

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

2 (9:01 a.m.)

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

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

8 (Laughter.)

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

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

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

1 be a good meeting.

2 And is Shantanu here?

3 MR. AGRAWAL: I'm here.

4 CO-CHAIR BAGLEY: Oh, there you are.

5 (Laughter.)

6 CO-CHAIR BAGLEY: The man of the hour.

7 I hear you have some words of greeting for us.

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

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

17 CO-CHAIR BAGLEY: Okay. Great.

18 Thanks for being here. Thanks for your
19 hospitality and taking care of us.

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

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

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

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

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

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

22 We will go around the room first to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MEMBER RASK: Kimberly Rask with

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

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

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

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

15 Susan from HealthPartners?

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

22 MS. MUNTHALI: Thank you very much.

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

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

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

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

1 conflicts.

2 MS. MUNTHALI: Thank you.

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

8 MS. MUNTHALI: Yes, thank you.
9 Stephanie?

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

15 MS. MUNTHALI: Okay.

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

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

8 And Reena and Michelle, would you
9 please introduce yourselves?

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

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

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

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

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

6 So thank you.

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

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

15 Taroon?

16 MR. AMIN: Taroon Amin, consultant for
17 NQF.

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

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

22 MR. STOLPE: Wonderful. Okay. So our

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 MR. STOLPE: Oh. Thank you.

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

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

22 All right. We're ready for Michelle.

1 MR. STOLPE: We are.

2 MEMBER SCHREIBER: You're ready?

3 Well, thank you.

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

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

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

18 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So because we've had really fewer

1 measures in these sessions for the last several
2 days, and significantly fewer -- a couple of
3 years ago there were over 100 measures that were
4 brought to the MAP, but I say this for all three
5 of the committees. There were over 100 measures
6 brought to the MAP. Last year there were about
7 41 measures brought to the MAP, and this year,
8 quite honestly, there are fewer than 20.

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

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

1 time for discussion, which has been very nice.

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

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

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

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

7 Next slide, please.

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

17 Next slide, please.

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

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

4 Next slide.

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

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

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

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

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

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

11 Next slide, please.

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

22 And so the six domains include

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

11 Next slide, please.

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

14 MEMBER DUSEJA: Absolutely. Thanks,
15 Michelle.

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

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

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

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

1 reduction of those measures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 and shining a spotlight on it better?

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

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

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

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

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

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

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

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

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

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

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

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

4 Next slide?

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

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

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

1 Next slide?

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

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

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

15 MEMBER YU: Yes. Microphone?

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

20 (Laughter.)

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

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

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

10 MEMBER YU: Okay.

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

14 MEMBER YU: All right. Thank you.

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

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

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

10 We're seeing that our maternal
11 mortality numbers are the highest in the world,
12 of any country. And so shining a spotlight there
13 -- now that obviously is not a traditional
14 Medicare measure, but Medicaid pays for
15 43 percent of all deliveries in the United
16 States. And so this is really a very important
17 issue.

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

1 individual measures.

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

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

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

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

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

17 CO-CHAIR BAGLEY: Sandy?

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

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

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

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

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

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

6 CO-CHAIR BAGLEY: Girma?

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

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

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

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

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

16 Thank you.

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

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

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

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

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

13 MEMBER SCHREIBER: I'll get right on
14 it.

15 (Laughter.)

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

18 MEMBER SCHREIBER: I know.

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

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

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

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

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

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

1 what would it be that would be more effective?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 CO-CHAIR BAGLEY: Joy?

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

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

1 is the measurement of that population.

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

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

11 CO-CHAIR BAGLEY: Louise?

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

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

4 PARTICIPANT: No.

5 PARTICIPANT: Not well.

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

8 PARTICIPANT: It's not good.

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

11 (Laughter.)

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

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

1 (Laughter.)

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

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

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

9 (Laughter.)

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

14 DR. SAHA: Sure.

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

17 DR. SAHA: I have a slide about it.

18 (Laughter.)

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

21 PARTICIPANT: Yes.

22 DR. SAHA: Excellent So it's such a

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

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

17 Can you all still hear me?

18 PARTICIPANT: Yes.

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

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

1 100 Million Healthier Lives. In our effort to
2 identify measures that matter, in a specific
3 initiative called Well-Being in the Nation, I
4 dive deeply into one particular measure that has
5 emerged as a measure that has unexpectedly gone a
6 little bit viral.

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

13 Next slide.

14 So who am I? I am a Vice President of
15 the Institute for Healthcare Improvement. I have
16 been serving as the executive lead for
17 100 Million Healthier Lives for the last five
18 years, which was really borne out of IHI's
19 recognition that, you know, 10 years into the
20 Triple Aim we were not actually moving population
21 health outcomes. Experience was still pretty
22 bad, and cost wasn't any better. And so part of

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

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

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

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

1 60 percent global payments in five years, and
2 really redesigned the way we delivered care in a
3 way that improved population health outcomes
4 while taking 10 percent of cost out and
5 substantially and statistically significantly
6 improving joy and meaning of work for the
7 workforce.

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

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

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

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

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

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

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

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

6 Next slide.

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

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

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

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

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

10 So they developed a framework called
11 an NCVHS framework, which is now known as the
12 Well-Being of the Nation framework and then Asked
13 100 Million Lives to steward the process across
14 both federal agencies and non-federal agencies to
15 identify measures for population and community
16 health that would align -- that would help us to
17 get to multi-sector agreement and find what
18 actually works across sectors.

19 Next slide.

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

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

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

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

5 Next slide.

6 So started with a landscape analysis,
7 over 500 measures, and then began a Delphi
8 process with groups of people. There were
9 100 organizations and communities represented,
10 including community residents and patients, as a
11 fundamental part of that. Each of those
12 500 measures, and the ones that sort of began to
13 be prioritized, were rated based on the decision
14 criteria through NQF that we have identified.

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

1 matter.

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

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

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

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

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

15 Next slide.

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

22 (Laughter.)

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

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

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

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

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

11 Next slide.

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

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

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

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

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

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

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

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

17 Next slide.

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

1 sector and relates to the well-being of people.

2 There is -- it has been administered about 2.7

3 million times.

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

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

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

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

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

22 And 5 and 6 is going to get a pretty

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

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

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

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

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

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

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

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

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

3 Next slide.

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

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

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

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

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

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

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

8 Next slide.

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

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

20 Next slide?

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

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

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

15 But the measures that clinicians and
16 patients cared about that actually made sense to
17 both of them was that the percent of people
18 suffering declined, and the percent of people
19 thriving increased, like that was fundamentally
20 important. It moved within six months by
21 30 percent, 84 percent by the end of a year. And
22 that -- the movability of the measure when you're

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

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

16 Next slide.

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

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

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

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

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

1 mental health services over time?

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

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

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

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

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

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

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

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

12 CO-CHAIR FIELDS: Yeah. So --

13 CO-CHAIR BAGLEY: Quick on the draw.

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

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

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

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

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

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

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

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

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

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

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

1 for my vehicle. They were like --

2 (Laughter.)

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

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

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

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

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

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

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

19 MEMBER BRISS: As it always is.

20 (Laughter.)

21 CO-CHAIR BAGLEY: Helen.

22 MEMBER BURSTIN: Thank you. So, thank

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

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

13 PARTICIPANT: Okay.

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

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

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

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

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

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

1 Actually, initially some work with NQF early on.

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

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

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

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

22 And I hope, one last comment is, I

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

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

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

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

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

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

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

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

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

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

9 CO-CHAIR BAGLEY: David.

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

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

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

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

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

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

21 MEMBER POGONES: I put it down.

22 CO-CHAIR BAGLEY: Okay. Amy.

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

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

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

10 And the question is around aligning
11 incentives with that. So we're talking about
12 EPMS, we're talking about population, health
13 management, we're talking about wellness in the
14 physician workforce.

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

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

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

5 And what's the time frame of that is,
6 I mean, there was a commitment after the LAN
7 meeting to move 100 percent of payment there by
8 2025. I don't know that that will happen, but
9 that's the current commitment from the table.

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

14 MEMBER SCHREIBER: Yes.

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

19 MEMBER SCHREIBER: Right.

20 MEMBER NGUYEN HOWELL: Design.

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

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

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

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

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

22 Not making the connection between cost

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

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

12 (Laughter.)

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

14 MEMBER PROBST: I also really
15 appreciate --

16 (Off record comments.)

17 CO-CHAIR BAGLEY: Speak up please.

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

20 (Laughter.)

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

1 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

22 (Laughter.)

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

6 MEMBER SCHREIBER: Flattering.

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

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

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

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

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

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

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

15 MEMBER KNUDSON: Yes, thank you. And
16 I apologize earlier, I was on the line but I
17 accidentally hit the line button instead of unmute
18 button --

19 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 CO-CHAIR BAGLEY: Kevin.

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

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

19 CO-CHAIR BAGLEY: Can you speak up
20 please?

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

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

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

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

16 CO-CHAIR BAGLEY: Peter.

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

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

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

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

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

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

20 CO-CHAIR BAGLEY: David.

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

1 (Laughter.)

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

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

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

22 And so, it's a really big problem.

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

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

7 CO-CHAIR BAGLEY: Kevin, last comment.

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

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

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

22 And be careful about putting the

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

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

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

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

22 So, get these other communities to

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

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

5 (Laughter.)

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

11 CO-CHAIR BAGLEY: Right.

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

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

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

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

10 CO-CHAIR BAGLEY: Great.

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

14 CO-CHAIR BAGLEY: Great.

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

17 CO-CHAIR BAGLEY: Yes.

18 MEMBER SEIDENWURM: I just have a
19 quick comment.

20 CO-CHAIR BAGLEY: Yes, Dave.

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

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

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

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

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

22 It seems like access is the number one

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

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

9 So, Kate --

10 MS. BUCHANAN: Yes.

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

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

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

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

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

4 CO-CHAIR BAGLEY: Speak up.

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

7 (Laughter.)

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

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

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

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

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

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

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

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

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

1 preliminary analysis algorithm.

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

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

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

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

1 specified.

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

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

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

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

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

1 MS. BUCHANAN: Okay.

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

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

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

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

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

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

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

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

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

12 MS. BUCHANAN: Yes.

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

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

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

20 MS. BUCHANAN: Oh.

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

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

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

5 (Simultaneously speaking.)

6 MS. BUCHANAN: -- higher, yes.

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

9 MS. BUCHANAN: Okay.

10 CO-CHAIR BAGLEY: Is that correct?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So then we will vote on acceptance of

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

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

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

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

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

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

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

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

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

15 MS. BUCHANAN: Please.

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

22 So if we hit 60 percent exactly then

1 it will pass.

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

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

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

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

22 If you do not have a recommendation

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

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

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

18 CO-CHAIR BAGLEY: Okay.

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

21 (Off record comments.)

22 (Laughter.)

1 CO-CHAIR BAGLEY: Okay.

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

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

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

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

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

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

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

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

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

1 you know, a range of perspectives.

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

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

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

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

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

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

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

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

1 on procedures?

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

5 (Laughter.)

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

8 (Whereupon, the above-entitled matter
9 went off the record at 11:04 a.m. and resumed at
10 11:16 a.m.)

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

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

16 CO-CHAIR BAGLEY: Speak up.

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

1 have any conflicts, anything to disclose.

2 CO-CHAIR BAGLEY: All right.

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

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

10 MS. MUNTHALI: Great, thank you. Amy?

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

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

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

18 MS. MUNTHALI: Hi, Robert.

19 CO-CHAIR BAGLEY: Robert.

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

22 (Laughter.)

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

6 MEMBER KRUGHOFF: Robert Krughoff.

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

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

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

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

1 (Off microphone comment.)

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

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

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

11 MEMBER ROBERTSON: Yes.

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

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

21 MR. STOLPE: Very good.

22 CO-CHAIR BAGLEY: Okay.

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

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

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

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

1 meaningful measure priority under which the
2 measure under consideration falls.

3 With that being said, Bruce --

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

8 PARTICIPANT: Yes.

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

11 MS. RUBIN: Public comment.

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

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

18 (Laughter.)

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

21 (Laughter.)

22 MS. RUBIN: I'm probably also the only

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

3 (Laughter.)

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

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

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

22 And also work that is going on in the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 Okay, thank you.

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

9 (Off microphone comment.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 MEMBER NICHOLS: I do not.

12 CO-CHAIR BAGLEY: Okay. And
13 Stephanie?

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

18 (Off microphone comment.)

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

1 this measure would apply in rural settings.

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

6 MEMBER RASK: Yes.

7 CO-CHAIR BAGLEY: And speak out.

8 (Laughter.)

9 MEMBER RASK: I'll do my outside
10 voice.

11 CO-CHAIR BAGLEY: Please.

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

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

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

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

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

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

18 CO-CHAIR BAGLEY: Does anybody have
19 that information?

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

22 CO-CHAIR BAGLEY: Yes, please.

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

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

13 MEMBER POGONES: Two hundred patients
14 or --

15 MS. BERNHEIM: Two hundred per TIN.

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

18 MS. BERNHEIM: Yes. Eligible for --

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

1 apply to individual doctors.

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

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

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

17 CO-CHAIR BAGLEY: David, you were
18 next?

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

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

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

7 (Laughter.)

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

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

1 care among clinicians and hospitals. I think a
2 200 patient sample size is probably a legitimate
3 number for a cutoff, if that's maintained, that
4 even a single provider would have the ability to
5 influence.

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

8 CO-CHAIR BAGLEY: Was your comment --

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

17 CO-CHAIR BAGLEY: So, directly to his

18 --

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

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

5 (Off microphone comments.)

6 CO-CHAIR BAGLEY: Do you need
7 clarification?

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

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

13 (Simultaneously speaking.)

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

16 (Off mic comments)

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

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

1 methodology.

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

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

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

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

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

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

4 CO-CHAIR BAGLEY: Please.

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

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

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

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

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

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

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

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

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

22 And the third is the outpatient

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

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

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

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

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

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

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

14 CO-CHAIR BAGLEY: Next in line is --

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

18 (Off microphone comment.)

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

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

1 information.

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

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

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

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

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

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

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

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

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

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

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

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

22 (Off microphone comments.)

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

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

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

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

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

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

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

4 MEMBER DUSEJA: May I address that?

5 CO-CHAIR BAGLEY: Yes, please.

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

9 This measure currently is within the
10 program and it's requiring that for, you know, if
11 it is attributed to the TIN level there has to be
12 16 plus clinicians that are actually in the TIN
13 in order for this measure to be applicable too.

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

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

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

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

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

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

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

1 CO-CHAIR BAGLEY: Will, you were next.

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

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

9 MS. BERNHEIM: May I respond to that?

10 CO-CHAIR BAGLEY: Please.

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

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

22 In that case, that clinician would

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

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

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

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

22 MS. BERNHEIM: Right. So, again, it

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

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

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

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

16 MEMBER FLEISCHMAN: Yes.

17 CO-CHAIR BAGLEY: Trudy.

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

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

5 CO-CHAIR BAGLEY: Peter, your next.

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

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

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

22 Now, I do need to be clear on that

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

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

7 MEMBER ROBERTSON: Thank you.

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

11 (Laughter.)

12 CO-CHAIR BAGLEY: However, they do
13 listen.

14 (Laughter.)

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

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

22 So, within the cardiovascular space,

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

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

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

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

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

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

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

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

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

16 (Laughter.)

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

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

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

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

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

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

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

22 And our sense is that it's not a huge

1 problem --

2 CO-CHAIR FIELDS: Okay.

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

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

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

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

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

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

22 Was that a fair kind of assessment

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

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

8 CO-CHAIR BAGLEY: Yes.

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

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

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

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

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

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

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

11 MS. BUCHANAN: Yes.

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

14 MS. BUCHANAN: That's great.

15 MEMBER BURSTIN: Okay.

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

18 MEMBER BURSTIN: Okay. I got lucky.

19 MS. BUCHANAN: Okay.

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

1 (Laughter.)

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

4 MR. STOLPE: Straight to it.

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

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

9 CO-CHAIR BAGLEY: Okay.

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

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

14 (Laughter.)

15 MS. BUCHANAN: Oh no, this will work.

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

18 CO-CHAIR BAGLEY: Speak up.

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

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

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

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

7 MR. HIRSCH: This is the real deal.

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

10 MEMBER YU: Can I ask a question?

11 MS. BUCHANAN: Yes.

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

14 MR. HIRSCH: That will be counted.

15 MEMBER YU: That counted, okay.

16 MR. HIRSCH: Yes.

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

19 (Laughter.)

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

1 MEMBER KNUDSON: Yes, I did too.

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

5 CO-CHAIR FIELDS: Yes.

6 MS. BUCHANAN: If you wouldn't mind
7 logging in.

8 CO-CHAIR FIELDS: Okay.

9 MS. BUCHANAN: Were you able to vote
10 for this one?

11 CO-CHAIR FIELDS: I can vote.

12 MS. BUCHANAN: Okay, great.

13 (Off record comments.)

14 MS. BUCHANAN: So we are missing two
15 votes.

16 CO-CHAIR BAGLEY: How many voting
17 members are in the room? Raise your hand please.

18 MS. BUCHANAN: There are 21.

19 CO-CHAIR BAGLEY: Would you count
20 them?

21 MS. BUCHANAN: Not in the room. One,
22 two, three, four, five, six, seven, eight, nine,

1 ten, 11, 12, 13, 14, 15, 16, 17, and on the phone
2 we have two, so that's 19. So we have 19.

3 PARTICIPANT: What about the Chairs?

4 MS. BUCHANAN: Oh, 21. We have 21.

5 MR. STOLPE: We're shy two votes. My
6 math doesn't count.

7 CO-CHAIR BAGLEY: All right. And,
8 Kevin, just sit back.

9 Now, if it's okay with you I'm going
10 to ask for yes votes by raising hands.

11 MS. BUCHANAN: That's fine.

12 CO-CHAIR BAGLEY: Okay. Yes votes?
13 We won't have to do this every time once we
14 verify that it's working.

15 MS. BUCHANAN: Not in the room. One,
16 two, three, four, five, six, seven, eight, nine,
17 ten, 11, 12, 13, 14, 15.

18 CO-CHAIR BAGLEY: And no votes please?

19 MS. BUCHANAN: One, two, three.

20 CO-CHAIR BAGLEY: Four.

21 MS. BUCHANAN: Four.

22 PARTICIPANT: Kevin is voting now.

1 PARTICIPANT: Kevin is voting.

2 MS. BUCHANAN: And then Chad and Sue,
3 can you type your votes into the chat box please?

4 CO-CHAIR BAGLEY: I want you all to be
5 comfy with this, not just me.

6 (Laughter.)

7 MEMBER SEIDENWURM: While people are
8 counting, it's interesting to discuss it so we
9 know, and the non-discussants, I'm going to
10 guess, I don't know what that tells us precisely.

