quite ready to implement that way, but we agree, that's a better, a more, I don't want to use the word reliable --

(Laughter.)

MS. DRYE: -- a more precise way.

I want to just give a number, and I don't know if this is helpful to the discussion, but there's a large concentration within MIPS, the patients in bigger provider groups.

So, 23 percent of the, because you know, providers report under a TIN, and many providers and one tax ID number or there may be one, just a solo provider.

But the way, so there was a whole range of how they're grouped. But 81 percent of the patients are attributed in this measure to 23, less than a quarter of the TINs.

So, if there is a minimum sample size set, the individual providers, many, many providers would fall out of the measure, but almost all patients, most of the patients will stay in the measure. A lot of groups are really, really big in the MIPS program.

So, I mean know, and CMS doesn't want to make, all of this will get vetted in the endorsement process, like what are the trade-offs

between reliability, you know, if you check out individual providers, what would that look like. We can go through all of that.

I know they don't, probably want to say today what -- but these patients, 80 percent of the patients are concentrated in 23 percent of the reporting groups under MIPS, so you will drop out half a million patients if you say, well, we'll use it in the ACO program but not in MIPS, they'll miss a lot of patients.

And I'm not, you know, I guess I'm just sharing that as a third context.

MS. BUSH: Yes. And again, we don't want to face right now what it might look like as it comes through the endorsement process, but there is some precedence for doing that in the value model program when we took a look at, I can't remember what measure right now, was it ECM measure, and we said, for a small group we're going to set the case minimum at a higher number because, then we did for a different sized group.

So there's a lot, I think, that can be

done with case minimum to address reliability and these small practices because, I think not necessarily because it's just a small practice, it could still be high volume of Medicare patients or it really may not be.

So, I don't know that practice dies, is the only thing to think about here. If we can get to a higher liability by taking a look at case minimums or some other things around that too we could consider.

MS. DRYE: I think we're hearing two things I just want to acknowledge. One is the reliability to score, which is always important, and the other is, thinking about individual clinicians and the --

MS. BUSH: Accountability.

MS. DRYE: -- accountability to the outcome. And I'm hearing those two as both individual concerns.

CO-CHAIR BAGLEY: Correct.

MS. DRYE: And what I'm hearing you say, you can design the way that's used in the

program to address both of those.

CO-CHAIR BAGLEY: Okay. Oh, I guess Will.

MEMBER FLEISCHMAN: Yes. So, and this goes more globally. We're discussing this as a MIPS measure, which people would choose to self-reflect, people would self-select to report on this measure from a group of other measures.

I think, and I think that should color the, that should really color what we're discussing because if we're talking about a measure that will apply to everyone mandatory, a mandatory measure of some sort, it makes sense, obviously internal validity you need internal validity, but whether it's fair and whether the, for example, the question about how different areas might have different resources, that obviously comes up as an issue.

But if it's people self-selecting to report on it, you would think that someone who thinks that this is unfair to them, they would not choose to report on this. So from, if it's

simply a matter of adding it to the repository, of getting someone options to report on it, my guess is that if you put this out there people, only people who think they perform well on it will choose to report on it, and then at some point it will be tossed out and removed from the list.

So, I think we should separate internal validity, whether this is actually a reliable measure, from, is this fair to reply to everyone. I'm wondering if that makes to you.

CO-CHAIR BAGLEY: That's a good point actually. Sandy, I want you --

MEMBER POGONES: Yes, I --

CO-CHAIR BAGLEY: -- to speak up and speak out.

MEMBER POGONES: Okay. I think I want to build on that point because some measures in MIPS do apply to everything. And they generally are the claims based measures that don't require any reporting. And they are considered for everybody.

So I guess that's a really important question, is this measure going to be considered for everybody because CMS can calculate what they've reported. Or will it be a self-selecting measure. That's the policy decision, not the plan.

I won't guess --

(Laughter.)

MEMBER POGONES: -- from history, because nobody has to report anything, that it's going to apply to everyone. That is traditionally what has been done.

PARTICIPANT: Yes, that's been done.

MEMBER POGONES: Right.

MEMBER DUSEJA: Except I will say we are moving to the MVP frameworks. So this potentially could be one of the MVPs on client conditions which then a provider will choose to report on that set of measures. But again, no decisions have been made at this point.

MEMBER POGONES: Thank you.

CO-CHAIR BAGLEY: Okay. It looks like

we're ready for a vote. I think that we should make sure we understand what the conditions are. Because this is a little different, so could you capsulize the conditions? So it's recommended under DA as conditional approval.

MR. STOLPE: Right. But there was some concern expressed around the individual level attribution, especially of that area. When this will be reviewed, the expectation is that if it's specified, NQF actually separates these two levels of analysis. That's the term of art level of analysis.

So when it comes to us for consideration, we'll expect to see testing separate, where the testing would be reliability and validity under the individual level, as well as the group level, separated out if the measure is to be endorsed in that way. We've actually had endorsement submissions where it was lumped together and it was only given the group level endorsement because the data was combined. So we do scrutinize that particular portion of analysis

when we undergo a review for endorsement. So I think it's appropriate to continue with the staff recommendation, which is conditional support pending NQF endorsement.

CO-CHAIR BAGLEY: Okay. Are you ready to vote?

MR. HIRSCH: Yes. For MUC2019-37 within MIPS, Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions and in Medicare Shared Savings Program, do you vote to support the preliminary analysis as the workgroup recommendation of conditional support for rulemaking? Your options are yes or no.

CO-CHAIR BAGLEY: I have a question. You said MSSP.

MR. HIRSCH: Did I say that? Oh, I apologize.

MR. STOLPE: That is actually how the measure is named in the MUC list. So --

MR. HIRSCH: That's correct, which is why, at the front, it's in parentheses, MIPS.

MR. STOLPE: Yes.

CO-CHAIR BAGLEY: Okay.

MR. HIRSCH: That is the title of the MUC.

CO-CHAIR BAGLEY: So let's be clear, we're voting on this for MIPS?

MR. HIRSCH: Yes.

CO-CHAIR BAGLEY: We're going to look at exactly the same measure and vote on it again later for ACOs, okay? So this is for MIPS.

MEMBER NGUYEN HOWELL: Note to change title.

CO-CHAIR BAGLEY: Say it again?

MEMBER NGUYEN HOWELL: Oh.

CO-CHAIR BAGLEY: Okay.

MEMBER NGUYEN HOWELL: I said: note to change title.

(Laughter.)

CO-CHAIR BAGLEY: All right. Are you ready? Ready for the votes?

MS. BUCHANAN: We are. So we are waiting on some votes. We need two more. We

need one more. And so we have -- we have 22. Okay.

MR. HIRSCH: For MUC2019-37 for MIPS, Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions, do you vote to support the preliminary analysis of the workgroup recommendation, seven votes for yes, 15 votes for no. The workgroup does not vote for conditional support for rulemaking for MUC2019-37.

CO-CHAIR BAGLEY: Okay. So what we're going to do is move down the list. I want to offer a vote that we would approve unconditionally. I'm just thinking of that choice here. Is that fair? And then move down to the next level, which would be to support, well --

MR. STOLPE: Do not support with potential for mitigation is the next --

CO-CHAIR BAGLEY: Yes. That's fine.

MR. STOLPE: But first, let's determine what those mitigating factors would be.

CO-CHAIR BAGLEY: Okay. That's fair enough.

MR. STOLPE: If anyone wants to proffer a suggestion for what would be a mitigating factor for how this could potentially be amended. And what those typically mean is modification to the specifications of the metric.

MEMBER NGUYEN HOWELL: Clinical group only, not individual.

PARTICIPANT: Can you say that louder?

MEMBER NGUYEN HOWELL: Clinical group only, not individual.

CO-CHAIR BAGLEY: Some indication of the size of the group. Some way to protect the small numbers.

PARTICIPANT: Yes.

CO-CHAIR FIELDS: Yes, I mean just to clarify that, because clinical group to me is not specific enough either. I would say clinical group of some reasonable size. But I'm not really sure -- it does have to be tested.

PARTICIPANT: We have definitions in

other areas like --

CO-CHAIR FIELDS: That could work.

PARTICIPANT: -- 60 clinicians.

CO-CHAIR FIELDS: It would require that just to protect the small practices.

CO-CHAIR BAGLEY: So we have a proposal to -- the third category is --

MR. STOLPE: So the category is: do not support with potential for mitigation.

CO-CHAIR BAGLEY: Right. And the mitigation would be to find some way to protect smaller groups. And you say you have mechanism --

MEMBER DUSEJA: Well, we have precedence with the HWR measure where we have -- the clinicians have to be more than 16 clinicians within the TIN, but you know, we're hearing it in terms of this concern.

CO-CHAIR BAGLEY: Thank you. Sandy. Accept clarification, Sandy.

MEMBER POGONES: Yes, I would add to that: minimum reliability of what's --

(Off mic comment.)

CO-CHAIR BAGLEY: Okay. Did you get that?

MEMBER YU: Just some clarification, do we vote -- are we going to vote on no vote if there is mitigation of it -- of the measure?

CO-CHAIR BAGLEY: Yes, that's a good point. The category invites the idea that once it's mitigated, we get to look at it again. Well that's just not the case.

(Laughter.)

CO-CHAIR BAGLEY: Oh. Is that correct? Yes, that's correct.

MEMBER NGUYEN HOWELL: Bruce, can you say that again please?

CO-CHAIR BAGLEY: As the category we're voting on, you know, sort of implies that after the mitigation, we get another whack at it. That's just not the case. We won't see it again unless it happens to come here next year with some other format. So it really isn't something we get to see again or rule on again or give

different advice about. But it does -- it should send up a figurative flag, if you will, to CMS that it needs more scrutiny. So I think that's what it does.

MR. AMIN: Bruce, can I just offer one clarification point? The intent of this voting category around do not support with potential for mitigation, was that there is -- the committee supports the concept, but some changes to the specifications are required before support can be offered. So it is clearly distinguishing what's in front of you right now is not being supported, but it's essentially giving guidance about how the specification should be updated. So consistent with the mitigating criteria around level of analysis specification, minimal, minimum number of clinicians and then reliability statistics would be the mitigating factors that would likely have to change.

CO-CHAIR BAGLEY: So in essence we're saying we still think it's important, but it's not currently constructed in a way that's going

to work out for clinicians. That's what we're here for. So are we all set? I'm sorry.

MEMBER YU: Just still a little confused. What I'm hearing is we all -- most of the majority support the general concept and think of this as an important measure, even we do right. So people want to improve this in certain way versus -- group versus individual level. So why can't we vote to say, if we address this concern whether we want the measure to come back, that would be more clear, isn't it? Yes.

CO-CHAIR BAGLEY: Well, the measure can't come back. And we just voted to -- not to accept conditional support. So we're on to the next lower category.

MEMBER YU: Right.

CO-CHAIR BAGLEY: And as Taroon just pointed out, it does preserve it within the system. That's what our expression of saying we think it's valuable. If we didn't think it was valuable, we should put do not support. And you'll have an opportunity of that. If you vote

down this next category, that's where we're going next.

MEMBER YU: Okay.

CO-CHAIR BAGLEY: Okay.

MEMBER YU: Okay. Thank you.

CO-CHAIR BAGLEY: Okay.

MEMBER GREINER: Can I just suggest an amendment that we also consider making --

CO-CHAIR BAGLEY: Speak to the table please.

MEMBER GREINER: -- that the PCP attribution, if we have that, that that is actually part of this as well.

CO-CHAIR BAGLEY: Say it again?

MEMBER GREINER: So the idea that if somebody has selected a PCP for attribution, that --

MR. STOLPE: For volunteering.

MEMBER GREINER: -- yes, that trumps the ten visits to the endocrinologist.

PARTICIPANT: Yes.

CO-CHAIR BAGLEY: Okay. Yes. Any

objection to any one of the recommendation conditions?

MEMBER NGUYEN HOWELL: No. We would just add to the notes that it should be the gold standard.

MR. STOLPE: Could you clarify what you mean by: it should be the gold standard?

MEMBER NGUYEN HOWELL: Well, as the Health Care Payment Learning and Action Network recommended a few years ago regarding patient attribution in our population-based payment models, is that the patient attribution, the first step is the patient's choice, and that should be the gold standard when we're looking at alternative payment models and patient attribution regardless of prospective or retrospective.

CO-CHAIR BAGLEY: Is that not already the case?

MS. DRYE: So we don't have the information yet. It's integrated in to be able to use it, so we didn't use it. But what the CMS

program staff is saying, and my team member is --

CO-CHAIR BAGLEY: Louder please.

MS. DRYE: -- once it's available to use, we would use it preferentially to the results of the algorithm. And so I think everybody agrees on that, but you guys can speak to the NQF's use of the gold standard. There's kind of a history to that, but --

MR. AMIN: I think the only thing I would say on the issue of attribution, because there is a lot of work that was done, we'll note that there is an entire NQF methods committee that looked into the question.

And best, the idea of patient choice should be preferred as part of the analysis going forward. And then we'll also note the attribution paper that Elizabeth identified earlier in comments.

MS. DRYE: I think that was a long way of saying yeah.

(Laughter.)

MEMBER POGONES: Yes, when we have the

data available to us.

MS. DRYE: When we have the data from patients.

CO-CHAIR BAGLEY: All right. I'd like to move to vote, unless there is a clarification about the conditions under which we're going to put this forward.

MEMBER YU: A clarification. Are we putting this patient's choice in there or not?

Because I do have a -- I understand patient's perspective being the care choice is important, but sometimes there's another element in there that is communication. Did it explain whether that discharge is risk that is really -- do they understand that?

So patient choice can't have a -- can it have some little unintended consequences if we use that as a measure?

MR. AMIN: We'll reflect it in the discussion. I think the best way to characterize -- that's why I'm trying to come up with the language on the fly, but in the way that we'll

write it, it will be that the patient choice, as it's determined in the attribution, should be considered and tested by the developer as the data becomes available. Right now it's not even available to the developer in a task.

MS. DRYE: And just as a reminder, we're -- this measure is about the primary care provider coordinating care. So we're really looking for that.

Who do you think your primary care provider literally is? And I think, you know, that how the Medicare program asks that question, we just have to look at: does that align with it? Then perfect.

MR. AMIN: Right.

CO-CHAIR BAGLEY: Jordan, we're ready.

MR. HIRSCH: For MUC2019-37 MIPs Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients With Multiple Chronic Conditions, do you vote do not support with potential for mitigation? Your options are yes or no.

All right. From our 2019-37 MIPS Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients With Multiple Chronic Conditions, do you vote do not support with potential for mitigation, there were 16 votes for yes, six votes for no. The workgroup has recommended MUC 2019-37 with a designation of do not support with potential for mitigation.

PARTICIPANT: For MIPS.

CO-CHAIR BAGLEY: Okay, the next thing we're going to do is move to the MSSP program. Oh, I'm sorry. Before we do that, during this discussion, we've talked about a lot of gaps. But are there gaps in the MIPS program where other measures might be useful, or a different approach? That's what you're looking for, right, is, you know --

PARTICIPANT: The overall measure set that we --

(Simultaneous speaking.)

CO-CHAIR BAGLEY: Yes, looking at the

overall measure set, which is hard when we've spent so much time looking very specifically at two or three measures. But for those of you who are in this field and look at a lot of measures, is there something that really would help the MIPS program take off like a rocket?

(Laughter.)

PARTICIPANT: That's a high bar.

(Simultaneous speaking.)

MEMBER ALEMU: To the previous portion, now I mean I just want to understand the duty. We don't support with potential mitigation, so no/yes. So if I mean the problems are solved, what is the logic why we don't use that measure?

If we have even the criteria how to, or how to resolve, you know, the situation, why would we use the measure? I mean what is the reason behind that? I have a question from the logic point of view.

CO-CHAIR BAGLEY: I'll give it a stab. First, I think we just said to CMS that we think

this is still important, but we have grave concerns about especially attribution to small numbers. So that's basically what --

MEMBER ALEMU: Yes. But how come we --

CO-CHAIR BAGLEY: We didn't actually stamp it out and say don't do this. We gave them an opportunity. And we will not see it again. That's just the way it works.

CO-CHAIR FIELDS: I think then it also requires more data, right? So then we have to -- it's almost like you've got to rerun the data now with voluntary alignment, with a different group cut off. You've got to look at it again with a different set of qualifications, I think is why we wouldn't just say, hey, you guys make the changes, we're good. I think we've got to look at it and see how it tests out.

CO-CHAIR BAGLEY: Okay, we're looking for electrifying measures. Sandy, you're up next.

MEMBER POGONES: Okay. Well, I did.

(Laughter.)

MEMBER POGONES: The AAFP really would like -- maybe I'm not supposed to say that, yes.

(Laughter.)

MEMBER POGONES: We would like to see some measures for primary care that really focus on the essence of primary care -- access, continuity, comprehensiveness, and coordination of services. Right now, the measures that we're measured on tend to be hand-me-downs from specialists. We look at diabetes, we look at blood pressure, we look at cardiovascular, we look at all kinds of things of these measures that are important to primary care, but they don't measure the essence of primary care.

And there are some measures being proposed out there that really do. So I would like to see some focus on that, because when you look at the number of whether or not patients had colorectal cancer screening in 10 years, that's really important. But it captures such a small piece of what primary care is all about that it's

almost like, it's almost irrelevant. Not really, but I think you know what I'm saying. It just doesn't reflect what primary care really does for patients.

I also -- we also think that looking at primary care spend would be an excellent way, since there has been some previous research showing that primary care spend can -- when increased can reduce overall costs. And that will get back to getting some resources into the ideas into primary care and community services, and social support services that really can have a huge impact on all-around health. So I think that would be -- we think that would be a good measure.

We'd also like to see some focus on preference-sensitive cases, where when given a fair choice, that patients actually can opt out, and the physician would not be penalized for that patient opting out. And we certainly would like to focus on some measures that determine whether a certain course of therapy is the best course

for the patient. There's a lot of surgeries being performed, but is that the best? Are there risks? Do the risks -- do the benefits outweigh the risks? And that's where we see a lot of spend. And I think there's a huge potential for decreasing costs as well as decreasing harm for patients. So I know we're not there yet, but I really would like to see -- we would like to see that. And then we also would like to see movement on diagnostic accuracy.

MEMBER SCHREIBER: Can I ask you to repeat your four categories? I have access, coordination, and then two others.

MEMBER POGONES: Access, continuity, comprehensiveness, and coordination of services. That's what primary care does. They have this relationship with the patient that relies on coordinating all of these different things. And maybe having a mammogram within two years isn't the most important things with that patient as far as what's going on right now. There might be other things that really outweigh the importance.

We're not saying those preventive tests aren't important. Yes, they are. But they're such a small segment of what primary care does that it doesn't reflect how good a primary care physician is. That's why I'm a primary care doc in Detroit. Am I right?

(Laughter.)

CO-CHAIR BAGLEY: Ann, can you top that?

(Laughter.)

MEMBER GREINER: So this is on our mind because we just had a workshop with our members. And we've got 64 members that span all the different parts of the healthcare system, but they share a passion for the importance of primary care. And so we had a whole conversation about primary care measurement, and we had some folks who were at the leading edge of primary care measurement come and present some ideas. And many of them echo what Sandy just talked about. And I think you are all in discussions with some of these developers.

So this whole notion about continuity, and comprehensiveness, the Barbara Starfield attributes of primary care, figuring out how to measure those, and if you ask patients, like there were focus groups done of patients about what they want from primary care, and they basically said they want coordination and integration.

They didn't say they want to make sure that we have our mammogram, you know, every -- and that's a great measure to understand something about the system and how it's working. And it is very important. But in terms of the value that primary care brings, it really is reflected more I think on the attributes that Barbara Starfield lifted up, and how can we measure those? And I think the American Board of Family Medicine is developing some really good measures in their registries to do exactly that.

And then on the patient side, Rebecca Etts (phonetic), and I think you are familiar with this 11-item patient-reported outcome

measure that gets at, from the patient standpoint, whether or not their care is integrated and coordinated, whether or not the clinician is spending time to help educate them about their condition, and partnering with them to improve their care and their lifestyle, et cetera.

So I think there are some great new measures coming on. And maybe we could retire some of the large number of measures that primary care reports now and slim it down to some measures that really do better reflect the value of primary care. On the primary care spend measure, lots of work being done. We're in the middle of that. We've got, you know, some good measures at the plan level. And states are taking this up and rolling out efforts. Six states passed legislation this year to start reporting primary care spend at the health plan level, which is great but also scary because they're all doing it differently.

So to the degree we can get a

consensus around what that measure would look like at the health plan level, all the health plans in the room would be happy about that. We'd be happy about that because then we could have some comparability, some standardization, and some benchmarking.

And I know we're not talking about MIPS and MSSP measures, but we have some of the MA measures at the health plan level. That could be an area ripe for future measurement exploration and development.

CO-CHAIR BAGLEY: Okay.

(Simultaneous speaking.)

CO-CHAIR BAGLEY: We have to be very quick --

CO-CHAIR FIELDS: And one concrete measure, for example, as a substitute relative to the context we discussed today, I could easily imagine evaluating PCPs, instead of their admission rates per 1,000 for folks with multiple chronic conditions, say, how many PCPs is this, or PCP to specialist ratios for people with

multiple chronic conditions.

If we're not arguing whether or not there's value in the work of PCPs to reduce total cost of care, and that we generally all agree that the outcomes are better if you have a strong PCP relationship, coming from a market where I can't go 10 feet without a concierge doc, an urgent care center, or a specialist, and my PCP to specialist ratios are like 0.5, if I can get some behavior change on the PCPs to take really more ownership and more engagement, and help improve -- it's an access issue to some degree, but some way of incentivizing making Medicare attractive for PCPs by affecting their rates in MIPS, by really participating more aggressively in patient engagement, would be a great process measure that likely gets us to the outcome without, again, like I was saying earlier, skipping to the big outcome that they have less control over.

CO-CHAIR BAGLEY: Okay, I think we need to move on. Does anybody else have a timed

agenda that shows that we're behind?

(Laughter.)

MR. STOLPE: All right. Very good. So now we're going to introduce the Medicare Shared Savings Programs. As you know, this was established as the Affordable Care Act where notable providers, hospitals, suppliers can participate in a shared savings program by creating or participating in an accountable care organization.

Within MSSP, there's four shared savings models that have varying degrees of risk. The goals of this program are to promote accountability for patient population, for care coordination and for the use of high quality and efficient services.

In order for a ACO to share in savings, as we know, they need to do two things: first, demonstrate savings, and then the second is to perform on the set of quality measures -- one of which we'll be considering, and it's going to be pretty easy for me to outline that measure,

since we've just talked about it.

CO-CHAIR BAGLEY: Before we do that, we should have public comment.

MR. STOLPE: Yes, before we do that, we move directly public comment.

CO-CHAIR BAGLEY: We'd like to have public comment on the program and the measures.

MR. STOLPE: Yes. Thank you.

CO-CHAIR BAGLEY: Come forward and stand up.

(Telephonic interference.)

MS. GASPERININI: Jennifer Gasperini with the National Association of ACOs. So I actually wanted to make a comment about alignment with MSSP and MIPS, both the quality measures and the scoring methods. This appeared in an earlier slide deck, so I hope this comment's still germane. I just keep it in the slide deck. But we wanted to just voice our concerns with a total sweeping alignment, to have the same methods and the same quality measure set for ACOs as we see in MIPS. And I think our discussion on the last

measure perfectly made my point about why sometimes we want to see a unique set of quality measures for ACOs, and why that might look really different for the ACO population versus someone in MIPS.

In particular, we would also like to see CMS make the measures more different, not more similar. In particular, we want to see the next generation, so to speak, of quality measures being applied to ACOs. For example, we have some ideas about how you could test measures that are not yet fully baked, so to speak, that are addressing a gap area, like social determinants of health would be a great example of something that you could start to test and not make ACOs accountable for, but really see how the measure works, if there are flaws that need to be addressed given more rapid cycle development.

So I really just want to make a comment about how we think alignment doesn't always make sense, and we actually want to see the ACO measure set evolve even more than it is

now. So thank you.

CO-CHAIR BAGLEY: Anyone else? And it's hard to -- anyone on the phone?

MS. BUCHANAN: Yes. So what we're going to ask people to do on the phone is hit *7 to unmute yourself if you have a comment, or you can chat it and we'll read it aloud. So it's *7 to unmute.

MR. STOLPE: So we'll pause for a moment to allow for them to unmute themselves, but then move on if there's no comments.

CO-CHAIR BAGLEY: And if that doesn't work, we can cancel the call and have them call back in, and that person who is on hold won't be able to talk.