11 MS. BUCHANAN: I have 21 votes. I do
12 not have --

13 CO-CHAIR BAGLEY: We've got one more.

14 MS. BUCHANAN: So now there's 21,
15 okay.

16 (Off record comments.)

17 CO-CHAIR BAGLEY: I think we're good.

18 CO-CHAIR FIELDS: One of those might
19 have been me because I put my name in, but then I
20 saw log in, you said to log in, so I went back
21 and logged in.

22 MS. BUCHANAN: Oh, okay. No need to

1 log in.

2 CO-CHAIR FIELDS: No need to log in,
3 all right.

4 MS. BUCHANAN: That's right.

5 CO-CHAIR FIELDS: So one of the,
6 probably, there are two of my votes in there.
7 The hand votes are still more reliable at this
8 point.

9 MS. BUCHANAN: So we are --

10 (Off record comments.)

11 MR. HIRSCH: For MUC2019-27, Hospital-
12 Wide, 30-Day, All-Cause Unplanned Readmission
13 Rate for the Merit-based Incentive Payment
14 Program, Eligible Clinician Groups, do you vote
15 to support the preliminary analysis as the
16 workgroup recommendation?

17 Seventeen votes for yes, four votes
18 for no. The workgroup has recommended
19 conditional support for Rulemaking for MUC2019-
20 27.

21 CO-CHAIR BAGLEY: Thank you.

22 Everybody okay with moving on if that feels okay?

1 All right.

2 All right. If it was half and half we
3 probably wouldn't be comfortable. So, are you
4 going to go to the next one?

5 MR. STOLPE: I am. All right, let's
6 move on to our next measure. We're considering
7 MUC2019-28. This is the Risk-standardized
8 Complication Rate Following Elective Primary
9 Total Hip Arthroplasty And/or Total Knee
10 Arthroplasty.

11 So this measure is based on a measure
12 inside of IQR, NQF-1550, but it also carries its
13 own NQF number as NQF-3493. And it's endorsed
14 under that measure.

15 So I'll briefly read the description
16 of the measure to you. And it's fairly
17 straightforward.

18 This measure assess each providers
19 complication rate defined as any one of the
20 specified complications occurring from the data
21 index submission to up to 90 days post date of
22 the index procedure.

1 NQF Staff's review of this measure
2 placed it under support for rulemaking. And I
3 just wanted to point out one or two things about
4 this.

5 That the developer didn't note any
6 consequences in 2017. Maintenance endorsement
7 submission for the measure, 1550, nor in the
8 submission for 3493. And that this measure is an
9 outcome measure.

10 And inside of the MIPS program we
11 identified approximately 30 measures related to
12 surgery and seven directly related to TKA and
13 THA. But none of the measures identified
14 actually deal with complications from both. This
15 is the current status of the measure.

16 CO-CHAIR BAGLEY: Okay. And the
17 recommendation in support for rulemaking I have
18 Wendy.

19 MEMBER GOZANSKY: Okay. So, I think
20 that overall this is a very important issue. We
21 have more and more older folks across the country
22 who are having more and more of these procedures.

1 I think the issues that were brought
2 up of concern in the room around the fact that
3 this is a claims-based retrospective, it's not
4 about patient outcomes around functional
5 outcomes, is reasonable. And yet I also think
6 that the issue is that this is about safety. And
7 this is an elective procedure.

8 And so the idea of having very high
9 safety and very high expectations for an elective
10 procedure I think is appropriate. I also think
11 that this speaks to sort of that team based
12 communication approach so that you actually are
13 looking at, it's not only what's happening in the
14 operative period.

15 And I think what's important when you
16 look at the specifications, when I first looked
17 at this I'm like, 90 days. But it is that the
18 complications are targeted to different dates.
19 So the idea that it is the acute myocardial
20 infarction within the seven, so did you do your
21 pre-ops gratification correctly in the 30 days,
22 did you get them on the right anticoagulant and

1 make sure we're not having bleeding issues. And
2 then the longer term is around sort of the joint
3 infection, lymph infection, those types of
4 things.

5 I also think they do a very nice job
6 for making sure that this is primary. This is
7 not revisions or any of that sort of thing.

8 I think there were a good number of
9 concerns. So what is beneficial is that there is
10 alignment so that if this is, you are looking at
11 not only the system issue but then you can get
12 alignment to the actual surgeons.

13 And I think this speaks to sort of the
14 surgeon as leader. And the idea that we should
15 have alignment between the hospital system as
16 well as the provider performing the surgery.

17 I think that part of the concern was
18 around volume. And the idea that you do see an
19 association between higher volume has lower
20 complication rates as we would expect.

21 There is a statement that this was
22 about 25 as the threshold. And I didn't actually

1 see that called out specifically so I think we
2 need to, I wanted to be sure that that is in the
3 specification. I think that is important.

4 The other piece that was raised as
5 well about the idea of the patient reported
6 outcomes, I do think that that would be
7 supplementary, but I think that this is a more
8 basic and important first step. I think the
9 combination.

10 And then as we talked earlier about
11 numbers of measures, do you use this as a
12 replacement to take the pieces and parts measures
13 away and consider that this might be the primary
14 measure that is more of an integrated and aligned
15 measure to use.

16 The other clear comment was really
17 about the reliability. And there was concerns in
18 the public comments that the reliability should
19 be .8 or greater.

20 I kind of, .79, I'm going to round
21 that to .8. I think that's still a substantial
22 reliability, I'm good with that.

1 And I also think when you look at the
2 variability of the 1.2 to 7.2 percent, the idea
3 that this actually is meaningful, again, and I
4 will remind us that it's an elective procedure.

5 I think the one concern that I was
6 also thinking about is, are we going to
7 incentivize orthopedic surgeons to avoid doing
8 high-risk patients?

9 And I think that's an important issue
10 as we have more older folks, more complications.
11 And there are a lot of people, I mean, having a
12 really bad hip or knee is just as impairing as
13 Stage 4 CHF. And so, there may be people who
14 want to take that risk.

15 I do think that there is risk
16 adjustment in the measure, and so I think that
17 that hopefully is going to account for that. But
18 I think that would be sort of the one adverse
19 consequence I would think about in the measure.

20 CO-CHAIR BAGLEY: Okay, next I'll
21 accept comments from the co-discussants, if you'd
22 like, Yanling, Joyce and Tracy.

1 MEMBER YU: Yes, I think you did a
2 very nice summary. I just want to point out
3 briefly.

4 I think, you know, patient report
5 outcomes are very important in term of improved
6 quality of care and safety. And I don't think it
7 has at least primer that we can really adopt into
8 a meaningful measure, at the time, in my opinion.

9 But it may, I agree that maybe use, in
10 the future, as a supplement measure, to
11 compliment the claim data. And claim data is
12 free. It's a lot more easier to use at this
13 time.

14 And also, I just want to say one thing
15 about, for risk adjustment. And I think a CMS,
16 there is one measure that also ask whether the
17 risk have been discussed in way of the patients.

18 So I think for, you know, even if it
19 is the elective of surgery, but this type of
20 surgery typically occurred to elderly patients.
21 So, the risk inherence in that population, so
22 maybe somewhere should have some type of a, I

1 don't know how it would do it, reflect that type
2 of communication having discussed with the
3 patients who you elected to do that surgery. So,
4 that's all I have. Thank you.

5 CO-CHAIR BAGLEY: Thank you. Joyce.

6 MEMBER KNESTRICK: I just wanted to
7 say I concur with the summary. When I looked at
8 the comments it kind of gave me pause, and so I
9 felt that I had to go back and look at the
10 science and evidence again. And I think that you
11 accurate reflected what I came up with too as
12 well.

13 CO-CHAIR BAGLEY: Tracy.

14 MEMBER VADEN: Excellent summary and
15 definitions.

16 CO-CHAIR BAGLEY: Okay. Sandy, you're
17 next.

18 MEMBER POGONES: It just occurred to
19 me, are there a lot of this type of surgeries
20 done by physicians who do less than 25 cases a
21 year? And if there are, aren't those the ones we
22 really want to target?

1 (Laughter.)

2 CO-CHAIR BAGLEY: Yes, I wanted to
3 have some clarification about that as well. Tell
4 us more about the 25 cases.

5 MS. BERNHEIM: So, two clarifications,
6 right. This is based on Medicare claims for over
7 65 for service Medicare patients. So you need to
8 have 25 of such patients.

9 So some clinicians may have just
10 reached that 25 threshold that actually is seeing
11 more patients, they're just not in that category.
12 So, just to acknowledge that.

13 And on the question that, don't we
14 want to measure them, this is the question that
15 came up when we were developing this measure and
16 with experts. And, you know, it's the tension
17 between making sure that when we're looking at an
18 outcome rate we have enough information to feel
19 like the measure can be fair versus yes.

20 I certainly want to know if I'm going
21 to a surgeon who does very few cases, what their
22 complication rate is. But we fell on the side of

1 making sure that the measure was assessing
2 clinicians more or less.

3 CO-CHAIR BAGLEY: My concern is that
4 any number like that is arbitrary. And could you
5 tell us how you did your arbitrary decision?

6 (Laughter.)

7 MR. HERRIN: Jeph Herrin, I'm a
8 methodologist at Yale CORE. The 25 number is one
9 we use for testing. And we selected that because
10 it provided sort of a minimal amount that we
11 thought was adequate in reliability. At 25
12 volume we realized the use of about 80 percent
13 for both clinicians and groups.

14 It's not baked into the use of the
15 measure, it's what we use for the testing. We
16 thought that 25 provided adequate reliability for
17 all the testing we did. So that's what we used.

18 Susannah said is 25 Medicare --

19 MEMBER POGONES: A little louder if
20 you could.

21 MR. HERRIN: Louder, okay.

22 (Laughter.)

1 MR. HERRIN: Sorry, I'm very soft
2 spoken. So the 25 is, we used 25 for our testing
3 because it's the number that provided adequate
4 reliability. Divided, about an 80 percent
5 reliability, 79 percent reliability, for
6 clinicians and clinician groups.

7 Is the number that's used at the
8 hospital level for this measure. Hospitals
9 report this measure if they have 25 cases. And
10 so that's where the 25 comes from.

11 But it's not baked into the use of the
12 measure. Higher thresholds could be used. But I
13 think a lower threshold would probably not be
14 useful.

15 CO-CHAIR BAGLEY: And if I might make
16 an observation, I think here's where we get into
17 the problem of using it for payment and judgment
18 versus using it for quality improvement.

19 So, if I were managing a group of
20 physicians with a couple of dozen orthopedic
21 surgeons, I might still use it for internal
22 purposes. And to combine it with what we know

1 about standing side-by-side with that particular
2 surgeon to make some changes.

3 CO-CHAIR FIELDS: I actually want to
4 know if the rural workgroup actually had any
5 comments or thoughts around the volume piece in
6 particular.

7 I mean, I think before I was in New
8 York City I was in rural North Carolina, so
9 radically different. And we had all sorts of
10 issues with docs in rural counties that had, I
11 mean, couldn't ever compete in terms of volume.
12 And I just wonder if that was a concern that the
13 workgroup brought up in terms of these measures.

14 And I totally get it, right. As a
15 consumer you want people who are experienced, and
16 that's certainly true.

17 The unintended consequence though,
18 differentially targeting a measure to those that
19 are less than 25, relative to that comment, is
20 that you can inadvertently then reduce access on
21 the rural side because then docs don't want to
22 touch it.

1 Thoughts about that from --

2 MEMBER POGONES: Yes. So the rural
3 group did talk about those issues and kind of
4 were balancing.

5 There was a strong feeling that this
6 was a really important measure for rural
7 residents. That these were common surgeries and
8 that they really want to know about quality and
9 the exists of complications.

10 They actually thought if it was
11 limited to the groups with at least 25 patients,
12 then low volume rural providers would not be
13 penalized by this program, so they felt --

14 CO-CHAIR FIELDS: They felt okay with
15 it.

16 MEMBER POGONES: -- they felt okay
17 with it.

18 CO-CHAIR FIELDS: Okay.

19 MEMBER POGONES: This kind of got sort
20 of a more neutral response. It was not the least
21 favorable measures, it was not the highest
22 favorable measures that came out within it. And

1 the other one unintended consequence --

2 CO-CHAIR FIELDS: So it's not the same
3 test, right?

4 (Laughter.)

5 MEMBER POGONES: The other unintended
6 consequences they did bring up is thinking,
7 keeping in mind, as these elected procedures
8 increasingly move to the outpatient setting, the
9 ability to have access to the local services to
10 support outpatient recovery might be an issue for
11 rural residents getting these kinds of
12 procedures.

13 CO-CHAIR BAGLEY: Trudy, you were
14 next.

15 MEMBER MALLINSON: So, you were asking
16 the question, that standard of physicians do less
17 than 25, like, what percentage of the overall, if
18 we can answer that question?

19 CO-CHAIR BAGLEY: Do you know that
20 folks?

21 MS. BERNHEIM: Our team certainly
22 does. I'm looking quickly to see if we can find

1 it in our notes.

2 CO-CHAIR BAGLEY: Okay. While you --

3 MS. BERNHEIM: Could you--What I
4 remember from the development time period is that
5 you lose a substantial percentage, right.

6 CO-CHAIR BAGLEY: Right. Yes.

7 MS. BERNHEIM: And there really are
8 low volume surgeons doing these procedures and
9 they tend to be doing just a wide range of
10 procedures. So it's not necessarily that they're
11 low volume surgeons overall, it tends to be that
12 they just have a very broad scope of practice.
13 And so the numbers that fit into this elective
14 set.

15 But we can get you that number. I
16 don't have it at my fingertips.

17 CO-CHAIR FIELDS: I would wonder if
18 you're like a trauma, like what if you're a
19 trauma person and you don't do hip replacements
20 all the time but you have to do one periodically.
21 Like you're doing a, to your point, you're doing
22 a ton of other common related orthopedic

1 surgeries and then every once in a while you have
2 to do a hip replacement or something?

3 MS. BERNHEIM: But not an elective.

4 CO-CHAIR FIELDS: Right.

5 MS. BERNHEIM: Certain --

6 CO-CHAIR FIELDS: Oh --

7 MS. BERNHEIM: -- these are really--

8 We do have a --

9 MR. HERRIN: Yes, so among the
10 clinicians, 52 percent did not meet the 25
11 Medicare case threshold. And among clinician
12 groups, 42 percent did not meet that threshold.

13 CO-CHAIR BAGLEY: Does that bother you
14 guys at CMS?

15 (Laughter.)

16 CO-CHAIR BAGLEY: I mean, what kind of
17 mitigation are you doing?

18 MEMBER SCHREIBER: Yes, I think one of
19 the --

20 CO-CHAIR BAGLEY: Speak to the group
21 please.

22 MEMBER SCHREIBER: Yes. One of the

1 issues that Susannah and others have pointed out
2 though, this is 25 Medicare fee for service
3 patients.

4 So you can clearly have an orthopedic
5 surgeon who has mainly Blue Cross patients. Or
6 whatever insurance you would like to say.

7 They would certainly meet what we
8 would think of as a high enough volume surgeon to
9 what we would say is competent. And so, I think
10 this was chosen so that we make sure the data is
11 valid.

12 But I don't think that we can use that
13 number to judge whether or not the --

14 CO-CHAIR FIELDS: Yes, it's --

15 MEMBER SCHREIBER: -- surgeon is a --

16 CO-CHAIR FIELDS: Right.

17 MEMBER SCHREIBER: -- high enough
18 volume surgeon.

19 CO-CHAIR FIELDS: Right. That's a
20 really good point.

21 CO-CHAIR BAGLEY: David.

22 MEMBER SEIDENWURM: Yes, I think to

1 some of the points that have been brought up,
2 bring up the importance of registry submission,
3 which would include all payer populations and not
4 just be segmented. So I think that's another
5 reason why there is differences in the registry,
6 as you mentioned earlier.

7 And you've discuss that there was a
8 big range between the desk performance and the
9 work performance. And I think that's an
10 important way to think of it.

11 But I think perhaps a more important
12 way to think of it is that with a gap of around
13 one percent between the 10th percentile and the
14 90th percentile, if someone is performing a
15 value, quadruple the threshold volume, if they
16 had one bad case that could shift them from the
17 98th to the 10th percentile.

18 So the ways to mitigate that would be
19 to look at these metric in terms of stability of
20 the clinicians in terms of their rankings from
21 year to year and see if that, in case a real
22 concern or not. Or perhaps they have a longer

1 period of look back or a longer period of
2 analysis and that has its own problems for
3 quality improvement.

4 Having said that, I think we might
5 even probably, we should go ahead and improve it.
6 But perhaps in the future we can work with the
7 refinements along those lines.

8 CO-CHAIR BAGLEY: Kim, did you have
9 additional comments?

10 MEMBER RASK: Yes. Sorry, one other
11 message or one other discussion on the division
12 on the rural workgroup that we felt was not as
13 important from a role perspective, but Mike
14 painted this as the notion of, for these measures
15 that are based on Medicare fee for service.

16 As we see the transition to Medicare
17 and Medicare advantage programs, again, the
18 denominator, the number of people that are fee
19 for service that can be used for these members
20 keeps getting smaller.

21 In the role perspective, the
22 perception was that there's not as much

1 penetration as the Medicare advantage in rural
2 communities relative to non-rural communities.
3 So we didn't think that impacted the measure from
4 the rural perspective.

5 CO-CHAIR BAGLEY: Wendy.

6 MEMBER GOZANSKY: I was just going to
7 say that I think having this as a, sort of a
8 hospital system based measure as well, allows for
9 the ability to say, if they have that and then
10 have providers who have the measure that you are
11 then able to look and see that there could be
12 signal that your providers look great and this
13 doesn't, then that would be the signal that there
14 is somebody who is not doing enough volume.

15 And so I think there, again, that
16 alignment gives you the potential for some
17 counterbalance. And I would also say, and if it
18 does drive people to do more high volume of high
19 risk patients and we're going to have better
20 outcomes, that could be a positive unattended
21 consequence.

22 (Laughter.)

1 CO-CHAIR BAGLEY: Yanling.

2 MEMBER YU: Yes, thank you. Just a
3 very brief clarification. On the statistics, you
4 just quote for 45 percent of 50 percent of group,
5 the clinician group.

6 Are those numbers include all
7 ambulatory, surgery center and in hospital or
8 just the hospital?

9 MS. BERNHEIM: Currently the measures
10 are based just on procedures done at the
11 hospital.

12 MR. STOLPE: Yes, in the hospital.

13 MEMBER YU: In the hospital, not
14 ambulatory.

15 MEMBER SCHREIBER: Not at this time.

16 MS. BERNHEIM: Not at this time.

17 CO-CHAIR BAGLEY: Oh, okay. Any
18 others?

19 MS. BERNHEIM: No. And I think CMS
20 just changed some of their payment roles around
21 this so you know, that's going to lead to the use
22 of these procedures and applicant settings

1 expanding, and obviously will be considered in
2 reevaluation of this measure in the future.