MS. BUCHANAN: That is true, Bruce. We can do that.

(Laughter.)

CO-CHAIR BAGLEY: Do we have a lot on the phone?

MS. BUCHANAN: We have 43.

CO-CHAIR BAGLEY: Okay. Whoo.

MS. BUCHANAN: Again, it's *7 to unmute.

CO-CHAIR BAGLEY: Do you have anything?

MS. BUCHANAN: No, we didn't.

CO-CHAIR BAGLEY: Okay, let's move on.

MR. STOLPE: So as I mentioned, the measure under consideration here is MUC2019-37, Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions -- the measure we just discussed.

Now we're going to be applying this specifically to SSP. The measure developer has prepared a document, which will project on the screens just behind us here, that will outline some of the reliability testing so that you can focus on remarks on that.

I'll just mention that the staff recommendations on this one, again, is conditional support. And the condition for that support is NQF endorsement.

CO-CHAIR BAGLEY: Okay. Elizabeth, you want to --

MS. DRYE: Sure. The specifications are the same for the cohort, the outcome, and risk adjustment. So this is a change from the currently reported ACO measure. And we already went over there and satisfied qualifying conditions, the outcomes narrowed to focus on admissions that can be affected by providers managing care in the ambulatory setting. And risk adjustment includes frailty variables, and our SES index, and specialist density.

These are, I think, the main, what we did is, actually, we aligned the measure, we ran the measure in 2015 data which is an older ACO data set. We will run it in 2018 data for submission this coming year to NQF and endorsement. We'll run it in the same data set, same year, as we run the other one, so it won't be confusing.

And we calculated what we thought were the most important, immediate things for you all

to see in this consideration. So one is just the range of the measure scores. When we think about importance, we want to see variation in performance across ACOs and the risk adjusted measure score, which is on unplanned admissions, taking out the ones I mentioned before, for 100 person years of exposure, was from 27 per 100 to 58, so these patients are pretty frequently admitted and that's almost a twofold range. The median was 41. That's not that different from -- it's a little lower than the current ACO measure because we pulled some of the admissions out of the outcome.

It's easier to get high reliability, as we already discussed. If you wanted to go to a reliability of 0.7, you would have to, for everyone and above, so 0.7 and more -- higher, you need at least 249 patients in the ACO that are within the measure. And that happens 99 percent of the time, so these are just bigger providers. I don't know that I need -- if there are other questions, but this is really fully

aligned now except attribution, as we discussed, and the reliability results.

CO-CHAIR BAGLEY: Okay. Was that somebody on the phone?

PARTICIPANT: Yes, sorry. It wasn't a committee member.

CO-CHAIR BAGLEY: Yanling?

MEMBER YU: Yes. A question. I'm not familiar with it. I'm new to this process. You mentioned that NQF recommends conditional support. Is conditional on the final approval or final endorsement by NQF, is this a requirement for this community to prove or not?

MR. STOLPE: So the answer to that question is no, it is not a requirement. But the algorithm that was approved by the Coordinating Committee puts a special emphasis on NQF endorsement as those measures are preferred. However, you may elect to support a measure without the NQF recommendation. In this instance, to do that you would need to say that you vote no, and then vote for unconditional

support.

MEMBER YU: But there's no choice on that, right?

MR. STOLPE: There is. Yes, the choice would be for you to vote no, and then for us to go through a stepwise process of selecting the appropriate one, assuming that your colleagues agree with you.

(Laughter.)

MEMBER YU: Okay. All right. Thank you.

CO-CHAIR BAGLEY: David.

MEMBER SEIDENWURM: So this is perhaps a question about the structure of the ACO program. But since there's cost components in the ACO program in terms of the shared savings, and the downside risk and so forth, and the principle driver of costs in healthcare are admissions, and the part of admissions that, you know, one can affect by appropriately managing one's patients are, you know, the avoidable ones, are we sort of double penalizing for avoidable

admissions by adding a quality focused metric on avoidable admissions when there's already, you know, the financial aspects? Is that --

(Simultaneous speaking.)

CO-CHAIR FIELDS: We track it anyway. To your point, it is like the major driver. So we track it anyway. It's not additional burden. And to be clear, the measure -- there is already a measure that's a lot like this one. This one's a little narrower in focus as was described. But it's already there. It's not new. Does that make sense?

MEMBER SEIDENWURM: Okay.

CO-CHAIR FIELDS: So we've been tracking it. We track it all the time. I look at score cards every month.

MEMBER SEIDENWURM: So it's not double counting then?

CO-CHAIR FIELDS: No, it's not double counting, yes.

CO-CHAIR BAGLEY: Amy?

MEMBER NGUYEN HOWELL: So I just

wanted to clarify. So would this be replacing ACO 38?

CO-CHAIR FIELDS: Sounded like it. It's replacing, right?

MS. BUSH: It would be. We would have to go through rulemaking to do that, but if we were to propose this, it would replace, yes. It wouldn't be in addition to.

So this one adds diabetes to the number of conditions, which we had received public comment that that was obviously an important chronic condition to address. So it adds diabetes, and then it takes away the patients who are two weeks or 10 days post-discharge from an in-patient facility.

MEMBER NGUYEN HOWELL: Okay.

MS. BUSH: Those are the major changes. And then it does the risk adjustments for SES which is --

MEMBER NGUYEN HOWELL: Right. Yes, we would support it as long as it is not duplicative at of the ACO 38.

MS. BUSH: Right. It would not be.

MEMBER NGUYEN HOWELL: Thank you.

CO-CHAIR BAGLEY: Okay. I'll bet we're ready for a vote.

MR. HIRSCH: For MUC2019-37 in SSP, Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients With Multiple Chronic Conditions, again, in the Medicare Shared Savings Program, do you vote to support the preliminary analysis as the workgroup recommendation? Conditional support for rulemaking was the preliminary analysis recommendation. Your options are yes or no.

CO-CHAIR BAGLEY: Do you have to read that in for the record, or can I just move on?

PARTICIPANT: We have to read it in.

CO-CHAIR BAGLEY: You do have to read it?

PARTICIPANT: Yes.

CO-CHAIR BAGLEY: Go for it.

MS. BUCHANAN: We have 21 for yes.

MR. HIRSCH: For MUC2019-37, SSP,

Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients With Multiple Chronic Conditions in the Medicare Shared Savings Program, do you vote to support the preliminary analysis of the workgroup recommendation? 21 votes for yes, one vote for no. The workgroup has voted for MUC2019-37 for conditional support for rulemaking.

CO-CHAIR BAGLEY: Excellent. Okay, any gaps in measures for ACOs, those of you who were involved with that? You guys getting tired? Do we need to stand up and do some jumping jacks or something?

CO-CHAIR FIELDS: And then while folks are looking at -- go ahead.

MEMBER POGONES: Oh, I would just repeat what I said for the other discussion with the -- especially the measure evaluating whether or not it puts the therapy at risk, the right course of therapy, not just whether there was a complication following the surgery, should the surgery have been done to begin with?

CO-CHAIR BAGLEY: Any others?

CO-CHAIR FIELDS: Along that line, I'd like for you to start to think about measures of diagnostic and therapeutic efficiency. Do you understand what I mean by that? How do we find out the right answer as quickly and efficiently as possible, and how do we select a treatment?

And it's very difficult to do that without some kind of an organization. But an ACO is a perfect organization to have that happen inside of. So try that idea out. You know, instead of figuring out, well how come you didn't do this, and how come you didn't do that? You know, if the ACO is established as an organization that can be the most efficient in care, that's how they actually get extra money. You know, why not help them measure it?

PARTICIPANT: I might also mention, you know, there's a lot of power in the reporting only measures. I don't know how that's viewed internally at CMS, but in terms of behavior and culture change, which is like 99 percent of my

job of leading a network of 4,000 doctors, is trying to get them to move.

So when we think about things like SDH, for example, measures that are -- to Jennifer's point a second ago, I think there's openness as of, in general among ACOs to try and step out, especially in a reporting only mode, to get people to have a conversation. There's a lot of power in that. So just would offer that there's movement that can happen with reporting only measures.

CO-CHAIR BAGLEY: Okay.

MEMBER SEIDENWURM: One thing I've been wondering about is there anything we can do about the topic of sort of share of care? If the point of an ACO is to integrate care, why not measure a share of care? And I don't know exactly how we would do that, you know, whether one would do it terms of spend or working MIPS, or, you know, but I think that's a topic --

CO-CHAIR BAGLEY: Are you talking about leakage --

MEMBER SEIDENWURM: Well --

(Simultaneous speaking.)

CO-CHAIR BAGLEY: -- into other systems?

MEMBER SEIDENWURM: -- as opposed to, yes.

MEMBER BURSTIN: Maybe just to build on that, I know there are a couple of measures in the set that look at admission and readmission, which are essentially some safe proxies for coordination of care.

But boy, we really do need some decent measures at some point that actually reflect true handoffs, coordination, really what ACOs are all about. Some of you may remember the famous line from years ago that care coordination is the Bermuda Triangle of measurement. Many have gone in and few have emerged with a measure.

(Laughter.)

MEMBER BURSTIN: I hope we're getting to the point where systems are getting close enough so we can tease systems. Things like

that, we could really begin to build some real eCQMs that actually reflect what the goal of ACOs are really about.

CO-CHAIR BAGLEY: Okay. We're ready to move?

CO-CHAIR FIELDS: So we'll start with the Medicare Part C and D Star Ratings program, another favorite. We'll start with the description for this.

MR. STOLPE: All right, very good. Well, I just want to acknowledge that we are officially at the half-way mark of going through our measures at 2:30. So we are a little bit behind schedule.

As you know, this is the first year that MAP Clinician will review measures for Parts C and D. We have five measures total to review. Parts C and D consist of two types of plans, our Medicare Advantage Plans, which are comprehensive, and the stand-alone prescription drug plans, our PDPs or Part D plans, both of which are attributed a Star rating.

The Star rating reflects the experiences of beneficiaries that assist beneficiaries in finding the best plan. For Medicare Advantage, it's also connected with what are termed quality bonus payments, where health plans that have achieved a critical threshold of four stars or more are eligible to receive a fairly substantial bonus to their normal Medicare payments.

So this program consists of 48 quality measures. Medicare Advantage-only contracts have 34, with the PDP contracts having 14. We'll be, as I mentioned, going over five measures, the first of which will be MUC2019-14, Follow-Up After Emergency Department Visits For People with Multiple High-Risk Chronic Conditions. But first, public comment.

CO-CHAIR FIELDS: Yes. Anyone, the public on the phone or in person first, any public comment?

MS. RUBIN: Yes, hi, Koryn Rubin from the AMA. In terms of with opioid utilization

measures, I think we need to evolve the conversation and discuss pain management and ensuring patients get their pain management and behavioral health needs met.

The Administration has done a very good job at targeting opioid utilization, and just putting dose duration limits actually is counter to providing when necessary appropriate care, and has led to adverse consequences for patients. So we need to tell you to begin to really evolve the conversation.

And then I know there's the opportunity to discuss gaps in the MA program -- the Star ratings program. The measures currently in the program are really clinical in focus. So you're really measuring the physicians and providers; that's what gets built into the contracts. Because the only way the AMA plans can obtain that data is from physicians, and so put in coverage decisions based on those measures.

And there needs to be movement towards

more looking at access, provider networks. Because that's not really adequately addressed, and that's also what patients are looking for when they're choosing, you know, MA plans. They need to understand what type of network they're engaging in and physician access when they sign up for Part C or D.

CO-CHAIR FIELDS: Thank you. Anyone else in person, or on the phone, or a chat?

MS. BUCHANAN: We don't have any chats. As a reminder, *7 to unmute yourself. And there is nothing in the chat.

CO-CHAIR FIELDS: Okay. And we'll make a comment about the opioid measures here in a minute, but do you want to just go ahead and start with the first one?

MR. STOLPE: Yes, thank you. Okay, so this first measure, as I mentioned, is MUC2019-14, Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions. The staff recommended this measure with conditions, those conditions being the usual

one which is to obtain NQF endorsement.

When first reviewed, staff did have a concern about the evidence link. One of our criteria is that a measure have a strong evidence base or be linked to outcomes or an outcome measure. There is a comparable measure, NQF 3435, which sought to establish the connection between desirable outcomes and follow-up. This may seem like we're being a little bit too meticulous in chasing it down, because it seems intuitive that follow-up would lead to good outcomes.