3 CO-CHAIR BAGLEY: Robert.

4 MEMBER KRUGHOFF: Is this measurement
5 being done for just one year, is it two years, is
6 it 30 years?

7 MS. BERNHEIM: It's based on case
8 findings for three years.

9 MR. STOLPE: Three years.

10 MEMBER KRUGHOFF: Three years.

11 Because I, I was a senior in here.

12 CO-CHAIR BAGLEY: Okay, I don't see
13 any other cards up so it looks like we're ready
14 to move to voting.

15 MEMBER SCHREIBER: I'm sorry, can I
16 just make one point?

17 CO-CHAIR BAGLEY: Oh, you have --

18 MEMBER SCHREIBER: I just want to make
19 one point to the group since we've been talking
20 about volumes and what this can be used for. And
21 the advantage of obviously having a complication
22 rate is that in medical staff credential, which

1 is really where you would start making decisions
2 of, do you have a high enough volume physician,
3 you could use this if you have, now, if somebody
4 who is an outlier here, I think that would lead
5 to medical staff credentialing issues.

6 So there is yet another way of using
7 this that gets at that question.

8 CO-CHAIR BAGLEY: Okay, my concern
9 exactly, especially when it's an arbitrary
10 number.

11 (Laughter.)

12 CO-CHAIR BAGLEY: Okay. All right,
13 let's, are you ready to vote, Jordan?

14 MR. HIRSCH: For MUC2019-28, Risk-
15 standardized Complication Rate Following Elective
16 Primary Total Hip Arthroplasty and/or Total Knee
17 Arthroplasty for MIPS Eligible Clinicians and
18 Eligible Clinician Groups.

19 Do you vote to support the preliminary
20 analysis as the workgroup recommendation, the
21 options are yes or no, and the preliminary
22 analysis with support for rulemaking?

1 CO-CHAIR BAGLEY: Any other votes from
2 the phone as well?

3 MS. BUCHANAN: And, Chad and Sue, were
4 you able to, so we are waiting on one vote. We
5 have 21 votes.

6 MEMBER TEETERS: I did vote.

7 MS. BUCHANAN: Okay, great.

8 MEMBER KNUDSON: I did.

9 MS. BUCHANAN: Okay, great. So, I'm
10 just going to do a quick walk around because
11 there is one vote that's not being captured. I
12 just want to make sure everyone's screen have --

13 CO-CHAIR BAGLEY: Does everybody have
14 301 at the top hand?

15 (Off record comments.)

16 MS. BUCHANAN: Okay, great.

17 CO-CHAIR BAGLEY: All right. And the
18 results are?

19 MR. HIRSCH: For MUC2019-28, Risk-
20 standardized Complication Rate Following Elective
21 Primary Total Hip Arthroplasty and/or Total Knee
22 Arthroplasty, MIPS Eligible Clinicians and

1 Eligible Clinician Groups, the Workgroup Has
2 Voted 21 yes, one no. The Workgroup has voted
3 for support for Rulemaking in MUC2019-28.

4 CO-CHAIR BAGLEY: Okay.

5 MS. BUCHANAN: And just --

6 CO-CHAIR BAGLEY: Yes, go ahead.

7 MS. BUCHANAN: -- one quick thing. So
8 when you hit your vote, don't hit clear, it will
9 be marked on so please don't clear your
10 responses. There is no need to, we'll fresh. So
11 that way, that's how we're losing some of the
12 votes.

13 CO-CHAIR BAGLEY: Okay. Helen.

14 MEMBER BURSTIN: Just one general
15 comment for our CMS colleagues. And I think
16 measure fails, exemplifies why we need a whole
17 payer data.

18 And again, I think it also exemplifies
19 the fact that volume measures are really
20 important. They have never been a part of our
21 public reporting through you.

22 And, again, just two small points, but

1 again, those are measures I think, and both
2 clinicians, to your point, I'd love to know who
3 doesn't do 25 year also, I am referring.
4 Clinicians and patients would find those really
5 valuable.

6 An all payer has to be, in fact, if MA
7 is out of this, this really --

8 CO-CHAIR BAGLEY: Okay, you've earned
9 lunch. Even though we're not quite finished with
10 the one agenda we're going to do lunch.

11 We would like you to come back at
12 quarter of. 12:45. Even though that's a little
13 less than half an hour, let's do it. And we'll
14 see you then.

15 MR. STOLPE: All right, before we dash
16 out, just one brief announcement. There was
17 materials shared by Yale CORE, which are posted
18 on the website.

19 But if you would like to review a hard
20 copy, they've been kind of printed down and
21 you're welcome to pick up a copy. I'll have one.

22 PARTICIPANT: Where is it on the

1 website?

2 (Off mic comment.)

3 PARTICIPANT: Where is it on the
4 website?

5 MR. STOLPE: So this is, sorry, this
6 is --

7 PARTICIPANT: We'll just pass them
8 around.

9 MR. STOLPE: -- all caused unplanned
10 admissions for patients with multiple chronic
11 conditions.

12 (Whereupon, the above-entitled matter
13 went off the record at 12:24 p.m. and resumed at
14 12:47 p.m.)

15 MR. STOLPE: All right, very good.
16 With that being said, let's move directly into
17 our next measure under consideration. This is
18 MUC2019-66. Hemodialysis Vascular Access,
19 Practitioner Level Long-Term Catheter Rate.

20 This measure is currently implemented
21 in a slightly different specification inside of
22 ESRD QIP. The measure description is the percent

1 of adult hemodialysis patient MUCs using a
2 catheter continuously for three months or longer
3 for vascular access attributable to an individual
4 practitioner or a group practice.

5 The NQF recommendation for this
6 measure is conditional support pending NQF
7 endorsement.

8 We didn't have any other significant
9 comments on that to share other than to emphasize
10 that the measure is feasible, as evidence by its
11 use in ESRD QIP that it draws from both claims
12 and CROWNWeb data and that no challenges have
13 been identified at this time.

14 CO-CHAIR BAGLEY: Okay, our
15 discussants. Let me get on the right page.
16 Chad, you're on the phone? Is Chad back with us?

17 (Off mic comments.)

18 MR. STOLPE: Chad, are you on the
19 line?

20 MEMBER TEETERS: Yes, I am.

21 CO-CHAIR BAGLEY: Okay. Do you have
22 initial comments on the measure?

1 MEMBER TEETERS: Oh, yes, I'm sorry.

2 MR. STOLPE: Chad --

3 (Simultaneous speaking.)

4 CO-CHAIR BAGLEY: Did you hear me,
5 Chad?

6 MEMBER TEETERS: Yes, I can hear you
7 now. Sorry.

8 CO-CHAIR BAGLEY: All right. Did you
9 initial comments on the measure, as the lead
10 discussant?

11 MEMBER TEETERS: Yes. The other
12 measure?

13 CO-CHAIR BAGLEY: Yes.

14 MEMBER TEETERS: Yes, okay. So, yes.
15 So, this measure is a percentage of adult human
16 analysis patient months using a continuous,
17 catheter continuous for three months or longer
18 for faster access, attributable to individual
19 practitioner or group practice.

20 Notably, the exclusions that were
21 listed for those who haven't had a chance to look
22 through it were peds patients apparently on

1 dialysis. Those that have one MCP provider
2 listed for the month.

3 And then in addition, patients with
4 catheter that had limited life expectancy under
5 lots of care, metastatic cancer, liver disease
6 and brain injury being called out.

7 This one was actually pretty unanimous
8 in the feedback that was provided online and that
9 most question the validity and fee statistic of
10 this particular measure, mainly because of, the
11 statistic was about .602 whereas the prior EMS
12 measure provided with NQF was (telephonic
13 interference). The facility rate showed a
14 correlation of about .765. So that called into
15 question the reliability of the measures.

16 Otherwise the other concerns that were
17 raised largely centered around this, is from the
18 main delegation, largely centered around the
19 concern for other vascular access measures and
20 other rounds of value-based payment on whether
21 this would be conflicting or potentially
22 redundant. And especially attributing it to the

1 provider level with that degree of correlation
2 and validity that's been demonstrated.

3 So, with that, those are my feedback
4 so far.

5 CO-CHAIR BAGLEY: Okay, any comments,
6 additional comments from the co-discussants?
7 David.

8 MEMBER SEIDENWURM: So, the noise
9 factor of 40 percent noise rather than the usual,
10 the accepted 30 percent noise is, I think,
11 important.

12 But I think that because, I think that
13 this is a disparity, health disparity sensitive
14 metric. And I think we might want to have some
15 flexibility there to improve on health
16 disparities.

17 The importance of the patients with
18 limited life expectancy is --

19 CO-CHAIR BAGLEY: Keep your volume up
20 please.

21 MEMBER SEIDENWURM: Sure. The
22 importance of patients with limited life

1 expectancy I think was mentioned.

2 And I think we just need to emphasize
3 that cost, complications, morality, hospital use
4 are all correlated with this type of care. So we
5 really want to push things in the direction.

6 And then push them into the provider
7 level. It has the same benefits and system as,
8 that we've seen before.

9 So, the one thing that I would say is
10 that we may also promote better team based care
11 with, there are some communities in which there's
12 a limited supply of vascular surgeons. There are
13 now some cutaneous devices that could be used to
14 facilitate this by interventional nephrology,
15 interventional radiology and other specialties.
16 Cardiology presumably.

17 So, I think that some of those access
18 problem are mitigated by the new technology. So
19 those are the comments I wanted to make.

20 CO-CHAIR BAGLEY: Okay. Yanling.

21 MEMBER YU: Yes, I just have a
22 question for NQF. And the recommendation is for

1 condition support. Is that based on the fact
2 that measure has now been submitted for
3 reliability and visibility of validity testing?

4 Is that wise condition?

5 MR. STOLPE: That is correct. So, the
6 expectation would be that the measure would be
7 submitted to NQF for core review. Including
8 evidence, the importance, the scientific
9 acceptability, feasibility and usability.

10 MEMBER YU: Okay. So what if this
11 Committee support this conditioning approval,
12 then what if the tasking did not pass those two
13 tests, what's going to happen?

14 MR. STOLPE: The assumption would be
15 that it would be inappropriate to carry use
16 inside of the specified workgroup.

17 MEMBER YU: Okay. Okay, thank you.

18 CO-CHAIR BAGLEY: Kim, did you have
19 any comments from the Rural Workgroup?

20 MEMBER RASK: Yes. From the rural
21 workgroup discussion, they felt this was really
22 relevant and important for rural residents

1 because of the prevalence of diabetes and
2 hypertension and subsequent kidney disease.

3 They were concerned about an
4 unintended consequence. If there's a higher
5 burden of disease.

6 Despite the, given some of the
7 exclusion criteria, if there is a lot of faulty
8 morbidities where people that were really too
9 sick and did not have a long life expectancy,
10 what might feel pressure to have fistulas placed
11 when there really wasn't going to be much benefit
12 for them long-term because of their poor
13 prognosis.

14 In terms of overall impression, this,
15 again, was one of the ones that was right in the
16 middle. Not a strong against and not a strong
17 four.

18 CO-CHAIR BAGLEY: Additional comments?
19 Will.

20 MEMBER FLEISCHMAN: I'm trying to
21 think I'm not a nephrologist. And I'm guessing
22 this is essentially targeting nephrologists, and

1 maybe some primary care doctors who will seek,
2 who are primarily caring for patients like this.

3 From a clinician's perspective, what
4 control do you have, other than saying to the
5 patient you should really get an AV fistula, what
6 control do you have over the patients actually
7 getting that?

8 You can't force a vascular surgeon to
9 do the procedure. You can refer them to one. Is
10 the idea that we're simply pushing people to
11 refer people for AV fistulas?

12 Because you really have limited
13 control over ensuring that this actually happens.
14 As opposed to having this at a system level.

15 MR. ROACH: Can I respond to that?

16 CO-CHAIR BAGLEY: Please.

17 MR. ROACH: Okay. Hi, I'm Jesse
18 Roach, I am the ESRD measure lead, I'm a
19 nephrologist.

20 So, I think that when you set up
21 vascular access, I think the clinician actually
22 does have a large degree of control. So first

1 off, there is the referral, but then there is
2 also followup and coordination.

3 There need to be a number of studies
4 done before that need to be ordered. And in
5 pushing the person to get it actually has been
6 shown to help, and to help get it done.

7 I think we've also seen, since this is
8 in the QIP, since it's been instituted and since
9 we have instituted the Fistula First program, and
10 has held the facilities accountable, that there
11 has been a steady decrease in the number of
12 catheters and an increase in the number of
13 fistulas. So it is definitely something that the
14 facilities and the physicians can control.

15 And then along with that decrease
16 there's been a significant decrease in mortality
17 as well, which we think a lot of it has to do
18 with this Fistula First.

19 CO-CHAIR BAGLEY: Helen.

20 MEMBER BURSTIN: Just a brief
21 question. And I'm glad you're here. So, what's
22 the, from your perspective, what's the added

1 benefit of taking an existing QIP measure and
2 bringing it to the clinician level? I want to
3 understand how you think that is useful from a
4 patient perspective?

5 MR. ROACH: So, I think that it, one,
6 allows nephrologists to, I think it allows
7 nephrologists to be, I'm trying to think of the
8 right term, recognized for, or to establish their
9 value of doing this for the patient. I think
10 it's an extra step to encourage physicians to
11 work for this instead of just facilities.

12 We've had facilities tell us that the
13 physicians are separate actors and that they are
14 not necessarily working in concert all of the
15 time.

16 And then also on top of that I think
17 that there is still a gap. There's about ten
18 percent of patients that have, that still
19 continue to have fistulas, I mean, catheters for
20 over three months. And I think that this would
21 work to continue to decrease that.

22 MEMBER BURSTIN: And I think the

1 safety issue is a given, I'm just trying to
2 understand how that added effect matters. But
3 thank you for that.

4 CO-CHAIR BAGLEY: Okay, other comments
5 or questions? Will.

6 MEMBER FLEISCHMAN: One follow-up
7 item. So how is, I didn't see the measure specs.
8 This is specifically targeting only nephrologists
9 or --

10 MR. ROACH: So, I imagine if you had
11 multiple, if you're a primary care provided and
12 had more than, I think it's ten patients that
13 were on dialysis, you could do that. I think
14 this is geared almost exclusively towards
15 nephrologists but there is potential for primary
16 care docs if they were sort of active primary
17 care doc with these people.

18 But most of the time the person that's
19 arranging all of this and billing it is going to
20 be a nephrologist.

21 MEMBER FLEISCHMAN: All right.

22 CO-CHAIR BAGLEY: Okay, Chad, do you

1 have any comment on the phone?

2 MEMBER TEETERS: Yes, I just have
3 another question, I guess, for the CMS folks. So
4 one concern I would raise, and I don't know,
5 maybe it should be a concern.

6 But with the plan to release mandatory
7 bundles to 50 percent of the nephrology groups in
8 the next, in January, and then with the advent of
9 the elective KCF, and I think KCC bundles soon to
10 follow, isn't there a concern that by putting us
11 in the mix down there that we're kind double
12 jeopardizing the groups who will be participating
13 in these other programs?

14 MR. ROACH: So, well, it's a little
15 hard to say right now because those are still
16 under development. They just have, they've just
17 been proposed right now and so the final
18 iterations of those isn't quite known.

19 I do think that the fistula part for
20 the QIP will be there. I think for the ETC, the
21 first one that you mentioned, that will just,
22 that's just going to be trying to push patients

1 towards transplant and home dialysis modalities.
2 I don't think that this will necessarily affect
3 that.

4 With the KCC models, which are the
5 Kidney Care Choices models for nephrology
6 practices, it's, I can't answer that fully just
7 because we don't know what those models are going
8 to look like right now when they're done.

9 MEMBER FLEISCHMAN: All right. Okay,
10 thank you.

11 CO-CHAIR BAGLEY: Thank you. Any
12 other comments or are you ready to go for a vote?
13 I don't see any cards up; are we ready?

14 MR. HIRSCH: For MUC 2019-66
15 Hemodialysis Vascular Access, Practitioner Level
16 Long-Term Catheter Rate, do you vote to support
17 the preliminary analysis as the workgroup
18 recommendation with the preliminary analysis
19 being conditional support for rulemaking? Your
20 options are yes or no.

21 MS. BUCHANAN: So, we need two more
22 votes, if people could just, oh, we need one more

1 vote. Just make a selection and not clear it.

2 CO-CHAIR BAGLEY: We got it.

3 (Off mic comments.)

4 MR. HIRSCH: For MUC 2019-66

5 Hemodialysis Vascular Access, Practitioner Level
6 Long-Term Catheter Rate, do you vote to support
7 the preliminary analysis as the workgroup
8 recommendation, there were 19 votes for yes,
9 three votes for no. The workgroup recommends
10 MUC2019-66 for conditional support for
11 rulemaking.

12 CO-CHAIR BAGLEY: Okay.

13 Congratulations on your efficiency. Next.

14 (Laughter.)

15 MR. STOLPE: Very good. So we
16 actually have some efficiency built into the next
17 two measures as they are the same.

18 So one will be applied to MIPS. Once
19 we finish with this one, that will conclude our
20 discussion of MIPS measures and we'll transition
21 directly to the single SSP measures that we'll be
22 reviewing this cycle. Which is the same measure.

1 Now, after I give a brief introduction
2 of this measure I'm going to hand it over to the
3 measure developer. Inside of your meeting
4 materials there's a supplementary memo that
5 outlines a couple of things that we thought would
6 be particularly pertinent for you to consider.

7 I'm to invite Jordan to screencast the
8 final portion.

9 (Off mic comment.)

10 MR. STOLPE: Yes, that's fine. Please
11 do so now.

12 The final portion of that memo that
13 outlines both the importance and the scientific
14 acceptability of the measure that we felt like
15 this group would particular benefit from
16 considering it a highly projected during the
17 course of the discussion. And I'll turn it over
18 to Elizabeth once we get through this initial
19 part.

20 So, the measure that we're discussing
21 now is measure, MUC2019-37. And that is the
22 Clinician Group Risk-Standardized Hospital

1 Admission Rates for Patients with Multiple
2 Chronic Conditions.

3 Now, just to briefly highlight the
4 measure description, this is the annual risk
5 standardized rate of acute, unplanned hospital
6 admissions among Medicare fee-for-service
7 patients age 65 years and older with multiple
8 chronic conditions. The Staff recommendation for
9 this measure is conditional support pending NQF
10 endorsement.