But we need to actually see that evidence. And that needs to be presented through research studies that test through a hypothesis, a research hypothesis, the outcome of interest and associate that with the process of interest. We've found some of those for some of the conditions inside of the program, but were not able to identify them for all, so just something to keep in mind.

The other thing that I will point out

is that this measure was initially introduced into HEDIS in 2018. The measure draws on encountered data, which is a lower burden data source that results routinely from just a normal practice of care.

CO-CHAIR FIELDS: Great. So the lead discussant, I'm sorry, is Susan on the phone.

MEMBER KNUDSON: Yes. Hello, everyone. So this measure --

(Telephonic interference.)

MEMBER KNUDSON: -- for Medicare Beneficiaries 18 and Older with Multiple High Risk Chronic Conditions. Those conditions were documented, if you had a chance to look at those. But the attempt here, even particularly given what Helen just said about care coordination, is to improve just that -- care coordination for Medicare Advantage members as they are transitioning between in-patient and out-patient care.

So the numerator is a follow-up service that remains after the ED visit, and the

denominator is Medicare beneficiaries 18 and older who had ED visits, and also had these multiple chronic conditions. There's a couple of important exclusions in the measure from some of the beneficiaries that are in hospice, as well as any ED visits that are followed by an admission to an acute or non-acute in-patient care setting on the date of the ED event or within seven days after that ED event.

So it is around the NQF priority implementation in care coordination. It is a process measure with relatively low burden. And what I would say also about the comments that were -- there were three comments. One offered full support. Another offered up an alternative, and then there was a third that questioned and wanted specifications on the definition of follow-up that was mentioned earlier in the tee-up of the measure, this is a HEDIS measure, so there is a detailed specification of it that's available to answer those questions.

So I think those are the main points.

The one perhaps editorial comment I would make on this is it wasn't --

(Telephonic interference.)

CO-CHAIR FIELDS: I'm sorry, Susan, do you mind repeating that last line, you're kind of cutting up a little bit.

MEMBER KNUDSON: Oh, I was just saying that the last editorial comment I had was that I didn't know if this measure may potentially lend itself to relatively small N-sizes in some areas.

CO-CHAIR FIELDS: So it's possible. I mean probably the measure developers can comment on it. Usually at the MA Stars level though, it's everyone involved in the plan. So it's usually at that level not much of a problem, as a rule, unless you have a tiny number of docs. But --

MEMBER KNUDSON: Yeah. So for example, we're a fairly large system, but we have a small MA population. So there are just, you know, some idiosyncrasies like that. I don't think it's a stopper, just something to be

mindful of.

CO-CHAIR FIELDS: Yes.

MR. ROMAN: Yes, so this is Dan Roman from NCQA. The measure has been in HEDIS for two years. We have not seen a small numbers issue for the majority of our HEDIS measures, you know, if your denominator is less than 30, you don't report the measure.

So this measure does have a range, but it goes into the thousands. So from 30 all the way up to thousands of people in the average denominator size is around 5,000. So we have not had an issue with the denominator size at the plan level for this measure so far.

CO-CHAIR FIELDS: Great. Robert, do you have any comments on the measure? Or Sandy, do you have any comments on the measure? You're at least listed as a co-discussant on the measure. No?

MEMBER POGONES: At this point?

CO-CHAIR FIELDS: Yes.

MEMBER POGONES: I have no comments.

CO-CHAIR FIELDS: We can come back.

(Laughter.)

CO-CHAIR FIELDS: William?

MEMBER POGONES: Actually I do have a comment.

CO-CHAIR FIELDS: Oh, you do? Sorry. Go ahead, Sandy.

MEMBER POGONES: I just wanted to make sure. So this is at the plan level? So to me, that would really give incentive for plans to make certain that primary care physicians, for example, were notified of an ED visit which tends to be the biggest problem for a follow-up if they don't even know they've had a visit. So it might be a good measure for a plan level because, to me, that gives incentive to make sure the communication goes.

CO-CHAIR FIELDS: Yes. William Fleischman?

MEMBER FLEISCHMAN: No, I'll just echo that access is the biggest problem for following up from the Emergency Department, and this is at

the right level. And I'll add some comments later in terms of the measures like that.

CO-CHAIR FIELDS: Great. I'm probably not going to say your name correctly. Not here, okay.

MEMBER BURSTIN: Just a question. So in some prior efforts, there has been some evidence that some smaller plans that take care of disadvantaged patients may also have differences in their Star ratings by social risk. Was there any consideration? Did NCQA look at that document?

MR. ROMAN: Do we look at social risk when testing this measure? We're limited in what data we have for testing at the plan level. So we have -- typically we have age, sex, we get some regional data. But I mean we're kind of limited in our ability to test to that at the plan level.

MEMBER BURSTIN: Does it include SNP plans, special needs plans?

MR. ROMAN: It does.

MEMBER BURSTIN: Yes. So some of the smaller special needs plans in particular tend to have large numbers of dual-eligibles who may just look different. So just a consideration, you probably at least have dual eligibility for consideration going forward.

MR. ROMAN: Yes, okay.

CO-CHAIR FIELDS: Any other comments or discussion? David, sorry, yes.

MEMBER SEIDENWURM: This is a question. I'm not sure I fully understand the logic here. If the service, the post-ED visit service would be provided within seven days, but patients who are admitted within seven days are excluded, that raises a question in my mind, at least, could that admission have been avoided had a, you know, contact or rescue been instituted within that seven-day interval? So can someone explain the logic around that?

MR. ROMAN: Yes. So again, this is Dan Roman with NCQA. The idea is we're trying to set up a clean window for follow-up to occur.

You know, so first the decision to make a seven-day follow-up, we do have to allow there to be time for some information transfer for data from, you know, the ED, from when the person was in the ED, when the health plan might know that that happened, for them to be able to have that information, and then do something about it.

It's not as though we can say that this follow-up must occur the day of or even the day after. It's really tough. So with our clinical expert panels, we landed on a seven-day follow-up. We looked at several different follow-up periods in testing. Seven days was the one we landed on. We thought it was reasonable, and doable, and kind of practical.

And then with regards to kind of the admission, and you know, if you go back to be within those seven days, we're trying to create a clean follow-up period. So if you do get admitted, you would follow into one of other measures that's about hospital discharge.

MEMBER SEIDENWURM: Discharge, right?

MR. ROMAN: Discharge. If you go back to the ED and then you're released, you follow into the measure and that second period of time. Because we're trying to see the follow-up happen. If you go to the ED, then you're saying the plan should have done some sort of follow-up, is it really fair because the person's already back in the Emergency Department.

So really there's a lot of decisions that kind of went into first getting to the seven-day follow-up period, which really is about prompt follow-up for this really vulnerable group of Medicare beneficiaries. And trying to make sure that, you know, if something does happen after this type of patient leaves the Emergency Department, that somebody reached out to make sure that they knew what happened and everything -- they understood what they were told happened, and what they need to do next, and then with that in mind, trying to make sure that we have a clean period of time that we can look at to see that follow-up actually happened, that's kind of what

you're seeing in the spec.

MEMBER SEIDENWURM: So it's the best compromise in a messy world? Okay.

CO-CHAIR FIELDS: Yes, and it's pretty consistent with transition windows in the hospital discharge when it's 7 to 14 days, even depending on the complexity, it's not inconsistent with that, probably for the same reasons.

And I'm sorry, I neglected, Kim, to ask about from the Rural Health Group. Sorry.

MEMBER RASK: The Rural Health Group was neutral to positive on this measure. And they thought the kind of conditions were irrelevant to rural populations. And the other concern was lack of local resources might mean that plans that worked in rural areas might be disadvantaged on the measure.

CO-CHAIR FIELDS: Now --

MEMBER GOZANSKY: I would just say that I'm very supportive of the fact that telephonics meets the requirements. And I think

that helps with the idea that, you know, if somebody may not be able to get in, you may not be able to get out. So I'm very appreciable of that.

CO-CHAIR FIELDS: And William, I'm sorry, I forgot you in the --

MEMBER FLEISCHMAN: No, no. And I'll just add to that. So this is more of a commentary, advisory for the rulemaking process. So yes, telephone follow-up is great, but what we need to make sure doesn't happen is the people, is that insurers simply implement some sort of automated system, press one and two, as opposed to follow-up that's actually meaningful.

Text-based follow-up can be great, or some other telephone follow-up, but it has to actually offer some sort of resource and check-in for the patient and not just check the box thing.

CO-CHAIR FIELDS: Good point. I'm not seeing any other cards. Any other comments for discussion? All right, I guess we're ready to vote then.

MR. HIRSCH: For MUC2019-14, Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions, do you vote to support the preliminary analysis as the workgroup recommendation? The preliminary analysis recommendation is conditional support for rulemaking. Your options are yes or no.

MS. BUCHANAN: I'm waiting just for one more vote. We have 21.

PARTICIPANT: She just left the room.

MS. BUCHANAN: Oh. And Chad and Sue, were you able to vote? Oh, we just got it.

MEMBER TEETERS: Yes, I was.

(Simultaneous speaking.)

MR. HIRSCH: For MUC2019-14, Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions, do you vote to support the preliminary analysis as the workgroup recommendation? 22 votes, yes, zero votes, no. The MUC2019-14 moves forward with conditional support for rulemaking.

CO-CHAIR FIELDS: Next one. All

right. So the next three measures we're going to look at, we're going to look at at least in the discussion as a group. Because we anticipate a tremendous amount of overlap in the discussion. And then I guess we can sort of decide, based on how the conversation goes, to vote on them as a group. Is that how you guys --

MR. HIRSCH: No, we need a vote --

CO-CHAIR FIELDS: We need to vote individually?

MR. HIRSCH: Yes.

CO-CHAIR FIELDS: All right. So purely on the discussion, we'll do that together. And then we'll vote individually on each of the next three measures, if that's okay with everyone.

So we'll -- you want to introduce the measures now?

MR. STOLPE: All right, thanks very much. So the first measure that we're going to be considering here is MUC2019-57, Use of Opioids at High Dosage in Persons without Cancer.

Now, this received a staff recommendation of conditional support. And this warrants some clarification. All three of these measures are endorsed by NQF. And staff was generally supportive of the three measures under consideration.

However, inside of the submissions, CMS clarified that only one measure was being considered for movement from the display ratings into the Stars. Staff operated under the assumption that we were selecting one as the best to move forward. That is the one that we elected to support.

Now, we have since conferred with our CMS colleagues, and what they would like us to do is to consider each of these measures independently for their suitableness for inclusion in the program. So the conditional support was under the assumption that you reject the other two. So just please keep that in mind as we're going through the process of consideration of the measure.

This measure, I'll briefly read the measure description if I can actually get to it. So forgive me while I shuffle through some papers.

The description is the percent of beneficiaries receiving opioid prescriptions with an average dated morphine milligram equivalent of greater than or equal to 90 milligrams over a period of 90 days or longer. And once again, the staff recommendation is conditional support.

CO-CHAIR FIELDS: Should we introduce, do you want to read the other two, since we're going to discuss another group, or how do you want to do that?

MR. STOLPE: Yes, that's fine by me. Actually, the next measure description, I'll go ahead and pull up. This is the multiple provider measure, so Use of Opioids from Multiple Providers in Persons without Cancer. And this is the percent of beneficiaries receiving opioid prescriptions from four or more prescribers and four or more pharmacies within 100 days or less.

And then the last measure, which if you pull that up, is the Multiple Provider at High Doses in Persons without Cancer. And it simply is the combination of these two, that you must have the 90 MMEs and the four or more providers and pharmacies.

CO-CHAIR FIELDS: Great, thank you. So we'll start with Joy, if that --

MEMBER BLAND: Yes. Yes, as you said, the kind of started, it kind of went down to, you know, what the focus on should be as far as the milligram versus, because they combine them, and then there's just one.

There were some arguments that I thought were strong on, you know, the Department of Justice has put some monitoring in place. Eleven states don't have the monitoring, so a lot of providers are already doing the monitoring of pharmacies and, you know, multiple prescribing.

There was also, you know, compelling, I thought, literature relevant to, you know, there really isn't any improvement in function

when you go over 90 milligrams. There was some literature to support that.

There is two pieces of literature, one that said two or more, one, four or more. So I kind of wondered where we came up with going with four. There wasn't a lot of literature to support either of those, whether you went with two, you were going to overdose, or four. So I didn't think that was as strong.