11 We wanted to point out a couple of
12 things related to it, mainly that MIPS currently
13 has 30 measures in the priority area of
14 communication in care coordination, including all
15 costs for readmission, unplanned hospital
16 readmission within 30 days of principle procedure
17 and unplanned re-operation within the 30 day
18 postoperative period. However, there are no
19 measures for admissions of patients with multiple
20 chronic conditions.

21 And the evidence review, we would
22 traditionally have found the evidence not

1 sufficient for this. However, when we looked at
2 a comparable NQF endorsed measure, NQF-2888,
3 which was last, sorry, excuse me, reviewed in
4 2016, there were a number of things that tied
5 this together that made it make sense a bit more.

6 And we found sufficient evidence that
7 this was actually the case. This measure doesn't
8 do the work.

9 So, that concludes our findings so
10 I'll hand it over to the measure developer to
11 walk through the importance and the scientific
12 acceptability, which you'll see projected on the
13 screens behind you for those of you that are
14 facing the other way.

15 MS. DRYE: Hi, Elizabeth Drye from
16 Yale. I'm six of seven kids so I'm just going to
17 shout because that's --

18 (Laughter.)

19 MS. DRYE: So, tell me I'm too loud.
20 So, just to clarify how these measures are the
21 same and what -- how they are coming at you, one
22 after the other, before we go over what's on the

1 board.

2 So this one we're going to talk about
3 first. It's for them merit-based incentive
4 payment system program.

5 There is a measure for multiple
6 chronic, of admissions for multiple chronic
7 condition patients that's already in use in the
8 ACO program. And so when we get to the share
9 savings program we're going to be talking about a
10 new version, a revised version of that measure
11 that is completely aligned with this new MIPS
12 admission measure.

13 So the, Sam, the stuff on the board
14 from that memo is for the ACO measure. So you
15 can, we're not there yet, at the ACO measure, but
16 I just, I always want to say that again.

17 So, CMS had an ACO, has an ACO
18 program, an admission measure for patients with
19 multiple chronic conditions. We developed one
20 for the merit-based incentive payment system.
21 Because the merit-based incentive payment system
22 is different, it has individual clinicians and

1 small groups, it's shaped differently. And
2 particularly the outcome is a lot narrower, the
3 kinds of admissions we count.

4 And then recently CMS just decided,
5 let's stay aligned. And so, the ACO measures
6 coming back at you, it's already approved NQF
7 measure, but it's coming back to this Committee
8 with a narrow outcome and aligned to be the same
9 as the new measure that we're showing you right
10 now.

11 So that's why you're getting both in
12 the MAP because the ACO measure is changed, and
13 particularly the outcome is narrower than the one
14 that already went through NQF and is in the
15 program.

16 The ACO program has the entire Shared
17 Savings Program to switch over and use this new
18 realigned measure. So, let me just pause there,
19 so you know before we start, these two measures,
20 their questions about what you're going to see
21 sequentially, because that's probably is a bit
22 confusing.

1 CO-CHAIR FIELDS: I guess so, I do
2 have a clarifying question but it is actually,
3 are we going to discuss them en masse then if I
4 have a question that's specifically related to
5 SFP, just wait?

6 CO-CHAIR BAGLEY: We have to wait.

7 CO-CHAIR FIELDS: Okay. All right,
8 then I'll defer.

9 MS. DRYE: Okay, other questions
10 about, okay, just before --

11 CO-CHAIR BAGLEY: So, same measure,
12 using two different programs, we actually have to
13 discuss them and vote on them separately. Just
14 in case you forgot about that.

15 MS. DRYE: Okay, so I'll just really
16 briefly highlight what you're seeing. You've
17 seen the, you know, you have a discussant on the
18 MIPS version of this measure which was fully
19 defined and in the public domain and had gone
20 through public comment.

21 So, the outcome is acute unplanned
22 admissions, but narrow to drop out of what is the

1 current ACO measure, things that ambulatory care
2 providers don't have the ability to influence.
3 Like admissions for complications of surgeries,
4 accidents or injuries or the patient went
5 directly from a skilled nursing facility --

6 (Teleconference music plays.)

7 (Laughter.)

8 (Off mic comments.)

9 CO-CHAIR BAGLEY: All right.

10 MS. DRYE: Okay. So, in just
11 describing the outcome and how it's narrower than
12 what has been being used in the Medicare savings
13 program today, there are, we take out of the ACO,
14 we don't count as an admission in this measure,
15 complications of surgeries because we are
16 measuring primary care providers and other
17 relevant clinicians who take care of chronic
18 disease patients and not surgeons, patients who
19 get admitted directly from a skilled nursing
20 facility, patients who are admitted within ten
21 days of being in the hospital. And this just
22 goes to thinking about, and we had another

1 measure where we talked about this, you know,
2 which providers are influencing that very
3 directly post-hospitalization period here.

4 We're trying to be conservative in the
5 sense that we don't want to hold ambulatory care
6 providers accountable for more types of
7 admissions than they can really influence.

8 Or if patients are in the Medicare
9 hospice benefits. Benefit when they get
10 admitted. Or if they hadn't seen the provider
11 prior to the admission.

12 So, the MIPS programs, like the Shared
13 Savings Program, there is a measurement near
14 January to December, and if the patient gets
15 admitted and they never saw the provider to whom
16 they're attributed, then we don't count that
17 admission in the outcome.

18 The structure of this measure, and the
19 next one, it's different than the readmission
20 measure. And this that the outcome is, or the
21 rate, is admissions per 100 person years of sort
22 of the patient availability to be admitted.

1 So it's not an either/or, you can be,
2 the time the patient is in primary care and the
3 outpatient setting is counted and the number of
4 admissions over that year are counted.

5 So, if they're admitted to a still
6 nursing facility for a long time, that's not put
7 in the denominator. So we adjust the denominator
8 just for when a patient is in the primary care
9 setting.

10 Questions about that? Either the way
11 we structured the outcome or what's in the
12 outcome or you do you want me to just go through
13 the whole thing?

14 CO-CHAIR BAGLEY: I think we'll just
15 hold until we have the lead discussants talk
16 about it.

17 MS. DRYE: Okay, so we just stop
18 there.

19 CO-CHAIR BAGLEY: So, Amy, would you
20 kick it off please?

21 MEMBER NGUYEN HOWELL: Sure, thank you
22 for that. I've had a lot of questions.

1 Clarifying questions.

2 So, I applaud CMS for really wanting
3 to bring this up, it's definitely needed in terms
4 of our chronic care, condition and management in
5 comp health and value-based care. I love the
6 fact that it's an outcome measure, so we really
7 like the direction that this is going.

8 And with the research, and I was a
9 little confused about the MIPS and the ACO
10 because there was different discussions, but I
11 liked the alignment. But just to review for the
12 folks in the room, there was issues around
13 attribution and risk adjustment. So I'm sure
14 you'll be able to clarify that. So I look
15 forward to hearing about that.

16 But I think the attribution point was
17 consistent with the other comments that have been
18 talked about at the clinician individual level.
19 Especially AMA's comment.

20 Earlier, Koryn, your comment at that
21 level versus at the provider group physician
22 organization level. So we, I think from what

1 I've read, it is preferred at the PO level.

2 And I just want to reiterate kind of
3 the LANS, our gold standard in terms of patient
4 attribution. We've done a lot of work on how the
5 patient's choice should always be the gold
6 standard.

7 So, I wanted to reiterate that and
8 make sure and confirm that that was consistent
9 with this measure.

10 And then the risk adjustment, I'm just
11 glancing over this memo so I'm hoping, if you
12 could clarify regards to the frailty index and
13 the risk adjustment, that that is, that would be
14 really enlightening and hoping to clarify that.
15 Because it will help, not just frailty but also
16 talk about the social and behavioral determinants
17 and how that's related to this in terms of the
18 revised methodology.

19 And glad to hear that it's not a
20 duplication of ACO-38 because that's always good
21 to know. And thank you for the clarification
22 about the narrower outcome. Especially excluding

1 hospice from that definition, from the
2 denominator.

3 Oh, and if you can clarify the
4 minimal, minimum reliability as well.

5 (Off mic comments.)

6 MS. DRYE: Okay. So, just to recap,
7 I think, you asked about attribution, risk
8 adjustment for frailty, but we'll talk about
9 social risk factors as well, and then
10 reliability. Those are your three --

11 MEMBER NGUYEN HOWELL: Yes.

12 MS. DRYE: Okay.

13 MEMBER NGUYEN HOWELL: Thank you.

14 MS. DRYE: And I'm going to contrast
15 this to the ACO program a little bit. This is
16 the one place they differ is attribution.

17 So, this was a great measure to think
18 about attribution with. I built on the
19 principles of, you know, the NQF's attribution
20 work with I was part of in our team. We really
21 tried to think about how do we get, how do we
22 accomplish the purpose of the measure within the

1 context of this program?

2 The thinking on attribution from our
3 technical expert panel and in our group was
4 really to drive accountability towards one
5 provider for this particular measure, to start to
6 address or have one to address the fragmentation
7 of care and accountability and fee-for-service
8 patients in the Medicare program.

9 So, we attribute to one provider. We
10 favor the primary care provider. We use a visit
11 based approach, so it's who's seeing the patient
12 the most in the measurement year.

13 And if there is not, if there is a
14 specialist, however, who is seeing the patient
15 more, and that could be, we narrow the group of
16 people who -- couldn't be a pediatricist, who
17 couldn't be a radiologist, this measure is not
18 designed for them.

19 We limit the group of types of
20 providers that the measure can be attributed to.
21 To those that plausibly are caring for chronic
22 disease patients. So that includes, obviously,

1 internist, but cardiologist, pulmonologist,
2 nephrologist, neurologist, endocrinologist.

3 And I'll just say one other thing,
4 it's a little detail about this measure, which we
5 want, we got comments and public comment on the
6 measure from clinical oncologists and we wanted
7 to think about how to handle patients who have
8 cancer that's active. That's in an acute phase.

9 And what we do in attribution is we
10 include hematologists-oncologists, and if they're
11 really seeing a patient frequently we make an
12 attribution of that patient, which means they
13 don't get attributed to an internist, for
14 example.

15 But the measure doesn't, they just get
16 pulled out of the measure. The score isn't
17 generated or done for hematologist-oncologist
18 because this measure really isn't designed for
19 that.

20 So, we tried through attribution to
21 find the dominant provider, limit it to the
22 relevant specialist and pull out patients that

1 were really in a unique phase that we couldn't
2 potentially deal with through risk adjustment,
3 for example. Questions about that?

4 It's -- there is an algorithm in our
5 technical report, which is in the public domain,
6 but I don't know that guys have seen it, but
7 gives the flow.

8 CO-CHAIR FIELDS: So, a simplified
9 form is related but not equal to the ACO
10 attribution?

11 MS. DRYE: So, ACO is different, and
12 I'm going to have the ACO team jump in.

13 CO-CHAIR FIELDS: So I'm really --

14 MS. DRYE: So let me just play on
15 difference and then you guys can talk. Is that
16 MIPS is, and this goes to the NQF framework for
17 attribution.

18 This attribution strategy is designed
19 for this measure in the MIPS program, just as the
20 hospital-wide readmission was its own, you know,
21 we considered.

22 ACO uses one attribution strategy to

1 assign all patients to the ACOs, and then the
2 measures that apply. So it's a different
3 starting point.

4 So, yes, it's not the same because the
5 inclusions, exclusions are all aligned but the
6 ACOs just get all their patients assigned in one
7 step --

8 CO-CHAIR FIELDS: Sure.

9 MS. DRYE: -- and then the measures
10 get run --

11 CO-CHAIR FIELDS: But there are
12 similarities. I'm just assuming, in terms of the
13 plurality of care issue with assigning the PCP
14 designated specialty codes as --

15 MS. DRYE: Now, we use --

16 CO-CHAIR FIELDS: -- their priority.

17 MS. DRYE: We use evaluation and
18 management codes --

19 MS. BUSH: Right.

20 MS. DRYE: -- when looking at -- do you
21 want to talk more to that?

22 MS. BUSH: I'm just going to say, we

1 begin with primary care providers and I think --

2 MS. DRYE: Yes, we do.

3 MS. BUSH: -- there is more, more
4 Shared Savings Programs. Initially they get
5 attributed to the ACO itself and then to the
6 measures that apply to the ACO --

7 CO-CHAIR FIELDS: Right.

8 MS. BUSH: -- based on the provision
9 of primary care.

10 So, primary care received from a
11 primary care provider type is first, and if the
12 beneficiary didn't receive any primary care from
13 the provider type, provider care provider type,
14 it's based on plurality of primary care by
15 itself.

16 CO-CHAIR FIELDS: And you start with
17 the plurality, or do you also start with primary
18 care?

19 MS. DRYE: We favor primary care
20 providers.

21 CO-CHAIR FIELDS: Okay.

22 MS. DRYE: But there is a dominant

1 specialist, we'll move the patient over.

2 CO-CHAIR FIELDS: So if they saw a PCP
3 three times and an endocrinologist five times
4 they'd be --

5 MS. DRYE: They go to the
6 endocrinologist, exactly. That's a good example.

7 Most people get assigned to a primary
8 care provider.

9 CO-CHAIR FIELDS: Okay.

10 CO-CHAIR BAGLEY: Kimberly.

11 MS. BUSH: I'm sorry, I'm Kim Spalding
12 Bush from CMS. I was supposed to introduce
13 myself, I apologize. And I run the division that
14 administers the quality program for SSP.

15 CO-CHAIR BAGLEY: And excuse me,
16 Kevin, hold on just a second. I think I'd like
17 to, was it directly to this point or can --

18 MEMBER BOWMAN: Yes, to one of, the
19 example that was given for the oncologists. So,
20 extension for that example, what you're saying is
21 patients being treated actively for cancer, you
22 would hold the oncologist accountable, not

1 necessarily PCP or any admissions or any outcomes
2 of the treatment that's going on, is that kind of
3 what you're saying?

4 MS. DRYE: This measure, the matter is
5 not designed to score oncologists.

6 MEMBER BOWMAN: Got you.

7 MS. DRYE: So, they would just,
8 they're just not affected by the measure at all.
9 It only is designed to score, to give a measure
10 score to the primary care doctors and the
11 specialists I mentioned, endocrinologists,
12 pulmonologists, cardiologists. They don't get a
13 score.

14 We assign the patient there to pull
15 the patient off of everybody else's panel because
16 they're really being cared by, for, primarily by
17 an oncologist for an acute process that's
18 dominated.

19 MEMBER BOWMAN: So they're taken out.

20 MS. DRYE: Taken out, exactly.

21 Through the --

22 (Simultaneous speaking.)

1 MEMBER BOWMAN: Okay.

2 CO-CHAIR BAGLEY: Before we go on I'd
3 like to allow the other co-discussants to weigh
4 in. Peter and Sandy and Louise.

5 MEMBER ROBERTSON: So, I think
6 generally supportive of the measure, I had
7 questions about contributions, so thank you for
8 those clarifications.

9 And just to compare, the data that's
10 presented here though is specific to the ACO
11 version of the metric, not clinician level
12 performance as it --

13 MS. DRYE: Right.

14 MEMBER ROBERTSON: -- will be in MIPS.

15 MS. DRYE: So, we --

16 MEMBER ROBERTSON: That testing
17 information is to come?

18 MS. DRYE: No. So the MIPS measure,
19 in the merit-based incentive payment system, I'm
20 just going to say it because there's too many
21 acronyms, ACO, MSSP. All that testing was in
22 what was submitted to the MAP already.

1 We did the ACO testing very recently.
2 And this is why some of the results that you
3 would want to see, like the reliability testing
4 and the measure score distribution just went up
5 online Tuesday because CMS made a decision, and I
6 think you guys jump in, but very recently we had
7 the whole data rerun on the measures and run all
8 the testing to fully align that ACO measure and
9 move it through the MAP process completely along
10 with the MIPS measures.

11 So we had to rerun and generate the
12 numbers with the new outcome definition with the
13 same inclusion exclusion. It's the same risk
14 adjustment including the frailty and the social
15 risk factors.

16 So, they then rerun all the results
17 and it's way too close. We're owning this
18 because it just isn't getting too early but these
19 measures are very similar and the numbers are
20 there now.

21 So, what, you want to cease the
22 number, we were going to walk through them on the

1 screen too because I know everybody can't look
2 online while you're traveling, et cetera.

3 CO-CHAIR BAGLEY: Sandy, comments?

4 MEMBER POGONES: Yes. I was also very
5 interested in admission rates. And we really do
6 appreciate the work that's been done on the
7 measure.

8 We do have some concerns, particularly
9 because when you look at this on an individual
10 level, it's one thing to have the entire hospital
11 community and provider community, multiple
12 different types of other multiple stakeholders
13 involved in addressing some of the social
14 determinants and addressing some of the issues
15 that are required to prevent hospitalization.

16 We know a lot of that comes back to
17 the social determinants. And when you are an
18 individual provider, you don't always have the
19 resources there with those things.

20 The research is pretty good that
21 improved care coordination and programs that are
22 focused on care management can lead to reductions

1 in admissions. But it also involves multiple
2 partners working together.

3 And when we start looking at a sole
4 provider in the community, there are not multiple
5 partners there. So that's our problem with
6 looking at the individual physician one-to-one,
7 that it holds this single physician responsible
8 for an awful lot of things that may not be under
9 their control.

10 Behavioral health services in rural
11 communities, you've already heard that that's a
12 huge problem for hospital admissions. A lot of
13 it points back to the behavioral health. But
14 those services aren't always available in rural
15 health in America.

16 And the social services, the housing,
17 those types of issues, the poverty, boy, it would
18 be nice if as the clinician you could impact
19 that. But it goes back to what was said earlier,
20 there is nothing more frustrating to be a
21 physician, knowing what's wrong but not being
22 able to do anything about it.

1 And I think a measure like this can
2 really reflect that. Really highly.

3 When you have a group of ACOs, an ACO
4 that has all of these other stakeholders working
5 together, you definitely have an advantage there.
6 Individually I think there could be some really
7 issues there.

8 We also agreed that ACOs, they know
9 it's attributed to their individual clinicians.
10 We didn't find out until 18 months later who was
11 actually under their care and who they were
12 supposed to be response for, for this admission.
13 So the upfront attribution is really important.

14 We had a little issue with the
15 reliability. And correct me if I'm wrong, but we
16 believe that reliability achieved for the -- at
17 the individual clinician level was .5. Is that
18 correct?

19 MS. DRYE: I'm so sorry, I was asking
20 a question.

21 Yes. So for this, the MIPS measure,
22 the -- so, when you look a measure of reliability

1 at the physician level, meaning every physician
2 has at least .5 that we calculated, in the data
3 set we have, we did this testing, which was 2015.

4 Which is really actually using the way
5 physicians were organized to report for the value
6 modifier program. I just want to say as an
7 aside, this measure is going to go to NQF in the
8 next, in the summer, and we'll use 2018 data.