Also there were some arguments that came up from some strong organizations. Cleveland Clinic commented their concern of, you know, this could potentially put members at risk of using illicit drugs came up, so back and forth.

The Advance Palliative Care organization had concerns about it being limited to cancer and hospice. What about chronic conditions? I know the HEDIS spec, we are reporting this in the Medicaid space, the 90, and they include sickle cell and some other chronic conditions I think should be considered that are

already in specification.

And another organization, the American Medical Association, had strong opinions to not support any of these, some of it around, you know, the same thing. Sickle cell, chronic conditions not being considered, as well as they've gone from being treated to treat each person as an individual, and now being told do limits, and some of that miscommunication that's gone to them as providers.

I know there would be even some things I had looked up in California where the medical board there is going back ten years to look at different opiate usage and deaths. So there's a lot of fuel around opiate prescribing.

For some of the other comments around it, that too being, you know, is this going to be -- do all these things put the members at, you know, the beneficiaries at harm? Because providers are becoming more and more afraid to prescribe. And there isn't a ton of people doing pain management doctors out there.

So, I mean, if I was going to recommend one, I probably would recommend greater than 90. It's already being used in the Medicaid space. We're reporting it this year in the adult core set. It would be my recommendation as --

CO-CHAIR FIELDS: Great. So, Carol, No? Okay, Helen, have you any comments at this --

MEMBER BURSTIN: What, do you mean all of them, then?

CO-CHAIR FIELDS: Yes.

MEMBER BURSTIN: So I -- I'm very familiar with these measures, I think they're very useful. I think there are some potential unintended consequences that, I think, a lot of folks are very concerned about on the steering committee for the National University and Opioid Collaborative. We've spent a lot of time talking about potential but unintended consequences.

And I think, in particular, concerns about the fact that we don't have very good strategies around tapering patients off high

doses of opioids is really quite a concern at this point. Some of that's just beginning. So there may really be some unintended consequences of pushing on, particularly, the measures at high dosage at this point.

I think even just the approach of using the marking equivalents may be shifting in terms of science as well. And I think there's concern, again, about not doing harm here.

On the other hand, I do think the one that looks specifically at multiple providers is a really important opportunity, I think, for preventive -- If I had to recommend one, that would be the one I would do. I would not do the composite, and I would not do the one based just on preventive.

CO-CHAIR FIELDS: Thank you. Ann?

MEMBER GREINER: Understanding that there is complexity here, and the challenges of tapering, and also that providers don't have a lot of other things in their arsenal, either because they're not trained to have alternative

ways to treat pain, or they're not comfortable with, you know, things like acupuncture and other methodologies.

And that's unfortunate, so they've got one thing, and unfortunately we know that there's been some unfortunate consequences. Still, we've got, like, a huge issue with opiates. And we're not -- I mean, we're making a little bit of progress. So to not move forward with some kind of measure doesn't seem wise.

I would imagine that, given the visibility of this public health issue, that there would be very careful attention and tracking to what the unintended consequences were if this measure moved into a public program.

So I guess I'm inclined to want to support some measure in this area and not be conservative and, you know, wait. Because there's such importance of trying to address this issue in some way.

I thought it was interesting that the staff felt that, you know, for Star ratings that

it would be relevant to patients. Because I don't know, I didn't think of patients thinking about this when they look at health plans.

I thought it'd be very relevant to regulators and others who are concerned that maybe plans aren't doing all they can to work with providers to make sure that there's appropriate prescribing. So that -- that just struck me as, and maybe staff can explain that, I was just kind of confused by that.

And I guess in terms of the measure that was most attractive, it is the one about multiple providers and, let me just make sure I've got this, the four or more providers since, like, it would be the most valuable. Because if you really are doing that kind of shopping, that's quite problematic.

In terms of the composite, I did wonder why it was an and, you know, the four or more providers as well as the multiple pharmacies, so multiple providers prescribing and multiple pharmacies. Maybe that's too overly

restrictive. Your sales will be very small. Can it be any more to try to bring in more. So I think I was attracted to both the second and the third measure.

CO-CHAIR FIELDS: Great, thank you. A brief one, and then I'll go to Kim.

CO-CHAIR BAGLEY: I think that you mentioned the patient aspect. And if I recall this conversation from last year talking about these measures, that this would not only trigger a plan to keep track of what their percentage was, but they would almost have to create a list of those people who are really, become a list of people who are likely to overdose.

In other words, that these people that are either in one of these three lists, and you only need two, would be attracting extra attention from the plan to either say, hey, this is what this person needs. That's the way the measure goes. Or this person needs some kind of tapering program, we've got to get some of that. So I think there is a patient-centered approach

to this and not just, oh, my God, you can't prescribe opioids.

MEMBER GREINER: So it's not the Star rating, per se, it's the list that we do generate as a result of this measure.

CO-CHAIR BAGLEY: Right.

PARTICIPANT: Well, I mean, if I'm signing up for a plan, wouldn't I want my plan to be doing that with the information?

MEMBER GREINER: Yes, we can agree on that.

(Laughter.)

MR. STOLPE: But this is what the staff thought as well. And one of our conversations that we've had on our opioid technical expert panel was a one-on-one conversation with a former Mississippi Medicaid director.

And he pointed out that some of the analytics that are going into this are quite sophisticated and that the multiple provider, multiple pharmacy measure was, in particular, as

well the larger, more of the milligram equivalent measures, led them to do a lot of different threshold analyses on what would be best for patients, including interventions like academic detailing, putting them on case management plans, and the like.

So the fact that those sophisticated methods fortified the health plans to be able to attend to the details of helping the patient population was something that we thought made it a very patient-centered measure.

CO-CHAIR FIELDS: I'd like to go to Kim next for the Rural Workgroup.

MEMBER RASK: Yes, the Rural Workgroup, on these three measures, went from their favorite measure to their worst measure --

(Laughter.)

MEMBER RASK: -- from the direction of the logic of why they liked it. So the high dosage, actually, was one of our highest, most popularly rated measures by the workgroup. They really thought that opioid misuse in the rural

community is something that impacts them, and they really want to address it.

They were concerned about the fact that, that others have already mentioned, the availability of services beyond opioids for pain management. In the rural community, that's really a challenge. So just kind of the opioids doesn't addressed that issue.

So overall, they felt pretty positively about that. The one thing in terms of a gap, they thought that there were several members who thought that those measures that combined opioids and benzodiazepine use would actually also be really controlled in the rural context.

The other two measures that were the multiple providers, the workgroup felt this wouldn't be useful for rural areas, because the number of communities that have four or more pharmacies or multiple providers to be prescribing, it wasn't that they thought -- they thought it would not be helpful to identify

issues in those communities.

So for that reason, they didn't find the multiple provider one useful, and they thought adding high dose with multiple providers would make it even less useful in rural areas. So that one they liked least of all.

CO-CHAIR FIELDS: Thank you. I would just provide some context for those that aren't on the provider side. Part of the issue of putting it in the Stars plan though, is I felt like if they'd be able to identify high risk patients, especially in the morphine-equivalent area, is a good thing to help drive a conversation about how to attack it.

The problem is, when you put it in the Stars Program, what actually happens is the plan doesn't actually do it. They produce a list, and then they give it to the providers or the system to do something about it.

And there is an intent, so not a pressure, especially in the last quarter of the year, to kind of get things to four stars, at all

costs. And so just keep that in mind for context, that it is no longer then a measure just to have a conversation or two, evaluate how bad, or big, or how developed a problem is.

It becomes an expectation that you will get folks below 90 milligrams, you know, and do it by December 31st so that we can submit or Stars rating. So there are no real consequences to this on the patient side that go beyond just trying to do good things for people. There's risk there. And it's real.

(Simultaneous speaking.)

MEMBER BLAND: The only concern of -- go ahead.

(Simultaneous speaking.)

MEMBER BLAND: -- like, health plans, we're already kind of looking at that. Like, that red flag that's with our PDF right now, you know, we see that come up. That's not something we allow to be happening. If they're in our case management, we track, like, it's --

CO-CHAIR FIELDS: Right. I think it's

great.

MEMBER BLAND: -- it's not a lot the provider can really do. It's really getting that member, and getting him help or whatever.

CO-CHAIR FIELDS: Yes.

CO-CHAIR FIELDS: Sorry, Yan.

MEMBER YU: No problem. I'm just trying to understand better the composite that put two things together, the last measure, that patient with a high dose at the same time as the multiple providers.

Are we trying to see some cause and effect with type of relationships or the high dose was caused by multiple provider prescription? Because sometime even to the single providers could cause a high dose. So, I'm just trying to wrap my mind to see what is --

CO-CHAIR FIELDS: Yes. I'm going to think that goes back to the and/or question though, and --

MEMBER GOZANSKY: Yes. And I think my comment is related to that.

CO-CHAIR FIELDS: Yes, let's go to you first, and then maybe we can go to --

MEMBER GOZANSKY: So I think part of it is that the population attributable, the rest that you're selecting, when you're doing the and is, I mean, it's a much smaller, it is the highest of the high risk, but it's much smaller. And I think that you're really narrowing how much of that is mutable when you don't have sort of the full, all-around resources. I very much find that problematic.

The other thing I would say, and this is a measure question, because I know that Kaiser Permanente has been concerned about this, and part of tapering oftentimes is to have somebody come in multiple times as you're watching them every couple of weeks, which might not be the same provider, and my understanding is it's, you know, my NPI and not the fact that my group practice, that they're seeing my partner as well as that my pharmacy that, if I'm only giving you a ten-day supply and the only pharmacy on the

weekend when you're open is going to be different, those are still, you know, one pharmacy versus the other.

So I have some concerns about unintended consequences as we're really trying to taper and follow people closely with short supplies, that that multiple provider thing will get us in trouble.

CO-CHAIR FIELDS: Thank you.

MS. HINES: Yes, so there's been several --

CO-CHAIR FIELDS: Can you introduce yourself --

MS. HINES: Yes, I'm Lisa Hines with the Pharmacy Quality Alliance. And there's been several question that I would like to address. The first is related to the exclusions, and sickle cell is a new exclusion to the measures. They're not in the specifications that were shared with you.

And we're always refining our measures over time to identify valid ways you can

administrate claims data. To identify palliative care is a little bit difficult, but we're working on that. So always, I'm welcome to suggestions that would mitigate any unintended consequences.

In terms of the four and four, why did we pick that number. There's a dose response in the studies that we looked at that, you know, two prescribers and two pharmacies increases the risk of overdose, but there's a dose response. So that would just concern the highest risk.

And there was one study that evaluated that's supposed to be the highest risk patient of the thresholds that were set. So that's why it was selected. You could argue for going lower and increasing the actual maintenance.

In terms of the high dose measure, so it's a great measure. It's used in the medicated dose course that is widely used. It is a population-level measure.

Retrospectively evaluating patients with these MMEs, it's not intended to guide the individual clinical decision. And that's where

there's a bit of a disconnect when there's interventions that are used to drive the measure. There needs to be care taken, a very careful approach from the pharma perspective, and not push the providers to cut off access to care.

So we care very much about ensuring that the measures are used appropriately, and are not aware of any evidence of unintended consequences, but know that overall that, with policy, and guidelines, and measures, that that could push the needle too far, so a little bit of context there.

And then in terms of the and, during development it was just thought to be the highest risk patients. There are actually independent risk factors for overdose. So, looking at it or is probably more meaningful. So I -- the two separate measures are probably the most useful.

CO-CHAIR FIELDS: Thank you.

MS. HINES: If you had to pick one, that was the thought. Even though those were developed in 2015, so the rates were much higher

then, and there has been progress over time. But that composite measure, the rates are pretty low.

CO-CHAIR FIELDS: Thank you.

MEMBER POGONES: I just have a quick question. The Pro Quality Managed plan which will discuss these measures, and one of the reasons that they did not like this measure was because it wasn't the HEDIS measure. They were under the impression that the HEDIS measure is different than this measure.

MS. HINES: When you say this measure, which one are you talking about?

MEMBER POGONES: Two of the measures, both the high dose as well as the multiple providers. So is that correct, or are they exactly alike?

MS. HINES: So NQA developed the measures first. NCQA adapted them for the HEDIS program. There are slight differences. We do work to harmonize. They're a little bit off-sync.

TQAs are the high dose measures used

in the adult core set, also used in Medicare on the display page. We do harmonize to the extent possible, but they are different measures, and we're different stewards.