9 So this should look different than it
10 does now. But basically using how physicians
11 were organized to report for a value modifier, we
12 needed at least 28 inpatients in the measure to
13 get a reliability of .5.

14 If you wanted two requirement -- a
15 higher minimum reliability because there is no
16 right way to do this, it's usually a tradeoff as
17 you know, then it would be 64 patients per
18 provider.

19 So, you have to have a fair number of
20 multiple chronic condition patients with, the
21 conditions you need to qualify for the measures
22 are very common.

1 MEMBER POGONES: Yes.

2 MS. DRYE: So you won't hit every
3 individual provider who will have 65, and that
4 many 65 and older patients, if we go to .7, which
5 is a pretty strict reliability, it equals 81
6 percent of the patients. So you cover most of
7 the patients but you're going to miss a chunk of
8 the providers.

9 MEMBER POGONES: And we would like to
10 see that reliability, go to at least .7 by
11 summer.

12 MS. DRYE: Okay.

13 MEMBER POGONES: We don't think .5 is
14 high enough. Mostly what we look at, we promote
15 .7 reliability. And I think that will also
16 relieve some of the pressure on physicians in
17 smaller communities that don't have the support
18 to make all this happen.

19 And not only financially, but they
20 don't have the structures in place and they can't
21 get it because they're, just because of where
22 they're at and how they're financed. So, I think

1 that would be really important to us.

2 There's also this constant struggle we
3 have with your hand measured at potentially at,
4 but never seeing your own data, or never seeing a
5 wide range of data that applies to physicians to
6 be able to look at it and say, oh, this measure
7 does some crazy things. And really can't
8 identify that until you really see your data.

9 And I think that's one of the
10 struggles we have with base validity, is that
11 there's some many algorithms and it's so
12 complicated that we don't have any idea. That's
13 transparency. We don't know what's going to
14 happen.

15 And I think we need to, I think we
16 need to know that. And I think physicians need
17 to see what happens to their data before they're
18 paid. So, we would like to see that. Thank you.

19 CO-CHAIR BAGLEY: Louise?

20 MEMBER PROBST: I just want to take up
21 on the comment of how positive I think the
22 measure is.

1 PARTICIPANT: Speak louder.

2 MEMBER PROBST: Okay. This is really
3 an important measure, I think, for people. I
4 think the staff has told us over 80 percent of
5 the people over 65 meet this criteria of two
6 chronic conditions.

7 And it's really about communications,
8 educating patients, self-care. You know, talking
9 with the team. It's really about the care
10 coordination and communications. Which is so
11 important.

12 And it just seems to be where our
13 health system needs to go. And so, I have a
14 little concern about the hematologist, so I
15 appreciate you clearing up the attribution
16 issues.

17 But things like the very, very
18 important measure from a consumer and public
19 perspective, so I just want to lend my support.
20 It does promote, as someone else said,
21 systemness.

22 CO-CHAIR BAGLEY: Okay. Amy, if

1 you'll hold on just a second.

2 MEMBER NGUYEN HOWELL: Sure.

3 CO-CHAIR BAGLEY: Kim, would you, on
4 the rural.

5 MEMBER RASK: From the rural group,
6 echoing what we've just been hearing here, our
7 feeling is that this is a really important
8 measure for rural residents. These are chronic
9 conditions to modern multi-morbidity in health
10 communities.

11 And then concern on the provider side,
12 depending on, to what extent availability and
13 local resources, to mitigate social determinates,
14 and health available in rural communities. And
15 so, technically it balanced out.

16 The group had sort of an intermediate
17 comfort level with the, at the provider level
18 MIPS measure and were highly supportive of the
19 MSSP measure.

20 CO-CHAIR BAGLEY: Okay. Amy.

21 MEMBER NGUYEN HOWELL: Oh, I get it.
22 So, speaking from a nurse position, we totally

1 agree about the ACO measure. We won't go against
2 that.

3 And I really concur with CMD and the
4 rural team and the AMA during one of the few
5 times we actually agreed --

6 (Laughter.)

7 MEMBER NGUYEN HOWELL: We get this all
8 the time, I'm an AMA member.

9 And it goes down to that individual
10 clinician level. Because what is the goal of
11 MIPS? The goal of MIPS is to encourage the
12 individual practice practitioners, providers,
13 physicians in our country to move along the
14 continuum to APMs, correct.

15 And maybe that's, at least that's my
16 understanding of where we're trying to go. And
17 so, we shouldn't, we should encourage them, and
18 perhaps put this as maybe informational for the
19 first couple of years, gather some more data.

20 I fully support increasing the minimum
21 reliability to at least .7. Because it does
22 cover your 80 percent of Americans with chronic

1 conditions so it meets that criteria.

2 But I think if we, I fully applaud
3 CMS's goal to align these measures. I think
4 it's, we definitely need to do that.

5 At least -- but for this one, it might
6 have unintended consequences that may discourage
7 individual physicians, practitioners to move into
8 APMS with this measure. Because it can penalize
9 them in a way that wasn't intended.

10 So, I think as a solution to maybe do
11 it information, gather some data. So, I'm
12 curious, you said you do have data for both MIPS
13 and ACOs in terms of reliability, were they
14 consistent? I know you're going to walk through
15 --

16 MS. DRYE: Yes. I mean, the ACO-1 is
17 on, I think, did you put it on the board there?

18 MR. STOLPE: It is.

19 MS. DRYE: Yes. So, if you look at,
20 ACO is easier to get a higher reliability because
21 ACOs are big. And so you need, actually it's
22 about 100 patients to get to a minimum of .5 and

1 over 200 patients to get to .7. But that's
2 basically everybody who can get there.

3 It's 99 percent of the patients on the
4 ACOs, would have a reliability of .7 or better.
5 Because they're just not, you know, they're big
6 compared to individuals.

7 So, reliability is easy now. I didn't
8 answer your question though. I don't know if you
9 still want me to answer about frailty and some of
10 those factors or move on.

11 MEMBER NGUYEN HOWELL: Yes. So, if
12 the reliability for ACOs is easy, then is that
13 inconsistent with the reliability when we look at
14 MIPS?

15 MS. DRYE: So, I'm going to guess
16 here. I mean, reliability is influenced by the
17 outcome rate, the sample size and the variation,
18 right? That within and between variation.

19 MIPS, there is a lot of variation.
20 The problem is, in any outcome measure, whether
21 it's -- or this one, we need enough cases. This
22 is a one year observation period.

1 And so we just can't get down to like
2 ten or 15 cases. If we were willing to accept a
3 reliability rate of .5, we can get down to 26
4 cases in MIPS.

5 Which I think a lot of providers, more
6 providers will read in the 2018 data than they
7 did in the 2015 data just because, again, we were
8 looking at how providers were grouped for
9 reporting under value modifiers.

10 But we will run that, when we take the
11 measure to NQF for endorsement, we will
12 recalculate the reliability in the 2018 data,
13 which will then be a MIPS, when MIPS is already
14 implemented and we'll be able to see that.

15 It's not that you can't get reliable
16 in the bigger groups or in physicians, we see a
17 lot of elder patients, it's just there are a lot
18 of individual clinicians who just don't have as
19 big of a case load. And we really can't assess
20 their quality with the outcome of admission and
21 reliability.

22 MEMBER NGUYEN HOWELL: Yes.

1 Certainly. Absolutely. Yes. I just I think
2 this is a really important measure.

3 It's great that we're discussing this,
4 I just don't see it at the MIPS level because it,
5 to Sandy's point, you need that care team, you
6 need the resources, you need that care
7 coordination piece to be successful in order to
8 set yourself up success for APMs, right, for the
9 ACOs.

10 So if we're trying to just measure
11 everyone the same that's in SSP on this
12 particular measure, I just think it's too
13 premature for the MIPS program.

14 MS. DRYE: I don't have these, I can
15 probably pull them up, but I just want to note
16 that in the MIPS program some of the provider
17 groups are very, very big, so they're not that
18 different in size in the ACOs. So one advantage
19 of keeping it in the MIPS program, and then CMS
20 would propose this specific reliability level in
21 the minimal sample size, because if you don't go
22 into MIPS you're not going to be covering those

1 groups that are actually big and have capacity.

2 So, the program is, gives you a sort
3 of, as you know, ACOs are all big, but MIPS is a
4 mix of very big groups, medium size groups,
5 virtual groups and individuals.

6 MEMBER NGUYEN HOWELL: Yes. So, I
7 agree with that. If it's MIPS measuring at the
8 PO level I agree with that.

9 Based on the same argument and
10 structure as the ACO, it's just at that
11 individual clinician level we just might be doing
12 our country a disservice by trying to measure
13 apples and oranges at this point in time with the
14 different, the varying degrees of resources that
15 we have in our country, the geographic, the other
16 social determinants.

17 But I'd be happy to hear about your,
18 the risk adjustment. The frailty and social
19 media roles. If we have time.

20 MS. DRYE: Yes. I was just, I didn't
21 mention earlier, and I just wanted to add one
22 other reasons, this measure differs from the

1 previous ones we discussed in that we adjust for
2 factor -- frailty factors.

3 This is a sort of move I would say
4 building on sort of the work other people have
5 done and others, to cull out readily accessible
6 adjusters that align with social risk factors.

7 So, we have walking aids, wheelchairs,
8 hospital beds, lifts, oxygen, supply or the
9 original reason for enrollment in Medicare. If
10 it was disability or ESRD. Those are individual
11 risk variables in the risk adjustment.

12 And then we also adjust the field, for
13 two -- we were thinking at this area level
14 indicators of deprivation or social economic
15 burden among the provider, patients providers are
16 seeing, which is the ARC SES index, which is an
17 area level index down to the nine zip code level.

18 And then also we use specialist
19 density here, as somebody mentioned earlier in
20 discussion, on other measure, you want -- might
21 want to refer from a specialist, but this is what
22 we heard from rural clinicians who gave input

1 that you might not have really any specialist
2 access. And so, we adjust for the density
3 specialists. Those are two area level
4 indicators.

5 This MIPS measure adjusts for, and
6 then when we align the ACO measure, we brought
7 those adjusters into that. Into that model as
8 well.

9 CO-CHAIR BAGLEY: Trudy.

10 MEMBER MALLINSON: I just wanted to
11 follow-up on a clarification about the size of
12 MIPS. Like the size of the groups versus the
13 size of the ACOs.

14 And just to keep in mind that the ACOs
15 are broader, are likely to have gotten many more
16 services, many more different kinds of
17 practitioners all collaborating, members of the
18 team collaborating, producing outcome.

19 And even though MIPS isn't solely
20 physicians, it's mostly physicians. And I think
21 that's partly the difference there, right. It's
22 only a physician responsible for, it is a much

1 broader set of problems. And I'm just not sure
2 that we're there yet.

3 And I think -- sorry, I can't remember
4 -- Sandy was saying that you were sort of
5 speaking to that earlier and I just want to, back
6 when we were just talking about sizes, and it's
7 not just about the numbers, it's about the
8 comprehensiveness of professionals who will
9 participate and just trying to solve, and do that
10 work for the patients.

11 CO-CHAIR BAGLEY: Okay, thank you for
12 that. I don't see, oh, Ann, go ahead.

13 MEMBER GREINER: So, there will be
14 discussion about, you know the systems that it
15 takes to manage people with chronic conditions.
16 And first of all, I would like to support
17 something like this.

18 I am concerned about this at the
19 individual clinician level because, and I know
20 it's beyond primary care, but primary care is a
21 lot of what is being, you know, will be managing
22 these patients.

1 We don't have good systems for primary
2 care. We don't invest in primary care. And so
3 we don't have the team that can really take care
4 of the patients.

5 So, I would like to hold the
6 individual clinicians responsible. I don't think
7 they have the systems there to do that well.
8 Even patients that are in medical homes. You
9 know, they're under power.

10 They're teammates, they're not full-
11 fledged teams because of what we invest. \$0.05
12 to \$0.07 on the dollar in primary care in terms
13 of total cost.

14 Could this measure be modified to get
15 clinician groups where there actually is scale
16 and more ability to bring in other parts of the
17 team to manage chronic conditions as opposed to
18 clinician groups and individual clinicians? That
19 might make it more palatable in this event.

20 CO-CHAIR BAGLEY: Robert.

21 CO-CHAIR FIELDS: I think what you're
22 hearing generally is that, and I suspect that

1 MSSP discussion will be a lot easier. It's part
2 of what your, and just to speak to some of the,
3 what's on the measure, no one is arguing that.
4 We care.

5 Everyone believes in the measure. The
6 tricky part is, at least when you are running
7 large networks you skip to an outcome measure at
8 a level of where we skip a lot of process
9 measures that could actually get us there, that
10 are probably way more valid at an individual
11 level, for instance.

12 You know, expanding on what is,
13 there's a process measure around that
14 communication. There was a mention of totally
15 one piece of achieving on this measure is
16 adequate communication with the inpatient system,
17 or whatever delivery system, let's measure that
18 or encourage that in a different way than what
19 had been done thus far because honestly -- it
20 hasn't worked, the communication is lousy still.

21 So let's measure that because that's
22 actually something we can get some behavior

1 change around on the primary care doctors that I
2 think that skip to such a complicated, and we all
3 know that the driver is there, communication is
4 like one, probably one hundredth of the driver of
5 this measure.

6 And there's all sorts of social
7 determinants and stuff, there's housing stuff, I
8 can't afford my meds, and I got for seven days
9 when I got discharged, I can't afford them when I
10 go home. That sort of stuff that there is no way
11 the PCPs can do it, as we've already heard.

12 So, I would just suggest that as
13 substitute at the individual level, especially
14 when you're talking about payment to an
15 individual doc, if it's not affecting the greater
16 system, it's affecting the solo docs, in
17 particular, are going to get hurt by this, very
18 aggressively, I think.

19 Especially in rural areas about the
20 high density of Medicare and Medicaid. I think
21 it's a mistake.

22 Just point blank, I think it's a

1 mistake to do this at the doctor level for that
2 reason, despite the fact that it's a hugely
3 important measure and would suggest, as a
4 solution, to think about an additional boosting
5 of process measure that would get to that
6 outcome.

7 CO-CHAIR BAGLEY: Stephanie.

8 MEMBER FRY: I was just, I was
9 thinking one step further along of, if you're
10 hurting the docs in terms of payment, is there
11 some unintended consequence or possibility for
12 unintended consequences around if you know there
13 are not the services fully to support that
14 patient, to not engage with that patient at all
15 to minimize your personal risk of taking
16 responsibility for that outcome. That's of
17 greater concern.

18 CO-CHAIR BAGLEY: David.

19 MEMBER SEIDENWURM: One question.

20 When a patient --

21 CO-CHAIR BAGLEY: One conversation --

22 MEMBER SEIDENWURM: -- collect a --

1 when a patient elects a primary care provider,
2 does that trump the other attribution in this
3 metric or is that only germane in the ACO
4 population?

5 MS. DRYE: I'm going to apologize
6 again because I was consulting with an ACMS
7 colleague. Could you just ask that again?

8 (Simultaneous speaking.)

9 CO-CHAIR FIELDS: If a patient selects
10 a PCP, via the voluntary alignment methodology,
11 does that trump any of the attribution in this?
12 Was that the right question?

13 MS. DRYE: Well, I would, going
14 forward we can apply that, it's not ready. It
15 wasn't technically ready when we put it in place.

16 But that would be the intent, right.
17 We just didn't have the, we don't have it in the
18 development data. I don't think it's quite ready
19 to implement that way, but we agree, that's a
20 better, a more, I don't want to use the word
21 reliable --

22 (Laughter.)

1 MS. DRYE: -- a more precise way.

2 I want to just give a number, and I
3 don't know if this is helpful to the discussion,
4 but there's a large concentration within MIPS,
5 the patients in bigger provider groups.

6 So, 23 percent of the, because you
7 know, providers report under a TIN, and many
8 providers and one tax ID number or there may be
9 one, just a solo provider.

10 But the way, so there was a whole
11 range of how they're grouped. But 81 percent of
12 the patients are attributed in this measure to
13 23, less than a quarter of the TINs.

14 So, if there is a minimum sample size
15 set, the individual providers, many, many
16 providers would fall out of the measure, but
17 almost all patients, most of the patients will
18 stay in the measure. A lot of groups are really,
19 really big in the MIPS program.

20 So, I mean know, and CMS doesn't want
21 to make, all of this will get vetted in the
22 endorsement process, like what are the trade-offs

1 between reliability, you know, if you check out
2 individual providers, what would that look like.
3 We can go through all of that.

4 I know they don't, probably want to
5 say today what -- but these patients, 80 percent
6 of the patients are concentrated in 23 percent of
7 the reporting groups under MIPS, so you will drop
8 out half a million patients if you say, well,
9 we'll use it in the ACO program but not in MIPS,
10 they'll miss a lot of patients.

11 And I'm not, you know, I guess I'm
12 just sharing that as a third context.

13 MS. BUSH: Yes. And again, we don't
14 want to face right now what it might look like as
15 it comes through the endorsement process, but
16 there is some precedence for doing that in the
17 value model program when we took a look at, I
18 can't remember what measure right now, was it ECM
19 measure, and we said, for a small group we're
20 going to set the case minimum at a higher number
21 because, then we did for a different sized group.

22 So there's a lot, I think, that can be

1 done with case minimum to address reliability and
2 these small practices because, I think not
3 necessarily because it's just a small practice,
4 it could still be high volume of Medicare
5 patients or it really may not be.

6 So, I don't know that practice dies,
7 is the only thing to think about here. If we can
8 get to a higher liability by taking a look at
9 case minimums or some other things around that
10 too we could consider.

11 MS. DRYE: I think we're hearing two
12 things I just want to acknowledge. One is the
13 reliability to score, which is always important,
14 and the other is, thinking about individual
15 clinicians and the --

16 MS. BUSH: Accountability.

17 MS. DRYE: -- accountability to the
18 outcome. And I'm hearing those two as both
19 individual concerns.

20 CO-CHAIR BAGLEY: Correct.

21 MS. DRYE: And what I'm hearing you
22 say, you can design the way that's used in the

1 program to address both of those.

2 CO-CHAIR BAGLEY: Okay. Oh, I guess
3 Will.

4 MEMBER FLEISCHMAN: Yes. So, and this
5 goes more globally. We're discussing this as a
6 MIPS measure, which people would choose to self-
7 reflect, people would self-select to report on
8 this measure from a group of other measures.

9 I think, and I think that should color
10 the, that should really color what we're
11 discussing because if we're talking about a
12 measure that will apply to everyone mandatory, a
13 mandatory measure of some sort, it makes sense,
14 obviously internal validity you need internal
15 validity, but whether it's fair and whether the,
16 for example, the question about how different
17 areas might have different resources, that
18 obviously comes up as an issue.

19 But if it's people self-selecting to
20 report on it, you would think that someone who
21 thinks that this is unfair to them, they would
22 not choose to report on this. So from, if it's

1 simply a matter of adding it to the repository,
2 of getting someone options to report on it, my
3 guess is that if you put this out there people,
4 only people who think they perform well on it
5 will choose to report on it, and then at some
6 point it will be tossed out and removed from the
7 list.

8 So, I think we should separate
9 internal validity, whether this is actually a
10 reliable measure, from, is this fair to reply to
11 everyone. I'm wondering if that makes to you.

12 CO-CHAIR BAGLEY: That's a good point
13 actually. Sandy, I want you --

14 MEMBER POGONES: Yes, I --

15 CO-CHAIR BAGLEY: -- to speak up and
16 speak out.

17 MEMBER POGONES: Okay. I think I want
18 to build on that point because some measures in
19 MIPS do apply to everything. And they generally
20 are the claims based measures that don't require
21 any reporting. And they are considered for
22 everybody.

1 So I guess that's a really important
2 question, is this measure going to be considered
3 for everybody because CMS can calculate what
4 they've reported. Or will it be a self-selecting
5 measure. That's the policy decision, not the
6 plan.

7 I won't guess --

8 (Laughter.)

9 MEMBER POGONES: -- from history,
10 because nobody has to report anything, that it's
11 going to apply to everyone. That is
12 traditionally what has been done.

13 PARTICIPANT: Yes, that's been done.

14 MEMBER POGONES: Right.

15 MEMBER DUSEJA: Except I will say we
16 are moving to the MVP frameworks. So this
17 potentially could be one of the MVPs on client
18 conditions which then a provider will choose to
19 report on that set of measures. But again, no
20 decisions have been made at this point.

21 MEMBER POGONES: Thank you.

22 CO-CHAIR BAGLEY: Okay. It looks like

1 we're ready for a vote. I think that we should
2 make sure we understand what the conditions are.
3 Because this is a little different, so could you
4 capsulize the conditions? So it's recommended
5 under DA as conditional approval.

6 MR. STOLPE: Right. But there was
7 some concern expressed around the individual
8 level attribution, especially of that area. When
9 this will be reviewed, the expectation is that if
10 it's specified, NQF actually separates these two
11 levels of analysis. That's the term of art level
12 of analysis.

13 So when it comes to us for
14 consideration, we'll expect to see testing
15 separate, where the testing would be reliability
16 and validity under the individual level, as well
17 as the group level, separated out if the measure
18 is to be endorsed in that way. We've actually
19 had endorsement submissions where it was lumped
20 together and it was only given the group level
21 endorsement because the data was combined. So we
22 do scrutinize that particular portion of analysis

1 when we undergo a review for endorsement. So I
2 think it's appropriate to continue with the staff
3 recommendation, which is conditional support
4 pending NQF endorsement.

5 CO-CHAIR BAGLEY: Okay. Are you ready
6 to vote?

7 MR. HIRSCH: Yes. For MUC2019-37
8 within MIPS, Clinician and Clinician Group Risk-
9 standardized Hospital Admission Rates for
10 Patients with Multiple Chronic Conditions and in
11 Medicare Shared Savings Program, do you vote to
12 support the preliminary analysis as the workgroup
13 recommendation of conditional support for
14 rulemaking? Your options are yes or no.

15 CO-CHAIR BAGLEY: I have a question.
16 You said MSSP.

17 MR. HIRSCH: Did I say that? Oh, I
18 apologize.

19 MR. STOLPE: That is actually how the
20 measure is named in the MUC list. So --

21 MR. HIRSCH: That's correct, which is
22 why, at the front, it's in parentheses, MIPS.

1 MR. STOLPE: Yes.

2 CO-CHAIR BAGLEY: Okay.

3 MR. HIRSCH: That is the title of the
4 MUC.

5 CO-CHAIR BAGLEY: So let's be clear,
6 we're voting on this for MIPS?

7 MR. HIRSCH: Yes.

8 CO-CHAIR BAGLEY: We're going to look
9 at exactly the same measure and vote on it again
10 later for ACOs, okay? So this is for MIPS.

11 MEMBER NGUYEN HOWELL: Note to change
12 title.

13 CO-CHAIR BAGLEY: Say it again?

14 MEMBER NGUYEN HOWELL: Oh.

15 CO-CHAIR BAGLEY: Okay.

16 MEMBER NGUYEN HOWELL: I said: note to
17 change title.

18 (Laughter.)

19 CO-CHAIR BAGLEY: All right. Are you
20 ready? Ready for the votes?

21 MS. BUCHANAN: We are. So we are
22 waiting on some votes. We need two more. We

1 need one more. And so we have -- we have 22.
2 Okay.

3 MR. HIRSCH: For MUC2019-37 for MIPS,
4 Clinician and Clinician Group Risk-standardized
5 Hospital Admission Rates for Patients with
6 Multiple Chronic Conditions, do you vote to
7 support the preliminary analysis of the workgroup
8 recommendation, seven votes for yes, 15 votes for
9 no. The workgroup does not vote for conditional
10 support for rulemaking for MUC2019-37.

11 CO-CHAIR BAGLEY: Okay. So what we're
12 going to do is move down the list. I want to
13 offer a vote that we would approve
14 unconditionally. I'm just thinking of that
15 choice here. Is that fair? And then move down
16 to the next level, which would be to support,
17 well --

18 MR. STOLPE: Do not support with
19 potential for mitigation is the next --

20 CO-CHAIR BAGLEY: Yes. That's fine.

21 MR. STOLPE: But first, let's
22 determine what those mitigating factors would be.

1 CO-CHAIR BAGLEY: Okay. That's fair
2 enough.

3 MR. STOLPE: If anyone wants to
4 proffer a suggestion for what would be a
5 mitigating factor for how this could potentially
6 be amended. And what those typically mean is
7 modification to the specifications of the metric.

8 MEMBER NGUYEN HOWELL: Clinical group
9 only, not individual.

10 PARTICIPANT: Can you say that louder?

11 MEMBER NGUYEN HOWELL: Clinical group
12 only, not individual.

13 CO-CHAIR BAGLEY: Some indication of
14 the size of the group. Some way to protect the
15 small numbers.

16 PARTICIPANT: Yes.

17 CO-CHAIR FIELDS: Yes, I mean just to
18 clarify that, because clinical group to me is not
19 specific enough either. I would say clinical
20 group of some reasonable size. But I'm not
21 really sure -- it does have to be tested.

22 PARTICIPANT: We have definitions in

1 other areas like --

2 CO-CHAIR FIELDS: That could work.

3 PARTICIPANT: -- 60 clinicians.

4 CO-CHAIR FIELDS: It would require
5 that just to protect the small practices.

6 CO-CHAIR BAGLEY: So we have a
7 proposal to -- the third category is --

8 MR. STOLPE: So the category is: do
9 not support with potential for mitigation.

10 CO-CHAIR BAGLEY: Right. And the
11 mitigation would be to find some way to protect
12 smaller groups. And you say you have mechanism -
13 -

14 MEMBER DUSEJA: Well, we have
15 precedence with the HWR measure where we have --
16 the clinicians have to be more than 16 clinicians
17 within the TIN, but you know, we're hearing it in
18 terms of this concern.

19 CO-CHAIR BAGLEY: Thank you. Sandy.
20 Accept clarification, Sandy.

21 MEMBER POGONES: Yes, I would add to
22 that: minimum reliability of what's --

1 (Off mic comment.)

2 CO-CHAIR BAGLEY: Okay. Did you get
3 that?

4 MEMBER YU: Just some clarification,
5 do we vote -- are we going to vote on no vote if
6 there is mitigation of it -- of the measure?

7 CO-CHAIR BAGLEY: Yes, that's a good
8 point. The category invites the idea that once
9 it's mitigated, we get to look at it again. Well
10 that's just not the case.

11 (Laughter.)

12 CO-CHAIR BAGLEY: Oh. Is that
13 correct? Yes, that's correct.

14 MEMBER NGUYEN HOWELL: Bruce, can you
15 say that again please?

16 CO-CHAIR BAGLEY: As the category
17 we're voting on, you know, sort of implies that
18 after the mitigation, we get another whack at it.
19 That's just not the case. We won't see it again
20 unless it happens to come here next year with
21 some other format. So it really isn't something
22 we get to see again or rule on again or give

1 different advice about. But it does -- it should
2 send up a figurative flag, if you will, to CMS
3 that it needs more scrutiny. So I think that's
4 what it does.

5 MR. AMIN: Bruce, can I just offer one
6 clarification point? The intent of this voting
7 category around do not support with potential for
8 mitigation, was that there is -- the committee
9 supports the concept, but some changes to the
10 specifications are required before support can be
11 offered. So it is clearly distinguishing what's
12 in front of you right now is not being supported,
13 but it's essentially giving guidance about how
14 the specification should be updated. So
15 consistent with the mitigating criteria around
16 level of analysis specification, minimal, minimum
17 number of clinicians and then reliability
18 statistics would be the mitigating factors that
19 would likely have to change.

20 CO-CHAIR BAGLEY: So in essence we're
21 saying we still think it's important, but it's
22 not currently constructed in a way that's going

1 to work out for clinicians. That's what we're
2 here for. So are we all set? I'm sorry.

3 MEMBER YU: Just still a little
4 confused. What I'm hearing is we all -- most of
5 the majority support the general concept and
6 think of this as an important measure, even we do
7 right. So people want to improve this in certain
8 way versus -- group versus individual level. So
9 why can't we vote to say, if we address this
10 concern whether we want the measure to come back,
11 that would be more clear, isn't it? Yes.

12 CO-CHAIR BAGLEY: Well, the measure
13 can't come back. And we just voted to -- not to
14 accept conditional support. So we're on to the
15 next lower category.

16 MEMBER YU: Right.

17 CO-CHAIR BAGLEY: And as Taroon just
18 pointed out, it does preserve it within the
19 system. That's what our expression of saying we
20 think it's valuable. If we didn't think it was
21 valuable, we should put do not support. And
22 you'll have an opportunity of that. If you vote

1 down this next category, that's where we're going
2 next.

3 MEMBER YU: Okay.

4 CO-CHAIR BAGLEY: Okay.

5 MEMBER YU: Okay. Thank you.

6 CO-CHAIR BAGLEY: Okay.

7 MEMBER GREINER: Can I just suggest an
8 amendment that we also consider making --

9 CO-CHAIR BAGLEY: Speak to the table
10 please.

11 MEMBER GREINER: -- that the PCP
12 attribution, if we have that, that that is
13 actually part of this as well.

14 CO-CHAIR BAGLEY: Say it again?

15 MEMBER GREINER: So the idea that if
16 somebody has selected a PCP for attribution, that
17 --

18 MR. STOLPE: For volunteering.

19 MEMBER GREINER: -- yes, that trumps
20 the ten visits to the endocrinologist.

21 PARTICIPANT: Yes.

22 CO-CHAIR BAGLEY: Okay. Yes. Any

1 objection to any one of the recommendation
2 conditions?

3 MEMBER NGUYEN HOWELL: No. We would
4 just add to the notes that it should be the gold
5 standard.

6 MR. STOLPE: Could you clarify what
7 you mean by: it should be the gold standard?

8 MEMBER NGUYEN HOWELL: Well, as the
9 Health Care Payment Learning and Action Network
10 recommended a few years ago regarding patient
11 attribution in our population-based payment
12 models, is that the patient attribution, the
13 first step is the patient's choice, and that
14 should be the gold standard when we're looking at
15 alternative payment models and patient
16 attribution regardless of prospective or
17 retrospective.

18 CO-CHAIR BAGLEY: Is that not already
19 the case?

20 MS. DRYE: So we don't have the
21 information yet. It's integrated in to be able
22 to use it, so we didn't use it. But what the CMS

1 program staff is saying, and my team member is --

2 CO-CHAIR BAGLEY: Louder please.

3 MS. DRYE: -- once it's available to
4 use, we would use it preferentially to the
5 results of the algorithm. And so I think
6 everybody agrees on that, but you guys can speak
7 to the NQF's use of the gold standard. There's
8 kind of a history to that, but --

9 MR. AMIN: I think the only thing I
10 would say on the issue of attribution, because
11 there is a lot of work that was done, we'll note
12 that there is an entire NQF methods committee
13 that looked into the question.

14 And best, the idea of patient choice
15 should be preferred as part of the analysis going
16 forward. And then we'll also note the
17 attribution paper that Elizabeth identified
18 earlier in comments.

19 MS. DRYE: I think that was a long way
20 of saying yeah.

21 (Laughter.)

22 MEMBER POGONES: Yes, when we have the

1 data available to us.

2 MS. DRYE: When we have the data from
3 patients.

4 CO-CHAIR BAGLEY: All right. I'd like
5 to move to vote, unless there is a clarification
6 about the conditions under which we're going to
7 put this forward.

8 MEMBER YU: A clarification. Are we
9 putting this patient's choice in there or not?

10 Because I do have a -- I understand
11 patient's perspective being the care choice is
12 important, but sometimes there's another element
13 in there that is communication. Did it explain
14 whether that discharge is risk that is really --
15 do they understand that?

16 So patient choice can't have a -- can
17 it have some little unintended consequences if we
18 use that as a measure?

19 MR. AMIN: We'll reflect it in the
20 discussion. I think the best way to characterize
21 -- that's why I'm trying to come up with the
22 language on the fly, but in the way that we'll

1 write it, it will be that the patient choice, as
2 it's determined in the attribution, should be
3 considered and tested by the developer as the
4 data becomes available. Right now it's not even
5 available to the developer in a task.

6 MS. DRYE: And just as a reminder,
7 we're -- this measure is about the primary care
8 provider coordinating care. So we're really
9 looking for that.

10 Who do you think your primary care
11 provider literally is? And I think, you know,
12 that how the Medicare program asks that question,
13 we just have to look at: does that align with it?
14 Then perfect.

15 MR. AMIN: Right.

16 CO-CHAIR BAGLEY: Jordan, we're ready.

17 MR. HIRSCH: For MUC2019-37 MIPS
18 Clinician and Clinician Group Risk-Standardized
19 Hospital Admission Rates for Patients With
20 Multiple Chronic Conditions, do you vote do not
21 support with potential for mitigation? Your
22 options are yes or no.

1 All right. From our 2019-37 MIPS
2 Clinician and Clinician Group Risk-Standardized
3 Hospital Admission Rates for Patients With
4 Multiple Chronic Conditions, do you vote do not
5 support with potential for mitigation, there were
6 16 votes for yes, six votes for no. The
7 workgroup has recommended MUC 2019-37 with a
8 designation of do not support with potential for
9 mitigation.

10 PARTICIPANT: For MIPS.

11 CO-CHAIR BAGLEY: Okay, the next thing
12 we're going to do is move to the MSSP program.
13 Oh, I'm sorry. Before we do that, during this
14 discussion, we've talked about a lot of gaps.
15 But are there gaps in the MIPS program where
16 other measures might be useful, or a different
17 approach? That's what you're looking for, right,
18 is, you know --

19 PARTICIPANT: The overall measure set
20 that we --

21 (Simultaneous speaking.)

22 CO-CHAIR BAGLEY: Yes, looking at the

1 overall measure set, which is hard when we've
2 spent so much time looking very specifically at
3 two or three measures. But for those of you who
4 are in this field and look at a lot of measures,
5 is there something that really would help the
6 MIPS program take off like a rocket?

7 (Laughter.)

8 PARTICIPANT: That's a high bar.

9 (Simultaneous speaking.)

10 MEMBER ALEMU: To the previous
11 portion, now I mean I just want to understand the
12 duty. We don't support with potential
13 mitigation, so no/yes. So if I mean the problems
14 are solved, what is the logic why we don't use
15 that measure?

16 If we have even the criteria how to,
17 or how to resolve, you know, the situation, why
18 would we use the measure? I mean what is the
19 reason behind that? I have a question from the
20 logic point of view.

21 CO-CHAIR BAGLEY: I'll give it a stab.
22 First, I think we just said to CMS that we think

1 this is still important, but we have grave
2 concerns about especially attribution to small
3 numbers. So that's basically what --

4 MEMBER ALEMU: Yes. But how come we
5 --

6 CO-CHAIR BAGLEY: We didn't actually
7 stamp it out and say don't do this. We gave them
8 an opportunity. And we will not see it again.
9 That's just the way it works.

10 CO-CHAIR FIELDS: I think then it also
11 requires more data, right? So then we have to --
12 it's almost like you've got to rerun the data now
13 with voluntary alignment, with a different group
14 cut off. You've got to look at it again with a
15 different set of qualifications, I think is why
16 we wouldn't just say, hey, you guys make the
17 changes, we're good. I think we've got to look
18 at it and see how it tests out.

19 CO-CHAIR BAGLEY: Okay, we're looking
20 for electrifying measures. Sandy, you're up
21 next.

22 MEMBER POGONES: Okay. Well, I did.

1 (Laughter.)

2 MEMBER POGONES: The AAFP really would
3 like -- maybe I'm not supposed to say that, yes.

4 (Laughter.)

5 MEMBER POGONES: We would like to see
6 some measures for primary care that really focus
7 on the essence of primary care -- access,
8 continuity, comprehensiveness, and coordination
9 of services. Right now, the measures that we're
10 measured on tend to be hand-me-downs from
11 specialists. We look at diabetes, we look at
12 blood pressure, we look at cardiovascular, we
13 look at all kinds of things of these measures
14 that are important to primary care, but they
15 don't measure the essence of primary care.

16 And there are some measures being
17 proposed out there that really do. So I would
18 like to see some focus on that, because when you
19 look at the number of whether or not patients had
20 colorectal cancer screening in 10 years, that's
21 really important. But it captures such a small
22 piece of what primary care is all about that it's

1 almost like, it's almost irrelevant. Not really,
2 but I think you know what I'm saying. It just
3 doesn't reflect what primary care really does for
4 patients.

5 I also -- we also think that looking
6 at primary care spend would be an excellent way,
7 since there has been some previous research
8 showing that primary care spend can -- when
9 increased can reduce overall costs. And that
10 will get back to getting some resources into the
11 ideas into primary care and community services,
12 and social support services that really can have
13 a huge impact on all-around health. So I think
14 that would be -- we think that would be a good
15 measure.

16 We'd also like to see some focus on
17 preference-sensitive cases, where when given a
18 fair choice, that patients actually can opt out,
19 and the physician would not be penalized for that
20 patient opting out. And we certainly would like
21 to focus on some measures that determine whether
22 a certain course of therapy is the best course

1 for the patient. There's a lot of surgeries
2 being performed, but is that the best? Are there
3 risks? Do the risks -- do the benefits outweigh
4 the risks? And that's where we see a lot of
5 spend. And I think there's a huge potential for
6 decreasing costs as well as decreasing harm for
7 patients. So I know we're not there yet, but I
8 really would like to see -- we would like to see
9 that. And then we also would like to see
10 movement on diagnostic accuracy.