MEMBER POGONES: I think that was our issue, is why can't they be the same?

MS. HINES: We would very much like for them to be our measures.

(Laughter.)

MS. HINES: So thank you for that question. We want to work with NCQA to harmonize the value sets and everything over time. And ultimately, I think that can make for a better measure. I wish there was one myself.

And then in terms of the tax ID number versus the national provider identifier, we do use the national provider identifier and understand the balance of the false positives and false negatives in identifying multiple providers and even pharmacies.

And, if you think about a chain pharmacy, for example, when this was analyzed by

CMS when they evaluated this for their overutilization monitoring system, the actual difference when they switched to using a tax ID number for multiple providers at a single practice was small. So it's really not, on average, a big difference.

I understand that, first, specific health systems, there could be a disparate effect. That is something that we plan to look at further and, again, always open to refining the measures to improve validity in that case. So thank you for that feedback.

CO-CHAIR FIELDS: Thanks. Robert?

MEMBER KRUGHOFF: I'm interrupting the flow here, but I don't agree with that the data will run out. Just wanted to say a couple of things here. One is we want to look at the meaningful measure development priorities, where exactly are they getting the power chords here.

I just wondered, do we have a, well, can we and do we have a role in trying to move measurement towards those priorities?

I think we're making a lot of good decisions, and very thoughtful decisions about the things that are sitting out there on the table as ways of measuring. But here, the top one on this list here is patient reported outcome measures. We haven't rejected or endorsed such measures here.

And one of the problems is that they just are not moving very quickly out there. We've been talking about it for ten years, that we need to have that kind of thing. And is there anything we can do to cause patient reported outcome measures to be creatively developed?

You know, the mechanics of doing that are much farther advanced than they were when we were talking about it ten years ago in terms of electronic records, in terms of the ability to survey people over time and stuff. But I'm just wondering is there a way for us to actually weigh in on getting that done.

The next one on my list is electronic clinical quality measures. If that's a priority,

you know, is there anything we can do to have that moved forward also. I'm just sort of wondering.

This is a lot of people who know a lot about the system. And I think we're not pushing things as much as we'd like. There are some things more difficult than that, such as measuring diagnostic skills, and diagnostic accuracy, and diagnostic creativity, that's not even on that list of things that need to happen.

But everybody I talk to says, well that's, you know, believes that's really very important. And so I have to get it on the list. And then I'd like to help make it happen.

But given that those patient reported outcome measures is number one on the list, I guess I'd like to see that, see us playing some role in pushing that going forward.

The other, the very next page of that is considerations for future meaningful measures. And the first one on that was, is developing more APIs for quality measured data submission. And,

you know, again, this is the kind of thing that I hope we can get sort of encourage that to happen more and think about why we don't have measures, just the way that that's happening.

And interoperable electronic registries, we've been talking about that for oh so many years, getting more useful information out of the registries than different societies, et cetera, and maintaining, how can we move that forward?

So I just want to, I'm just hoping that before, somehow in the course of our existence here, we can push some of those things forward.

MR. AMIN: I think those are good comments. We'll make sure and reflect those in the priority section of the report.

MEMBER KRUGHOFF: Sorry to interrupt.

CO-CHAIR FIELDS: No, that's all right. Any further discussion on the three measures? Go ahead.

MEMBER GREINER: From your point about

Star ratings and how seriously they are taken by the health plans and what downstream effects they may have, I mean, I think that's really something that I have heard as well, you know, that so much rides on those measures.

The other measure related to, you know, number of providers and the number of pharmacies, that's more structural, and that's something that the health plans can work on. Not that the dosage isn't important, it's really important, but I do worry about that downstream pressure.

CO-CHAIR FIELDS: All right. I'm not seeing any more cards up for reports. So we'll start voting, I guess. Yes?

MEMBER YU: Before we vote, could you please give us a little bit instruction on how we vote this --

PARTICIPANT: Individual.

MEMBER YU: The individual. Could you remind us?

CO-CHAIR FIELDS: Certainly. So just

to be very clear, we're going to be considering each one of these separately for their appropriateness for inclusion inside the CMS Stars. So as always, vote your conscience.

(Laughter.)

CO-CHAIR FIELDS: So just keep that in mind. But CMS is going to only be implementing one of these. But you're just thinking about the appropriateness of each one of them individually irrespective of whether or not the others are adopted.

MEMBER YU: Thank you.

CO-CHAIR FIELDS: All right.

MR. HIRSCH: For MUC2019-57, Use of Opioids at High Dosage in Persons without Cancer, do you vote to support the preliminary analysis as the workgroup recommendation with conditional support for rulemaking with the preliminary analysis recommendation? Your options are yes or no.

MS. BUCHANAN: And we need just one more.

CO-CHAIR FIELDS: Did we lose somebody? There was 22, did we lose --

MS. BUCHANAN: Oh, there we are. He left, oh yes, Peter left. He's still on phone, but he's not voting. So we have 21.

MR. HIRSCH: For MUC2019-57, Use of Opioids at High Dosage in Persons without Cancer, do you vote to support the preliminary analysis with the workgroup recommendation, 14 votes yes, 8 votes no. The workgroup has recommended MUC2019-57 for conditional support for rulemaking.

CO-CHAIR FIELDS: So we didn't lose anyone?

MS. BUCHANAN: No. Apparently Peter is voting on his own.

CO-CHAIR FIELDS: Okay, great. Thanks, Peter.

(Laughter.)

CO-CHAIR FIELDS: Okay. So we're moving on to the next measure.

MR. HIRSCH: For MUC2019-60, Use of

Opioids from Multiple Providers and Persons Without Cancer, do you vote to support the preliminary analysis as the workgroup recommendation, sorry, as the workgroup recommendation, the preliminary analysis with support for rulemaking. Your options are yes or no.

MR. HIRSCH: For MUC2019-60, Use of Opioids from Multiple Providers and Persons Without Cancer, do you vote to support the preliminary analysis with the workgroup recommendation, 17 votes yes, 5 votes no. The workgroup supports MUC2019-60 for rulemaking.

MR. AMIN: Robert, before we move on from this, can we just take a moment to just characterize the rationale. The rationale generally here was around, it's around unintended consequences for high dose.

CO-CHAIR FIELDS: All right. In our last measure, the combination that they're, I think we're ready.

MR. HIRSCH: For MUC2019-61, Use of

Opioids from Multiple Providers and at a High Dosage to Persons without Cancer, do you vote to support the preliminary analysis as the workgroup recommendation? The preliminary analysis was support for rulemaking. Your options are yes or no.

MR. HIRSCH: For MUC2019-61, Use of Opioids from Multiple Providers and at a High Dosage to Persons without Cancer, do you vote to support the preliminary analysis as the workgroup recommendation, 8 votes yes, 14 votes no. The workgroup does not support for rulemaking MUC2019-61.

CO-CHAIR FIELDS: Okay, thank you, Jordan.

MR. STOLPE: So now we need to do some algorithm work. So now, the assumption is that, if there's a mitigating circumstance around how this measure could potentially be incorporated, and we would articulate what that is, if not then we should probably move directly to a do not support vote. Would we be in agreement with

that?

CO-CHAIR FIELDS: Yes, that sounds right. So any suggestions on what mitigating circumstances might be that would cause you to affect a vote?

No, all right. So I guess we're going straight to a --

PARTICIPANT: No, that's --

(Simultaneous speaking.)

MR. HIRSCH: For MUC2019-61, Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer, do you vote do not support? Your options are yes or no.

MS. BUCHANAN: And we only have 21 votes, we had someone leave.

CO-CHAIR FIELDS: If we're doing this, so we vote do not support, what happens?

MR. STOLPE: We don't support, that's what that means. We will just write in our report that we did not support this measure.

PARTICIPANT: With all of all the language.

CO-CHAIR FIELDS: Yes, right.

MR. STOLPE: So we will list the reasons that were articulated, such as the downward pressure on providers, the sense of duplicity, as well as what the measure developer pointed out, that there's low numbers inside these measures and --

MS. BUCHANAN: So we are, okay.

MR. HIRSCH: We're looking for one more vote. For MUC2019-61, Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer, do you vote do not support, 15 votes yes, 5 votes no. The workgroup does not support MUC2019-61, Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer.

MR. STOLPE: Let's move on to our next measure, shall we?

All right, thanks to all of you for making it to this point in the day. So we're now at our last measure for consideration. And this is MUC2019-21, Transition of Care Between the In-

Patient and Out-Patient Settings Including Notifications of Admissions and Discharges, Patient Engagement, and Medication Reconciliation Post-Discharge.

This is implied by the, so a long title, this is a composite measure that consists of several components. I'll just briefly read the measure description. The measure, it says, is the percentage of discharges for members 18 years of age and older who had each of the following four indicators. First, notification of in-patient admission, receipt of, sorry, second, receipt of discharge information, third, patient engagement after in-patient discharge, and lastly, medication reconciliation post-discharge.

Plans report separate rates for individuals 18 to 64 years of age and those 65 year and older, as well as a total rate for each indicator in the measure.

The staff's recommendation on this was a conditional support and the NQF endorsement.

This measure is a little bit complex. The staff noted that there's one of the components, the medication reconciliation portion, is currently included and that, further, NCQA stated that it will work with CMS so the plans will not have to report both this proposed measure and the stand-alone MedRec measure. And we can now move to discussion.

CO-CHAIR FIELDS: Great. All right, Kevin Bowman is our lead discussant.

MR. BOWMAN: Yes. So the intent of the measure is to improve coordination of care for any members as they transition between in-patient and out-patient settings. The measure set assesses the percentage of discharges watching essentially four components.

So we're starting notification of in-patient admissions, so documentation of in-patients, admissions for the following day. There's receipt of discharge information, and there's the patient engagement after discharge component, and then the MedRec component. So the

medication reconciliation post-discharge is already a Stars measure, MRT, so that's already in place with Stars. And then you have the three remaining components.

I would add that there were two comments. One was a general positive, providing positive kind of global comments on the measure. And then the other one was pointing out or highlighting the patient engagement component, how that's very critical and important.

The other thing that I would add is that per the CMS call letter, this was earlier this year, the proposal to proceed with this as a display measure. So I think there's already some traction on the display.

So as previously noted, the MRT components are already part of the Stars rating, Stars measures. So this essentially would be kind of folding this back into this which would also include these other three components.

CO-CHAIR FIELDS: Great, thank you.

MEMBER GOZANSKY: So I think certainly

it's a good measure. I think it's problematic that it is not fully electronic. I think there is the burden and how representative this really is as to whether we're going to get the kind of behavior change that would actually drive the outcome when it's just, it's very problematic that way.

And I think the idea that, if there could be something about this that was more actionable rather than just an acknowledgment, and I think this does get to the issue of, you know, something that was more patient-reported, I think this is still a good process measure. But an understanding measure from a patient would obviously be much more significant.

CO-CHAIR FIELDS: Thank you. Susan, on the phone, any comments?

MEMBER KNUDSON: No. I think the previous two commenters said it. I would just echo everything Gwendolyn just said.

CO-CHAIR FIELDS: Great, thank you. Kim, can we go to you next on the rural workgroup

and then --

MEMBER RASK: Yes. The rural workgroup had a couple of, overall, they ranked this kind of intermediately, felt neutral about it on the measurement side. What they liked about was that they regard transitions of care for rural residents are a big deal, especially if they are getting care at places and then coming back to their home location. So they like the idea that it was trying to get some of this transition information.

On the other hand, they didn't know even if it was being done at a plan level. If it was chart abstraction, would that be burdensome to smaller rural providers? They liked that it was at the plan level.

And then there was another concern about whether or not, for the MedRec component, did you have the level of pharmacy and pharm tech staffing to be able to do those services? So would rural providers be disadvantaged?

CO-CHAIR FIELDS: Great, thank you.

All right, Kevin?

MR. BOWMAN: Yes, so I just, I do want to reiterate that there, so first the components, the admission and the discharge, that administrative reporting, that was not available. So it does place a burden on these to have to go and do the chart cases. I mean, it is essentially, for MRP, as it is right now, you have to do that. So it does place an additional issue.

CO-CHAIR FIELDS: Thank you.

MEMBER NGUYEN HOWELL: And I had a question. Is there any data on the display measure?

MR. ROMAN: What kind of data do you mean?

MEMBER NGUYEN HOWELL: I had it quoted before.