11 MEMBER SCHREIBER: Can I ask you to
12 repeat your four categories? I have access,
13 coordination, and then two others.

14 MEMBER POGONES: Access, continuity,
15 comprehensiveness, and coordination of services.
16 That's what primary care does. They have this
17 relationship with the patient that relies on
18 coordinating all of these different things. And
19 maybe having a mammogram within two years isn't
20 the most important things with that patient as
21 far as what's going on right now. There might be
22 other things that really outweigh the importance.

1 We're not saying those preventive tests aren't
2 important. Yes, they are. But they're such a
3 small segment of what primary care does that it
4 doesn't reflect how good a primary care physician
5 is. That's why I'm a primary care doc in
6 Detroit. Am I right?

7 (Laughter.)

8 CO-CHAIR BAGLEY: Ann, can you top
9 that?

10 (Laughter.)

11 MEMBER GREINER: So this is on our
12 mind because we just had a workshop with our
13 members. And we've got 64 members that span all
14 the different parts of the healthcare system, but
15 they share a passion for the importance of
16 primary care. And so we had a whole conversation
17 about primary care measurement, and we had some
18 folks who were at the leading edge of primary
19 care measurement come and present some ideas.
20 And many of them echo what Sandy just talked
21 about. And I think you are all in discussions
22 with some of these developers.

1 So this whole notion about continuity,
2 and comprehensiveness, the Barbara Starfield
3 attributes of primary care, figuring out how to
4 measure those, and if you ask patients, like
5 there were focus groups done of patients about
6 what they want from primary care, and they
7 basically said they want coordination and
8 integration.

9 They didn't say they want to make sure
10 that we have our mammogram, you know, every --
11 and that's a great measure to understand
12 something about the system and how it's working.
13 And it is very important. But in terms of the
14 value that primary care brings, it really is
15 reflected more I think on the attributes that
16 Barbara Starfield lifted up, and how can we
17 measure those? And I think the American Board of
18 Family Medicine is developing some really good
19 measures in their registries to do exactly that.

20 And then on the patient side, Rebecca
21 Etts (phonetic), and I think you are familiar
22 with this 11-item patient-reported outcome

1 measure that gets at, from the patient
2 standpoint, whether or not their care is
3 integrated and coordinated, whether or not the
4 clinician is spending time to help educate them
5 about their condition, and partnering with them
6 to improve their care and their lifestyle, et
7 cetera.

8 So I think there are some great new
9 measures coming on. And maybe we could retire
10 some of the large number of measures that primary
11 care reports now and slim it down to some
12 measures that really do better reflect the value
13 of primary care. On the primary care spend
14 measure, lots of work being done. We're in the
15 middle of that. We've got, you know, some good
16 measures at the plan level. And states are
17 taking this up and rolling out efforts. Six
18 states passed legislation this year to start
19 reporting primary care spend at the health plan
20 level, which is great but also scary because
21 they're all doing it differently.

22 So to the degree we can get a

1 consensus around what that measure would look
2 like at the health plan level, all the health
3 plans in the room would be happy about that.
4 We'd be happy about that because then we could
5 have some comparability, some standardization,
6 and some benchmarking.

7 And I know we're not talking about
8 MIPS and MSSP measures, but we have some of the
9 MA measures at the health plan level. That could
10 be an area ripe for future measurement
11 exploration and development.

12 CO-CHAIR BAGLEY: Okay.

13 (Simultaneous speaking.)

14 CO-CHAIR BAGLEY: We have to be very
15 quick --

16 CO-CHAIR FIELDS: And one concrete
17 measure, for example, as a substitute relative to
18 the context we discussed today, I could easily
19 imagine evaluating PCPs, instead of their
20 admission rates per 1,000 for folks with multiple
21 chronic conditions, say, how many PCPs is this,
22 or PCP to specialist ratios for people with

1 multiple chronic conditions.

2 If we're not arguing whether or not
3 there's value in the work of PCPs to reduce total
4 cost of care, and that we generally all agree
5 that the outcomes are better if you have a strong
6 PCP relationship, coming from a market where I
7 can't go 10 feet without a concierge doc, an
8 urgent care center, or a specialist, and my PCP
9 to specialist ratios are like 0.5, if I can get
10 some behavior change on the PCPs to take really
11 more ownership and more engagement, and help
12 improve -- it's an access issue to some degree,
13 but some way of incentivizing making Medicare
14 attractive for PCPs by affecting their rates in
15 MIPS, by really participating more aggressively
16 in patient engagement, would be a great process
17 measure that likely gets us to the outcome
18 without, again, like I was saying earlier,
19 skipping to the big outcome that they have less
20 control over.

21 CO-CHAIR BAGLEY: Okay, I think we
22 need to move on. Does anybody else have a timed

1 agenda that shows that we're behind?

2 (Laughter.)

3 MR. STOLPE: All right. Very good.

4 So now we're going to introduce the Medicare
5 Shared Savings Programs. As you know, this was
6 established as the Affordable Care Act where
7 notable providers, hospitals, suppliers can
8 participate in a shared savings program by
9 creating or participating in an accountable care
10 organization.

11 Within MSSP, there's four shared
12 savings models that have varying degrees of risk.
13 The goals of this program are to promote
14 accountability for patient population, for care
15 coordination and for the use of high quality and
16 efficient services.

17 In order for a ACO to share in
18 savings, as we know, they need to do two things:
19 first, demonstrate savings, and then the second
20 is to perform on the set of quality measures --
21 one of which we'll be considering, and it's going
22 to be pretty easy for me to outline that measure,

1 since we've just talked about it.

2 CO-CHAIR BAGLEY: Before we do that,
3 we should have public comment.

4 MR. STOLPE: Yes, before we do that,
5 we move directly public comment.

6 CO-CHAIR BAGLEY: We'd like to have
7 public comment on the program and the measures.

8 MR. STOLPE: Yes. Thank you.

9 CO-CHAIR BAGLEY: Come forward and
10 stand up.

11 (Telephonic interference.)

12 MS. GASPERININI: Jennifer Gasperini
13 with the National Association of ACOs. So I
14 actually wanted to make a comment about alignment
15 with MSSP and MIPS, both the quality measures and
16 the scoring methods. This appeared in an earlier
17 slide deck, so I hope this comment's still
18 germane. I just keep it in the slide deck. But
19 we wanted to just voice our concerns with a total
20 sweeping alignment, to have the same methods and
21 the same quality measure set for ACOs as we see
22 in MIPS. And I think our discussion on the last

1 measure perfectly made my point about why
2 sometimes we want to see a unique set of quality
3 measures for ACOs, and why that might look really
4 different for the ACO population versus someone
5 in MIPS.

6 In particular, we would also like to
7 see CMS make the measures more different, not
8 more similar. In particular, we want to see the
9 next generation, so to speak, of quality measures
10 being applied to ACOs. For example, we have some
11 ideas about how you could test measures that are
12 not yet fully baked, so to speak, that are
13 addressing a gap area, like social determinants
14 of health would be a great example of something
15 that you could start to test and not make ACOs
16 accountable for, but really see how the measure
17 works, if there are flaws that need to be
18 addressed given more rapid cycle development.

19 So I really just want to make a
20 comment about how we think alignment doesn't
21 always make sense, and we actually want to see
22 the ACO measure set evolve even more than it is

1 now. So thank you.

2 CO-CHAIR BAGLEY: Anyone else? And
3 it's hard to -- anyone on the phone?

4 MS. BUCHANAN: Yes. So what we're
5 going to ask people to do on the phone is hit *7
6 to unmute yourself if you have a comment, or you
7 can chat it and we'll read it aloud. So it's *7
8 to unmute.

9 MR. STOLPE: So we'll pause for a
10 moment to allow for them to unmute themselves,
11 but then move on if there's no comments.

12 CO-CHAIR BAGLEY: And if that doesn't
13 work, we can cancel the call and have them call
14 back in, and that person who is on hold won't be
15 able to talk.

16 MS. BUCHANAN: That is true, Bruce.
17 We can do that.

18 (Laughter.)

19 CO-CHAIR BAGLEY: Do we have a lot on
20 the phone?

21 MS. BUCHANAN: We have 43.

22 CO-CHAIR BAGLEY: Okay. Whoo.

1 MS. BUCHANAN: Again, it's *7 to
2 unmute.

3 CO-CHAIR BAGLEY: Do you have
4 anything?

5 MS. BUCHANAN: No, we didn't.

6 CO-CHAIR BAGLEY: Okay, let's move on.

7 MR. STOLPE: So as I mentioned, the
8 measure under consideration here is MUC2019-37,
9 Clinician and Clinician Group Risk-Standardized
10 Hospital Admission Rates for Patients with
11 Multiple Chronic Conditions -- the measure we
12 just discussed.

13 Now we're going to be applying this
14 specifically to SSP. The measure developer has
15 prepared a document, which will project on the
16 screens just behind us here, that will outline
17 some of the reliability testing so that you can
18 focus on remarks on that.

19 I'll just mention that the staff
20 recommendations on this one, again, is
21 conditional support. And the condition for that
22 support is NQF endorsement.

1 CO-CHAIR BAGLEY: Okay. Elizabeth,
2 you want to --

3 MS. DRYE: Sure. The specifications
4 are the same for the cohort, the outcome, and
5 risk adjustment. So this is a change from the
6 currently reported ACO measure. And we already
7 went over there and satisfied qualifying
8 conditions, the outcomes narrowed to focus on
9 admissions that can be affected by providers
10 managing care in the ambulatory setting. And
11 risk adjustment includes frailty variables, and
12 our SES index, and specialist density.

13 These are, I think, the main, what we
14 did is, actually, we aligned the measure, we ran
15 the measure in 2015 data which is an older ACO
16 data set. We will run it in 2018 data for
17 submission this coming year to NQF and
18 endorsement. We'll run it in the same data set,
19 same year, as we run the other one, so it won't
20 be confusing.

21 And we calculated what we thought were
22 the most important, immediate things for you all

1 to see in this consideration. So one is just the
2 range of the measure scores. When we think about
3 importance, we want to see variation in
4 performance across ACOs and the risk adjusted
5 measure score, which is on unplanned admissions,
6 taking out the ones I mentioned before, for 100
7 person years of exposure, was from 27 per 100 to
8 58, so these patients are pretty frequently
9 admitted and that's almost a twofold range. The
10 median was 41. That's not that different from --
11 it's a little lower than the current ACO measure
12 because we pulled some of the admissions out of
13 the outcome.

14 It's easier to get high reliability,
15 as we already discussed. If you wanted to go to
16 a reliability of 0.7, you would have to, for
17 everyone and above, so 0.7 and more -- higher,
18 you need at least 249 patients in the ACO that
19 are within the measure. And that happens 99
20 percent of the time, so these are just bigger
21 providers. I don't know that I need -- if there
22 are other questions, but this is really fully

1 aligned now except attribution, as we discussed,
2 and the reliability results.

3 CO-CHAIR BAGLEY: Okay. Was that
4 somebody on the phone?

5 PARTICIPANT: Yes, sorry. It wasn't
6 a committee member.

7 CO-CHAIR BAGLEY: Yanling?

8 MEMBER YU: Yes. A question. I'm not
9 familiar with it. I'm new to this process. You
10 mentioned that NQF recommends conditional
11 support. Is conditional on the final approval or
12 final endorsement by NQF, is this a requirement
13 for this community to prove or not?

14 MR. STOLPE: So the answer to that
15 question is no, it is not a requirement. But the
16 algorithm that was approved by the Coordinating
17 Committee puts a special emphasis on NQF
18 endorsement as those measures are preferred.
19 However, you may elect to support a measure
20 without the NQF recommendation. In this
21 instance, to do that you would need to say that
22 you vote no, and then vote for unconditional

1 support.

2 MEMBER YU: But there's no choice on
3 that, right?

4 MR. STOLPE: There is. Yes, the
5 choice would be for you to vote no, and then for
6 us to go through a stepwise process of selecting
7 the appropriate one, assuming that your
8 colleagues agree with you.

9 (Laughter.)

10 MEMBER YU: Okay. All right. Thank
11 you.

12 CO-CHAIR BAGLEY: David.

13 MEMBER SEIDENWURM: So this is perhaps
14 a question about the structure of the ACO
15 program. But since there's cost components in
16 the ACO program in terms of the shared savings,
17 and the downside risk and so forth, and the
18 principle driver of costs in healthcare are
19 admissions, and the part of admissions that, you
20 know, one can affect by appropriately managing
21 one's patients are, you know, the avoidable ones,
22 are we sort of double penalizing for avoidable

1 admissions by adding a quality focused metric on
2 avoidable admissions when there's already, you
3 know, the financial aspects? Is that --

4 (Simultaneous speaking.)

5 CO-CHAIR FIELDS: We track it anyway.
6 To your point, it is like the major driver. So
7 we track it anyway. It's not additional burden.
8 And to be clear, the measure -- there is already
9 a measure that's a lot like this one. This one's
10 a little narrower in focus as was described. But
11 it's already there. It's not new. Does that
12 make sense?

13 MEMBER SEIDENWURM: Okay.

14 CO-CHAIR FIELDS: So we've been
15 tracking it. We track it all the time. I look
16 at score cards every month.

17 MEMBER SEIDENWURM: So it's not double
18 counting then?

19 CO-CHAIR FIELDS: No, it's not double
20 counting, yes.

21 CO-CHAIR BAGLEY: Amy?

22 MEMBER NGUYEN HOWELL: So I just

1 wanted to clarify. So would this be replacing
2 ACO 38?

3 CO-CHAIR FIELDS: Sounded like it.
4 It's replacing, right?

5 MS. BUSH: It would be. We would have
6 to go through rulemaking to do that, but if we
7 were to propose this, it would replace, yes. It
8 wouldn't be in addition to.

9 So this one adds diabetes to the
10 number of conditions, which we had received
11 public comment that that was obviously an
12 important chronic condition to address. So it
13 adds diabetes, and then it takes away the
14 patients who are two weeks or 10 days post-
15 discharge from an in-patient facility.

16 MEMBER NGUYEN HOWELL: Okay.

17 MS. BUSH: Those are the major
18 changes. And then it does the risk adjustments
19 for SES which is --

20 MEMBER NGUYEN HOWELL: Right. Yes, we
21 would support it as long as it is not duplicative
22 at of the ACO 38.

1 MS. BUSH: Right. It would not be.

2 MEMBER NGUYEN HOWELL: Thank you.

3 CO-CHAIR BAGLEY: Okay. I'll bet
4 we're ready for a vote.

5 MR. HIRSCH: For MUC2019-37 in SSP,
6 Clinician and Clinician Group Risk-Standardized
7 Hospital Admission Rates for Patients With
8 Multiple Chronic Conditions, again, in the
9 Medicare Shared Savings Program, do you vote to
10 support the preliminary analysis as the workgroup
11 recommendation? Conditional support for
12 rulemaking was the preliminary analysis
13 recommendation. Your options are yes or no.

14 CO-CHAIR BAGLEY: Do you have to read
15 that in for the record, or can I just move on?

16 PARTICIPANT: We have to read it in.

17 CO-CHAIR BAGLEY: You do have to read
18 it?

19 PARTICIPANT: Yes.

20 CO-CHAIR BAGLEY: Go for it.

21 MS. BUCHANAN: We have 21 for yes.

22 MR. HIRSCH: For MUC2019-37, SSP,

1 Clinician and Clinician Group Risk-Standardized
2 Hospital Admission Rates for Patients With
3 Multiple Chronic Conditions in the Medicare
4 Shared Savings Program, do you vote to support
5 the preliminary analysis of the workgroup
6 recommendation? 21 votes for yes, one vote for
7 no. The workgroup has voted for MUC2019-37 for
8 conditional support for rulemaking.

9 CO-CHAIR BAGLEY: Excellent. Okay,
10 any gaps in measures for ACOs, those of you who
11 were involved with that? You guys getting tired?
12 Do we need to stand up and do some jumping jacks
13 or something?

14 CO-CHAIR FIELDS: And then while folks
15 are looking at -- go ahead.

16 MEMBER POGONES: Oh, I would just
17 repeat what I said for the other discussion with
18 the -- especially the measure evaluating whether
19 or not it puts the therapy at risk, the right
20 course of therapy, not just whether there was a
21 complication following the surgery, should the
22 surgery have been done to begin with?

1 CO-CHAIR BAGLEY: Any others?

2 CO-CHAIR FIELDS: Along that line, I'd
3 like for you to start to think about measures of
4 diagnostic and therapeutic efficiency. Do you
5 understand what I mean by that? How do we find
6 out the right answer as quickly and efficiently
7 as possible, and how do we select a treatment?

8 And it's very difficult to do that
9 without some kind of an organization. But an ACO
10 is a perfect organization to have that happen
11 inside of. So try that idea out. You know,
12 instead of figuring out, well how come you didn't
13 do this, and how come you didn't do that? You
14 know, if the ACO is established as an
15 organization that can be the most efficient in
16 care, that's how they actually get extra money.
17 You know, why not help them measure it?

18 PARTICIPANT: I might also mention,
19 you know, there's a lot of power in the reporting
20 only measures. I don't know how that's viewed
21 internally at CMS, but in terms of behavior and
22 culture change, which is like 99 percent of my

1 job of leading a network of 4,000 doctors, is
2 trying to get them to move.

3 So when we think about things like
4 SDH, for example, measures that are -- to
5 Jennifer's point a second ago, I think there's
6 openness as of, in general among ACOs to try and
7 step out, especially in a reporting only mode, to
8 get people to have a conversation. There's a lot
9 of power in that. So just would offer that
10 there's movement that can happen with reporting
11 only measures.

12 CO-CHAIR BAGLEY: Okay.

13 MEMBER SEIDENWURM: One thing I've
14 been wondering about is there anything we can do
15 about the topic of sort of share of care? If the
16 point of an ACO is to integrate care, why not
17 measure a share of care? And I don't know
18 exactly how we would do that, you know, whether
19 one would do it terms of spend or working MIPS,
20 or, you know, but I think that's a topic --

21 CO-CHAIR BAGLEY: Are you talking
22 about leakage --

1 MEMBER SEIDENWURM: Well --

2 (Simultaneous speaking.)

3 CO-CHAIR BAGLEY: -- into other
4 systems?

5 MEMBER SEIDENWURM: -- as opposed to,
6 yes.

7 MEMBER BURSTIN: Maybe just to build
8 on that, I know there are a couple of measures in
9 the set that look at admission and readmission,
10 which are essentially some safe proxies for
11 coordination of care.

12 But boy, we really do need some decent
13 measures at some point that actually reflect true
14 handoffs, coordination, really what ACOs are all
15 about. Some of you may remember the famous line
16 from years ago that care coordination is the
17 Bermuda Triangle of measurement. Many have gone
18 in and few have emerged with a measure.

19 (Laughter.)

20 MEMBER BURSTIN: I hope we're getting
21 to the point where systems are getting close
22 enough so we can tease systems. Things like

1 that, we could really begin to build some real
2 eCQMs that actually reflect what the goal of ACOs
3 are really about.

4 CO-CHAIR BAGLEY: Okay. We're ready
5 to move?

6 CO-CHAIR FIELDS: So we'll start with
7 the Medicare Part C and D Star Ratings program,
8 another favorite. We'll start with the
9 description for this.

10 MR. STOLPE: All right, very good.
11 Well, I just want to acknowledge that we are
12 officially at the half-way mark of going through
13 our measures at 2:30. So we are a little bit
14 behind schedule.

15 As you know, this is the first year
16 that MAP Clinician will review measures for Parts
17 C and D. We have five measures total to review.
18 Parts C and D consist of two types of plans, our
19 Medicare Advantage Plans, which are
20 comprehensive, and the stand-alone prescription
21 drug plans, our PDPs or Part D plans, both of
22 which are attributed a Star rating.

1 The Star rating reflects the
2 experiences of beneficiaries that assist
3 beneficiaries in finding the best plan. For
4 Medicare Advantage, it's also connected with what
5 are termed quality bonus payments, where health
6 plans that have achieved a critical threshold of
7 four stars or more are eligible to receive a
8 fairly substantial bonus to their normal Medicare
9 payments.

10 So this program consists of 48 quality
11 measures. Medicare Advantage-only contracts have
12 34, with the PDP contracts having 14. We'll be,
13 as I mentioned, going over five measures, the
14 first of which will be MUC2019-14, Follow-Up
15 After Emergency Department Visits For People with
16 Multiple High-Risk Chronic Conditions. But
17 first, public comment.

18 CO-CHAIR FIELDS: Yes. Anyone, the
19 public on the phone or in person first, any
20 public comment?

21 MS. RUBIN: Yes, hi, Koryn Rubin from
22 the AMA. In terms of with opioid utilization

1 measures, I think we need to evolve the
2 conversation and discuss pain management and
3 ensuring patients get their pain management and
4 behavioral health needs met.

5 The Administration has done a very
6 good job at targeting opioid utilization, and
7 just putting dose duration limits actually is
8 counter to providing when necessary appropriate
9 care, and has led to adverse consequences for
10 patients. So we need to tell you to begin to
11 really evolve the conversation.

12 And then I know there's the
13 opportunity to discuss gaps in the MA program --
14 the Star ratings program. The measures currently
15 in the program are really clinical in focus. So
16 you're really measuring the physicians and
17 providers; that's what gets built into the
18 contracts. Because the only way the AMA plans
19 can obtain that data is from physicians, and so
20 put in coverage decisions based on those
21 measures.

22 And there needs to be movement towards

1 more looking at access, provider networks.
2 Because that's not really adequately addressed,
3 and that's also what patients are looking for
4 when they're choosing, you know, MA plans. They
5 need to understand what type of network they're
6 engaging in and physician access when they sign
7 up for Part C or D.

8 CO-CHAIR FIELDS: Thank you. Anyone
9 else in person, or on the phone, or a chat?

10 MS. BUCHANAN: We don't have any
11 chats. As a reminder, *7 to unmute yourself. And
12 there is nothing in the chat.

13 CO-CHAIR FIELDS: Okay. And we'll
14 make a comment about the opioid measures here in
15 a minute, but do you want to just go ahead and
16 start with the first one?

17 MR. STOLPE: Yes, thank you. Okay, so
18 this first measure, as I mentioned, is MUC2019-
19 14, Follow-Up After Emergency Department Visit
20 for People with Multiple High-Risk Chronic
21 Conditions. The staff recommended this measure
22 with conditions, those conditions being the usual

1 one which is to obtain NQF endorsement.

2 When first reviewed, staff did have a
3 concern about the evidence link. One of our
4 criteria is that a measure have a strong evidence
5 base or be linked to outcomes or an outcome
6 measure. There is a comparable measure, NQF
7 3435, which sought to establish the connection
8 between desirable outcomes and follow-up. This
9 may seem like we're being a little bit too
10 meticulous in chasing it down, because it seems
11 intuitive that follow-up would lead to good
12 outcomes.

13 But we need to actually see that
14 evidence. And that needs to be presented through
15 research studies that test through a hypothesis,
16 a research hypothesis, the outcome of interest
17 and associate that with the process of interest.
18 We've found some of those for some of the
19 conditions inside of the program, but were not
20 able to identify them for all, so just something
21 to keep in mind.

22 The other thing that I will point out

1 is that this measure was initially introduced
2 into HEDIS in 2018. The measure draws on
3 encountered data, which is a lower burden data
4 source that results routinely from just a normal
5 practice of care.

6 CO-CHAIR FIELDS: Great. So the lead
7 discussant, I'm sorry, is Susan on the phone.

8 MEMBER KNUDSON: Yes. Hello,
9 everyone. So this measure --

10 (Telephonic interference.)

11 MEMBER KNUDSON: -- for Medicare
12 Beneficiaries 18 and Older with Multiple High
13 Risk Chronic Conditions. Those conditions were
14 documented, if you had a chance to look at those.
15 But the attempt here, even particularly given
16 what Helen just said about care coordination, is
17 to improve just that -- care coordination for
18 Medicare Advantage members as they are
19 transitioning between in-patient and out-patient
20 care.

21 So the numerator is a follow-up
22 service that remains after the ED visit, and the

1 denominator is Medicare beneficiaries 18 and
2 older who had ED visits, and also had these
3 multiple chronic conditions. There's a couple of
4 important exclusions in the measure from some of
5 the beneficiaries that are in hospice, as well as
6 any ED visits that are followed by an admission
7 to an acute or non-acute in-patient care setting
8 on the date of the ED event or within seven days
9 after that ED event.

10 So it is around the NQF priority
11 implementation in care coordination. It is a
12 process measure with relatively low burden. And
13 what I would say also about the comments that
14 were -- there were three comments. One offered
15 full support. Another offered up an alternative,
16 and then there was a third that questioned and
17 wanted specifications on the definition of
18 follow-up that was mentioned earlier in the tee-
19 up of the measure, this is a HEDIS measure, so
20 there is a detailed specification of it that's
21 available to answer those questions.

22 So I think those are the main points.

1 The one perhaps editorial comment I would make on
2 this is it wasn't --

3 (Telephonic interference.)

4 CO-CHAIR FIELDS: I'm sorry, Susan, do
5 you mind repeating that last line, you're kind of
6 cutting up a little bit.

7 MEMBER KNUDSON: Oh, I was just saying
8 that the last editorial comment I had was that I
9 didn't know if this measure may potentially lend
10 itself to relatively small N-sizes in some areas.

11 CO-CHAIR FIELDS: So it's possible. I
12 mean probably the measure developers can comment
13 on it. Usually at the MA Stars level though,
14 it's everyone involved in the plan. So it's
15 usually at that level not much of a problem, as a
16 rule, unless you have a tiny number of docs. But
17 --

18 MEMBER KNUDSON: Yeah. So for
19 example, we're a fairly large system, but we have
20 a small MA population. So there are just, you
21 know, some idiosyncrasies like that. I don't
22 think it's a stopper, just something to be

1 mindful of.

2 CO-CHAIR FIELDS: Yes.

3 MR. ROMAN: Yes, so this is Dan Roman
4 from NCQA. The measure has been in HEDIS for two
5 years. We have not seen a small numbers issue
6 for the majority of our HEDIS measures, you know,
7 if your denominator is less than 30, you don't
8 report the measure.

9 So this measure does have a range, but
10 it goes into the thousands. So from 30 all the
11 way up to thousands of people in the average
12 denominator size is around 5,000. So we have not
13 had an issue with the denominator size at the
14 plan level for this measure so far.

15 CO-CHAIR FIELDS: Great. Robert, do
16 you have any comments on the measure? Or Sandy,
17 do you have any comments on the measure? You're
18 at least listed as a co-discussant on the
19 measure. No?

20 MEMBER POGONES: At this point?

21 CO-CHAIR FIELDS: Yes.

22 MEMBER POGONES: I have no comments.

1 CO-CHAIR FIELDS: We can come back.

2 (Laughter.)

3 CO-CHAIR FIELDS: William?

4 MEMBER POGONES: Actually I do have a
5 comment.

6 CO-CHAIR FIELDS: Oh, you do? Sorry.
7 Go ahead, Sandy.

8 MEMBER POGONES: I just wanted to make
9 sure. So this is at the plan level? So to me,
10 that would really give incentive for plans to
11 make certain that primary care physicians, for
12 example, were notified of an ED visit which tends
13 to be the biggest problem for a follow-up if they
14 don't even know they've had a visit. So it might
15 be a good measure for a plan level because, to
16 me, that gives incentive to make sure the
17 communication goes.

18 CO-CHAIR FIELDS: Yes. William
19 Fleischman?

20 MEMBER FLEISCHMAN: No, I'll just echo
21 that access is the biggest problem for following
22 up from the Emergency Department, and this is at

1 the right level. And I'll add some comments
2 later in terms of the measures like that.

3 CO-CHAIR FIELDS: Great. I'm probably
4 not going to say your name correctly. Not here,
5 okay.

6 MEMBER BURSTIN: Just a question. So
7 in some prior efforts, there has been some
8 evidence that some smaller plans that take care
9 of disadvantaged patients may also have
10 differences in their Star ratings by social risk.
11 Was there any consideration? Did NCQA look at
12 that document?

13 MR. ROMAN: Do we look at social risk
14 when testing this measure? We're limited in what
15 data we have for testing at the plan level. So
16 we have -- typically we have age, sex, we get
17 some regional data. But I mean we're kind of
18 limited in our ability to test to that at the
19 plan level.

20 MEMBER BURSTIN: Does it include SNP
21 plans, special needs plans?

22 MR. ROMAN: It does.

1 MEMBER BURSTIN: Yes. So some of the
2 smaller special needs plans in particular tend
3 to have large numbers of dual-eligibles who may
4 just look different. So just a consideration,
5 you probably at least have dual eligibility for
6 consideration going forward.

7 MR. ROMAN: Yes, okay.

8 CO-CHAIR FIELDS: Any other comments
9 or discussion? David, sorry, yes.

10 MEMBER SEIDENWURM: This is a
11 question. I'm not sure I fully understand the
12 logic here. If the service, the post-ED visit
13 service would be provided within seven days, but
14 patients who are admitted within seven days are
15 excluded, that raises a question in my mind, at
16 least, could that admission have been avoided had
17 a, you know, contact or rescue been instituted
18 within that seven-day interval? So can someone
19 explain the logic around that?

20 MR. ROMAN: Yes. So again, this is
21 Dan Roman with NCQA. The idea is we're trying to
22 set up a clean window for follow-up to occur.

1 You know, so first the decision to make a seven-
2 day follow-up, we do have to allow there to be
3 time for some information transfer for data from,
4 you know, the ED, from when the person was in the
5 ED, when the health plan might know that that
6 happened, for them to be able to have that
7 information, and then do something about it.

8 It's not as though we can say that
9 this follow-up must occur the day of or even the
10 day after. It's really tough. So with our
11 clinical expert panels, we landed on a seven-day
12 follow-up. We looked at several different
13 follow-up periods in testing. Seven days was the
14 one we landed on. We thought it was reasonable,
15 and doable, and kind of practical.

16 And then with regards to kind of the
17 admission, and you know, if you go back to be
18 within those seven days, we're trying to create a
19 clean follow-up period. So if you do get
20 admitted, you would follow into one of other
21 measures that's about hospital discharge.

22 MEMBER SEIDENWURM: Discharge, right?

1 MR. ROMAN: Discharge. If you go back
2 to the ED and then you're released, you follow
3 into the measure and that second period of time.
4 Because we're trying to see the follow-up happen.
5 If you go to the ED, then you're saying the plan
6 should have done some sort of follow-up, is it
7 really fair because the person's already back in
8 the Emergency Department.

9 So really there's a lot of decisions
10 that kind of went into first getting to the
11 seven-day follow-up period, which really is about
12 prompt follow-up for this really vulnerable group
13 of Medicare beneficiaries. And trying to make
14 sure that, you know, if something does happen
15 after this type of patient leaves the Emergency
16 Department, that somebody reached out to make
17 sure that they knew what happened and everything
18 -- they understood what they were told happened,
19 and what they need to do next, and then with that
20 in mind, trying to make sure that we have a clean
21 period of time that we can look at to see that
22 follow-up actually happened, that's kind of what

1 you're seeing in the spec.

2 MEMBER SEIDENWURM: So it's the best
3 compromise in a messy world? Okay.

4 CO-CHAIR FIELDS: Yes, and it's pretty
5 consistent with transition windows in the
6 hospital discharge when it's 7 to 14 days, even
7 depending on the complexity, it's not
8 inconsistent with that, probably for the same
9 reasons.

10 And I'm sorry, I neglected, Kim, to
11 ask about from the Rural Health Group. Sorry.

12 MEMBER RASK: The Rural Health Group
13 was neutral to positive on this measure. And
14 they thought the kind of conditions were
15 irrelevant to rural populations. And the other
16 concern was lack of local resources might mean
17 that plans that worked in rural areas might be
18 disadvantaged on the measure.

19 CO-CHAIR FIELDS: Now --

20 MEMBER GOZANSKY: I would just say
21 that I'm very supportive of the fact that
22 telephonics meets the requirements. And I think

1 that helps with the idea that, you know, if
2 somebody may not be able to get in, you may not
3 be able to get out. So I'm very appreciable of
4 that.

5 CO-CHAIR FIELDS: And William, I'm
6 sorry, I forgot you in the --

7 MEMBER FLEISCHMAN: No, no. And I'll
8 just add to that. So this is more of a
9 commentary, advisory for the rulemaking process.
10 So yes, telephone follow-up is great, but what we
11 need to make sure doesn't happen is the people,
12 is that insurers simply implement some sort of
13 automated system, press one and two, as opposed
14 to follow-up that's actually meaningful.

15 Text-based follow-up can be great, or
16 some other telephone follow-up, but it has to
17 actually offer some sort of resource and check-in
18 for the patient and not just check the box thing.

19 CO-CHAIR FIELDS: Good point. I'm not
20 seeing any other cards. Any other comments for
21 discussion? All right, I guess we're ready to
22 vote then.

1 MR. HIRSCH: For MUC2019-14, Follow-Up
2 After Emergency Department Visit for People with
3 Multiple High-Risk Chronic Conditions, do you
4 vote to support the preliminary analysis as the
5 workgroup recommendation? The preliminary
6 analysis recommendation is conditional support
7 for rulemaking. Your options are yes or no.

8 MS. BUCHANAN: I'm waiting just for one
9 more vote. We have 21.

10 PARTICIPANT: She just left the room.

11 MS. BUCHANAN: Oh. And Chad and Sue,
12 were you able to vote? Oh, we just got it.

13 MEMBER TEETERS: Yes, I was.

14 (Simultaneous speaking.)

15 MR. HIRSCH: For MUC2019-14, Follow-Up
16 After Emergency Department Visit for People with
17 Multiple High-Risk Chronic Conditions, do you
18 vote to support the preliminary analysis as the
19 workgroup recommendation? 22 votes, yes, zero
20 votes, no. The MUC2019-14 moves forward with
21 conditional support for rulemaking.

22 CO-CHAIR FIELDS: Next one. All

1 right. So the next three measures we're going to
2 look at, we're going to look at at least in the
3 discussion as a group. Because we anticipate a
4 tremendous amount of overlap in the discussion.
5 And then I guess we can sort of decide, based on
6 how the conversation goes, to vote on them as a
7 group. Is that how you guys --

8 MR. HIRSCH: No, we need a vote --

9 CO-CHAIR FIELDS: We need to vote
10 individually?

11 MR. HIRSCH: Yes.

12 CO-CHAIR FIELDS: All right. So
13 purely on the discussion, we'll do that together.
14 And then we'll vote individually on each of the
15 next three measures, if that's okay with
16 everyone.

17 So we'll -- you want to introduce the
18 measures now?

19 MR. STOLPE: All right, thanks very
20 much. So the first measure that we're going to
21 be considering here is MUC2019-57, Use of Opioids
22 at High Dosage in Persons without Cancer.

1 Now, this received a staff
2 recommendation of conditional support. And this
3 warrants some clarification. All three of these
4 measures are endorsed by NQF. And staff was
5 generally supportive of the three measures under
6 consideration.

7 However, inside of the submissions,
8 CMS clarified that only one measure was being
9 considered for movement from the display ratings
10 into the Stars. Staff operated under the
11 assumption that we were selecting one as the best
12 to move forward. That is the one that we elected
13 to support.

14 Now, we have since conferred with our
15 CMS colleagues, and what they would like us to do
16 is to consider each of these measures
17 independently for their suitability for
18 inclusion in the program. So the conditional
19 support was under the assumption that you reject
20 the other two. So just please keep that in mind
21 as we're going through the process of
22 consideration of the measure.

1 This measure, I'll briefly read the
2 measure description if I can actually get to it.
3 So forgive me while I shuffle through some
4 papers.

5 The description is the percent of
6 beneficiaries receiving opioid prescriptions with
7 an average dated morphine milligram equivalent of
8 greater than or equal to 90 milligrams over a
9 period of 90 days or longer. And once again, the
10 staff recommendation is conditional support.

11 CO-CHAIR FIELDS: Should we introduce,
12 do you want to read the other two, since we're
13 going to discuss another group, or how do you
14 want to do that?

15 MR. STOLPE: Yes, that's fine by me.
16 Actually, the next measure description, I'll go
17 ahead and pull up. This is the multiple provider
18 measure, so Use of Opioids from Multiple
19 Providers in Persons without Cancer. And this is
20 the percent of beneficiaries receiving opioid
21 prescriptions from four or more prescribers and
22 four or more pharmacies within 100 days or less.

1 And then the last measure, which if
2 you pull that up, is the Multiple Provider at
3 High Doses in Persons without Cancer. And it
4 simply is the combination of these two, that you
5 must have the 90 MMEs and the four or more
6 providers and pharmacies.

7 CO-CHAIR FIELDS: Great, thank you.
8 So we'll start with Joy, if that --

9 MEMBER BLAND: Yes. Yes, as you said,
10 the kind of started, it kind of went down to, you
11 know, what the focus on should be as far as the
12 milligram versus, because they combine them, and
13 then there's just one.

14 There were some arguments that I
15 thought were strong on, you know, the Department
16 of Justice has put some monitoring in place.
17 Eleven states don't have the monitoring, so a lot
18 of providers are already doing