MR. ROMAN: Yes. So the measures dated -- the measures already in for the last two years, and I can tell you what performance is at the plan level. And if so, just to be clear,

there are four indicators. It's like four measures.

And they're grouped together because we are trying to look at the coordination of care for anybody who's discharged and going from in-patient to out-patient. And it felt like the right thing to do to group these together so that you're seeing the whole thing.

At the plan level, so let's see, let me just pull this up, so if we talk about the, let's start with the notification of in-patient admission, performance the year was around 12 percent. And the second year, this past year, it was around 16 percent. So it did go up as the measure's been out there.

That is one of the indicators that does require chart review. And just to be clear about that too, the reason it requires chart review is there is no administrative way to capture this information yet, it's new, for plans to be looking at what the communications are that are occurring between in-patient/out-patient.

And we have prioritized this at NCQA as something to try to work with the standards groups that are out there to get some of that in place. Because there isn't great standardization for how that data goes, so notifying, like, a communication from an in-patient to out-patient setting, or from the plan, to say that this admission occurred.

So it is a new thing that we are working on, but it is going to take time. There is no way for us to do it administratively yet. So that's the first indicator.

For the receipt of discharge information, which is looking at was there information sent on the day of discharge, or the day after, to the provider, and did it make it into kind of the provider's record, what they're able to use for care.

The performance on that the first year was around 7 percent. And the second year it went up to 11 percent. So we do see some change. And that's the same thing. There is, you're

looking for something that is documented somewhere. It's not the typical data that plans are using, that anybody's using for reporting.

There is more standardization around discharge summaries. But it's not there yet in a way that we could use it to get it to an administrative spec. But again, it's something we are working with the standards groups on to try to get there, so we can ease some of that burden.

For the next indicator, the medication reconciliation post-discharge measure, as you noted, that is already in Stars. It's been in HEDIS for a while. The plan is to roll that into this set of measures so that there isn't dual reporting, or plans don't have to report both measures separately.

That's something we have to work with CMS on, though, on the decision making of how that, you know, retired one measure from the program and added in the other. That's not something we make on our own. So we are working

on that. For performance for that, the first year was around 44 percent. The second year went up to 53 percent.

And then the final piece, the patient engagement piece, which is really looking at follow-up of some type, so after the specs -- because there were three indicators that actually don't require you to say anything to the patient, because it's all communications and looking at medications.

So the follow-up piece, that you're actually saying are you okay, do you understand what happened, when you've just been released do you know what you're supposed to do next, that is the highest performance. The first year it was around 78 percent. And it went up to 81 percent the second year.

CO-CHAIR FIELDS: Great, thank you.

MEMBER YU: Thank you. I really like this piece, the patient engagement in this measure, because the transition is really is part of an important equation in this safe transition.

I'm just wondering, the data we are going to use is claim data and the records review. So my question is for the patient engagement part, is this just going to be check the box or you actually, you know, are you going to do a survey, say you get to actually review the records or the document that are in the medical records?

MR. ROMAN: Yes. So the plans right now can report it by looking at, they can look at the claims data to see that there was a visit or some sort of telephone follow-up or online follow-up or they can look in the record and see that there is documentation that there was a visit that took place or there was some sort of communication with a patient.

So they have two ways of reporting because it is a hybrid measure currently, so we allow them to use administrative claims alone or they can do kind of a combination of looking at claims and looking at what's in the record.

MEMBER YU: Great. I like that.

Thank you.

CO-CHAIR BAGLEY: I think Helen was next.

MEMBER BURSTIN: I just have more of a future tense question for you. I saw one of the options when I pulled up the details of it is that plants can use the ADT system to do this.

It would be a great standalone measure to at least get a measure that got at an e-measure using ADT and I would hope NCQA would move in that direction if they haven't already.

MR. ROMAN: Yes, we're trying to make sure that we include data sources like that, but there are plans that are enabling the providers to have that information that they get about admissions and discharging transfers.

MEMBER BURSTIN: Right.

MR. ROMAN: And so we wanted to make sure we -- When that's in place, when that information can make it to the provider we recognize it.

So it something that we actually

worked to include and then are trying to make sure that the language in the spec is really capturing it and making it clear that that's something that we allow.

MEMBER BURSTIN: Well it should actually be an expectation on the part of the plan not just we allow it, but that information flows is good evidence as far as the clinician cares better, particularly primary care.

So I hope that would be a new e-measure perhaps you guys could look at.

(Simultaneous speaking.)

MR. ROMAN: I will put it on a list.

MEMBER SCHREIBER: -- NCQA on this. They are actually looking at many of their measures for re-specifying --

MEMBER BURSTIN: I know.

(Simultaneous speaking.)

MEMBER SCHREIBER: -- and developing electronic measures. So they are really being very supportive in this area.

CO-CHAIR BAGLEY: Will, you're next.

MEMBER FLEISCHMAN: Given that this is already a HEDIS measure do you expect any additional burden to, I guess, trickle down to clinicians or groups by making it part of Part C and D?

MR. ROMAN: So additional -- I think the plan is going to put more focus on trying to improve their rates and trying to make sure that this communication where -- because the two hardest indicators are the pieces that are about communication and information sharing and it doesn't happen well and that is part of what we are seeing I think with the low rates.

The burden is actually is absolutely an aspect of the low rates as well without a doubt, but I mean I think you will see that providers are going to hear from plans more that, you know, why isn't there communication happening or that the plan is providing that information to them, because that's really what we hear quite often from the plans that are really engaged is that they take the step and they provide

information.

They have the discharge information and the admission information and say this admission has happened, this discharge has happened.

So we hope that it's not necessarily adding burden but that it's improving the communication and the information sharing that the plans do have, which is why we have it at the plan level.

MEMBER FLEISCHMAN: Are they going to be I guess hurting the providers by -- I don't know how they get their information now in terms of let's say knowing whether the provider received a discharge summary from the discharging institution.

So having this, you know, more prominent, it's obviously on their end, on the plan's end, is that going to trickle back to the provider to somehow have to, I don't know, give, survey a sample a random number of charts to see what percentage they have?

MR. ROMAN: So I mean right now the plans themselves identify patients when the do the report of this measure.

So Medicare plans are already reporting this measure, it's just whether or not it's in their discharge program, right?

MEMBER FLEISCHMAN: Right.

MR. ROMAN: So they are already asking the plans -- we are have the plans reporting the measure and because there is a component that requires medical record review they do, they select a sample and they reach out to their providers, or if they have access to the records already they look at those records and get a sampling from the provider.

So there is that level but that's with any chart view measure that we have is that there is some outreach to providers to get that information so that they can look at the charts and see if the patient they have identified does actually qualify for the measure or not.

MEMBER FLEISCHMAN: Yes, back to what

Helen said I think this could be eventually converted to a completely electronic measure. ADT could also report whether the discharge summary was faxed or somehow submitted to the provider.

MR. ROMAN: Yes, absolutely. We have had a lot of discussions with some of these groups about this and we were hoping that we would be further along but found that especially with the notification of admission piece the communication piece which you are trying to capture to have that be an electronic measure, we're just not there yet, what is available that we could code into an e-measure, but it is, like I said, it is something we are working on.

CO-CHAIR BAGLEY: Joy, you are next.

MEMBER BLAND: Yes, I mean I think the intent of the measuring period I think it, again, comes to the medical records retrieval burden and the inconsistency of how health plans identify some of those.

I mean some you're sitting there, you

know, abstracting, circling, oh, he said "hi" instead of patient is at considered engagement.

There is a lot of room here and I think with probably some of the goals we've talked about is when do we kind of put the stop on, if we're going to go towards e-measures do we not implement anymore hybrid and start going that direction or do we continue on the path?

CO-CHAIR BAGLEY: Trudy?

MEMBER MALLINSON: No.

CO-CHAIR BAGLEY: Okay. Wendy?

MEMBER GOZANSKY: I guess the only other question I would ask is that these changes that you've seen year over year are they actually associated with decreases in the PCR at the plan level?

MR. ROMAN: We have --

MEMBER GOZANSKY: Because I think that's the question is that what we are talking about is that just hypothetically the plans that are improving are simply going and capturing the existing data.

It doesn't necessarily mean -- because I think that's the problem with this as a process measure that just gets me a little concerned.

PARTICIPANT: What is PCR?

MEMBER GOZANSKY: That's the readmission measure.

PARTICIPANT: Oh, thank you.

MEMBER GOZANSKY: Which is what we are trying to drive.

PARTICIPANT: Right.

MR. ROMAN: And that is something we want to explore, but the measure, so, you know, with HEDIS measures the first year is really put it out there and see how performance works.

It's almost like the final last test of the measure before we start reporting on public rates and start holding anybody accountable for it.

So this is just in its second year and based off the first year we did make some changes to the language that is being implemented in this next version of the measure because we want to

make sure that we are recognizing all the good care that is being provided.

So I think that that is something that the analysis of two measures together and looking at the outcomes or, you know, how this might relate to the re-admissions is something that is definitely what we are planning to do, we just have not gotten to it yet.

CO-CHAIR BAGLEY: Okay. Before we go to a vote, I just wanted to explain why Rob left. Rob got to the counter at the airport this morning to find out that his reservation had been cancelled, not the flight, his whole reservation.

So the only way he could get back on a same-day kind of trip was to go on a 5 o'clock flight. So he didn't do that intentionally, it was kind of done to him by the system, I guess. So, anyway, let's go on to the vote.

PARTICIPANT: Okay.

MR. STOLPE: While we are pulling that up, we did want to add that we would especially recognize Rob for his efforts in getting here.

So we did award him the first annual PQA diligence and valor award.

(Laughter.)

CO-CHAIR BAGLEY: His first email was I can't make it, I'll be on the phone, so he did well.

(Off mic comments.)

MR. HIRSCH: For MUC 2019-21 transitions of care between the inpatient and outpatient settings including notifications of admissions and discharges, patient engagement, and medication reconciliation post discharge do you vote to support the preliminary analysis as the workgroup recommendation, conditional support for rulemaking as the preliminary analysis option? Your options are yes or no.

CO-CHAIR BAGLEY: We have 19 total.

MS. BUCHANAN: Yes. And that is if Peter is still here tomorrow.

(Off mic comments.)

MS. BUCHANAN: It looks like we are looking for one or two more votes. So, Chad and

Susan, were you able to vote?

MEMBER TEETERS: Yes, I was.

MS. BUCHANAN: Great. Sue, were you able to vote?

MEMBER KNUDSON: Yes, I did.

MS. BUCHANAN: Okay. So it looks like --

(Off mic comments.)

MS. BUCHANAN: Is it not coming through?

(Off mic comments.)

MS. BUCHANAN: You said yes, okay, great.

MR. HIRSCH: Okay. For MUC 2019-21 transitions of care between the inpatient and outpatient settings, including notifications of admissions and discharges, patient engagement, and medication reconciliation post-discharge, do you vote to support the preliminary analysis of the workgroup recommendation?

Fourteen votes yes, four votes no. For MUC 2019-21 the workgroup recommends

conditional support for rulemaking.

CO-CHAIR BAGLEY: Okay. We have to have a quick chat, thank you, about gaps and some other things. We are almost at the end.

I have taken a count and I have noticed that almost everybody has taken their own individual break as needed, so instead of breaking and coming back I think we'll press on and get out of here, how about that.

Okay. So this is a wide open question, how about gaps in the Star Program, what should we be putting in there?

(Off mic comments.)

CO-CHAIR BAGLEY: Any thought about that?

MR. STOLPE: Yes, we're going to put up a list of the current measures for you to consider as we discuss gaps.

PARTICIPANT: Yes.

CO-CHAIR BAGLEY: Any of you have a lot of experience with the Star Program? Amy, you're kind of an expert, right? What does it

need?

DR. ANDERSON: What does it mean or do I --

(Laughter.)

DR. ANDERSON: I think what I would like to see and I think it's not exclusive to Stars, but really more patient-reported outcome measures and experience measures, so PROMs and PREMs.

And also within PROMs the patient-reported, I think it's called patient measurement measure, so they are evaluating their actual perception and their change in status and function.

So I think that's one thing that is pretty demonstrably noticeable second to care coordination, transitions of care, it's really the patient's voice and the consumer's perspective in this.

CO-CHAIR BAGLEY: Wendy?

MEMBER GOZANSKY: Yes. So I would just second that and I think that the measures

that we have in the health outcomes survey I think are around sort of physical and mental health.

I don't think that we note that they are sensitive to change or that they necessarily have the reliability, so I think new measures something along the lines of, you know, self-rated health, the Cantril Ladder, that type of thing, or it would be just so much more meaningful and would actually drive people to be trying to do things to impact outcomes.

I would also say that if we get to the place where, you know, reducing risk of falling, those sorts of things, that are truly going to increase or improve the health of folks, I think actually getting whether people are diagnosing falls or urine incontinence or those types of things and getting to an administrative measure for addressing things rather than just a report I also think would be really beneficial.

And I think the other thing I would say is just simply on the medication adherence

measures we are getting to a place where I am not clear that, you know, randomized clinical trials with highly, you know, compliant folks, we are at levels of adherence that make me think that people are not taking those medicines.

I am a geriatrician, I go do home visits. The medicines are sitting there, they are just not taking them, and so I think we need to really think about what we are driving currently with where we are with those measures and being three-fold weighted, you know, really important.

But I guess this also gets to the issue around how, you know, if you have a shared decision making discussion with somebody and they don't want to take a medication or they don't want to have their breast cancer screening, you know, how do we capture that, that we sat with them, they made an informed decision, and not penalized because that actually takes me way more time to sit and have the discussion with a patient, as you all well know, than that.

I know it's very hard to capture. How do you capture it that I didn't just check the box, but I think that's where is it a patient-reported outcome measure.

CO-CHAIR BAGLEY: Kim?

MEMBER RASK: And I think one of the things that comes through from the rural workgroup a lot, which echoes some of what Sandy has already said, is that appropriately managing someone's care when they are challenged by geographic isolation, it's not clear whether it's better to always transfer for a higher rated setting or have more timely accessible care with what is available in the area and answering those kinds of questions are impossible to do, very difficult to do at the individual provider level or individual clinician, but at the plan level we have the opportunity to think about appropriateness of care measures and what are those outcomes.

Are there times when surgery is better done by a low volume provider that is nearby that

has good -- that you could have timely follow-up care, or is it better to fly 300 miles to the expert center and do it.

And so they really struggled that a lot of the measurement doesn't feel like it -- a lot of the measures that are out there don't feel like they address the needs of the rural communities that really want to know what is appropriate care, what is best care, not in an ideal setting, but given the setting that we live in.

And as we bring in telehealth, can you replace some of that travel with telehealth, but we need to have measurement and quality monitoring at a level where we can see as these things come in what are the best practices and what seems to have the best outcomes so that people kind of know what that path should be and how do some of those measures at the plan level seems to come up to people as like that's the right level where you might get enough experience and enough observations to be able to figure out

kind of what is good and what is better.

CO-CHAIR BAGLEY: Helen, you were next.

MEMBER BURSTIN: I am just very much echoing what has been said. If you just look at the list there are just a lot of older process measures that have been there forever split out into the separate screening measures of diabetes and I don't think that's how people pick their MA plans and I think it would be great to begin thinking about it.

I know NCQA has been thinking about is as have others, but what are the kind of measures that a consumer who actually does pick among a set of MA plans could find useful and given this day in age first dollar coverage, out-of-pocket costs, the kinds of issues that are really often pocketbook issues and combing that with some real quality outcome measures would be better.

So I'd go for a much smaller set of measures that get at how people actually select plans.

CO-CHAIR BAGLEY: Louise?

MEMBER PROBST: Along the same lines and to underscore what Kimberly said, I think we really need complication rates by surgeons by types of procedures.

I think you said that the people aren't just looking at their geography. I live in St. Louis, there is all kinds of specialists, but I can chose to go to Cleveland or Washington D.C. or somewhere else, and so I like the fact that your Star ratings so far compare people across markets and I hope you will continue to do that.

CO-CHAIR BAGLEY: Amy, you have your card up again?

DR. ANDERSON: Yes. I just wanted to add maybe with the kidney care choices model perhaps looking at the measurement and performance there and seeing if there is any relevance to the Stars Program as you look at alignment and the need with our patient population changing with kidney care.

MEMBER GOZANSKY: And then in a

perfect world something that is about over diagnosis or over treatment for frail elders because they get excluded on the upper level but that 85-plus as we started is the growing group, so, you know, it might be interesting to say something in that realm.

CO-CHAIR BAGLEY: Girma?

MEMBER ALEMU: Yes. I just want the opportunity to say yesterday we learned about the importance of telehealth, including telehealth into existing measures or developing, you know, separate data health measures, that's very important, especially for the rural health population and also to find, you know, looking forward to develop measures that can be used at multiple levels of analysis in multiple settings.

You have a large number of quality measures out there and we have to focus on those high volume measures and that can be used really in, you know, instead of developing separate measures for all, you know, settings that we have. So just to pay attention to those areas.

CO-CHAIR BAGLEY: Yanling?

MEMBER YU: Thank you. I really like that CMS is putting patient-reported outcomes as one of your top priorities and I think it's very important.

I just wonder if the agency has thought about, you know, the AHRQ who is pushing, you know, the CAHPS surveys on patients, you know.

I'm just wondering if there is any correlate efforts between AHRQ and CMS and then to expand on this effort, CAHPS, and then add more attributes of, you know, the survey to including different aspects of when you come to a procedure measures or outcome measures.

MEMBER SCHREIBER: Can I answer that.

CO-CHAIR BAGLEY: Go for it.

MEMBER SCHREIBER: So the answer is yes, we are having conversations with the people who are in charge of both CAHPS and HCAHPS.

MEMBER YU: Yes.

MEMBER SCHREIBER: Because that's --

And I'm not saying that's the direction we'll take, but it is kind of a natural way of doing it.

We are already surveying patients. You could in theory then add other questions related to outcomes, functional status, or any other uses for it.

MEMBER YU: Yes, I am glad to hear that. Another thing is I have been attending this overall webinar by AHRQ about AHRQ's CAHPS survey and, you know, like any survey it's not a 100 percent return rate and lots of times consumers are --

MEMBER SCHREIBER: No, that's true.

(Simultaneous speaking.)

MEMBER YU: -- you know, you are surveying them. They are not -- They don't say the need or incentive or whatever it is to participate, so you may have to pay some attention to how to really get people participating in this type of a survey to provide a useful information.

MEMBER SCHREIBER: I agree. I would hate though for us to all look like car sales people though.

(Laughter.)

MEMBER SCHREIBER: But you're point is well taken, the response rates are very low in some cases.

MEMBER YU: Right, yes.

CO-CHAIR BAGLEY: And if I might add on the same topic, you know, as somebody who is trying to drive quality improvement at the practice, you know, microsystem level, if you will, things like suggestion boxes and patient advisory boards are far more useful in terms of driving improvement and change than CAHPS will ever be for the actionable stuff you get back.

Now once in a while you identify an outlier provider, but you knew about that person before because he's a jerk.

(Laughter.)

CO-CHAIR BAGLEY: So any others that --

(Simultaneous speaking.)

CO-CHAIR BAGLEY: The margin and utility of all that effort that we are putting into CAHPS I would call into question. Stephanie, you were next.

MEMBER FRY: Following on to some of the recent comments I think, you know, with response rates declining there are different strategies for different purposes, so for your own quality improvement purposes, you know, absolutely, your suggestion box, but I still think that, you know, you're not going to get where we've talked about like what is the reliability and validity of measures, that won't be the threshold for that and to kind of relegate the patient voice to quality improvement and just hope that it comes through I don't think is quite the way to go.

But I really like CMS's idea in terms of moving toward how can you reduce burden in the collection of that information by combining patient-reported outcomes with experience.

You know, if you are going to get people to respond to a slimmest number of items and minimize their burden, you know, can you put that in one place.

And I think there is also, you know, as we look at coordination there has been a number of measures trying to get at what's the coordination so it's not just siloed healthcare being delivered.

I think it's the patient experience across the various settings of care also that we need to start figuring out how to do a better measurement job of, so not just what was your experience in a hospital, what was your experience with your, you know, primary care doc, but, you know, how do we try to have a better understanding of how to improve that overall experience for patients because that's where I think we'll be able to see improvements in their outcomes.

CO-CHAIR BAGLEY: Other comments? If not we have an opportunity for public comment.

I'm not exactly sure what they are supposed to comment on, but we'll let them say whatever they want.

(Laughter.)

CO-CHAIR BAGLEY: And if anybody on the phone still wants to have something to say it's time to do it right now.

MS. BUCHANAN: To unmute your line is *7.

CO-CHAIR BAGLEY: Maybe I could say a few comments while you are waiting. The next thing on the agenda is for me to summarize the day and I don't think that I would be willing to do that in terms of trying to summarize the discussion.

But let me say this, that if our purpose today was to inform CMS about how we think the measures should be used and implemented and modified and whatever then I think we have accomplished our purpose, in a sense that they have been attainable thereon and kudos to you guys for the third day you are looking pretty

good.

(Laughter.)

CO-CHAIR BAGLEY: And still paying attention. And to the staff who has been here all day kind of taking notes and probably on the phone as well, so thanks to all of you guys for -- it makes us feel like our time was well spent because you are paying attention.

So the next group I would like to thank is you, each one of you who took a whole day out of your life to come here and I hope that you enjoyed the conversation as much as I did.

I always learn something. I always see things in a different way and in a different perspective and I appreciate the growth it allows for each of us kind of professionally to know a little bit more about how this all fits together.

I especially want to thank those lead discussants who put, you know, extra effort into making sure they are ready to talk about the measures. And, Kim, you had to actually do that for all the measures, thank you for that.

And I think finally a real lot of thanks to the NQF staff and, you know, if it's okay with you I'll talk to your boss after the meeting and let him know what a good job you did

In case you want to know they are the ones that do the heavy lifting and you guys make my job easy, but, anyway, from Rob and me thank you for spending your day with us.

Anybody have any other -- Did you guys have any comments or --

MEMBER SCHREIBER: I mean our only comment is really to echo what you said, your input to CMS is extraordinarily valuable. We took some extensive notes.

You're right, we have lots of people on the phone also taking notes. But even as I sit here and reflect on the last three days it is clear that the feedback that we got is going to change some of the measures, I can tell you that already because of some of these sidebar conversations we've been having is going to impact the measures, impact them as to how we use

them in the programs, and we have particularly really appreciated first of all the opportunity to discuss some strategic direction and then to really have some significant input on it, so thanks you.

And, of course, as always, thank you to NQF, but, Bruce, to you and Rob we would really like to say thank you for co-chairing.

CO-CHAIR BAGLEY: You're welcome. I always like to do at least a brief meeting assessment. So if you have a comment about something you liked about the meeting or if you have a comment about what could have been done a little better that is fine.

And it goes everything from the food to the temperature to the speaker system, or lack thereof, anyway, whatever you would like to say to help us do better next time. Louise?

MEMBER PROBST: This is my first MAP in many years, a big difference. I really appreciated the user guide, so thank you.

CO-CHAIR BAGLEY: Yes?

MEMBER BOWMAN: I thought the IHI presentation was very good, very informative.

CO-CHAIR BAGLEY: Other comments?

MEMBER GOZANSKY: My first time here, I appreciated the level of dialogue. I thought it was very collegial, appropriate, and very informal and comfortable, although still heard to hear.

(Laughter.)

PARTICIPANT: We'll fix it.

MEMBER BURSTIN: I was just going to say our CMS colleagues were remarkably open and really listening.

CO-CHAIR BAGLEY: Okay. If that is all -- Mr. Hirsch, do you have any comments?

MR. HIRSCH: Yes. Thanks for very much. I guess we're heading down the final stretch then so on behalf of NQF leadership and staff I just wanted to say a very big thank you to each one of you for all of the hard work necessary to come prepped.

It was clear that you did a lot, so --

and in a very short turnaround. Just the way that the MAP is structured requires us to act quickly and you all just did an absolutely wonderful thing, so thank you all for everything that you do, especially to our Co-Chairs, we recognize that Rob Fields isn't here to accept our thanks, but, Bruce, thank you so much.

(Applause.)

MR. HIRSCH: One more thing that we would like to add is to our CMS colleagues, thanks for staying with us these three days.

The sincerity that you bring to your jobs is really clear that you take this very seriously and the earnestness by which you engage with us it truly means a lot, so thanks very much for your engagement for the two days and with that I think that we can adjourn. Thanks very much.

CO-CHAIR BAGLEY: Safe travels, everybody.

(Whereupon, the above-entitled matter went off the record at 3:59 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: MAP Clinician Workgroup

Before: NQF

Date: 12-05-19

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter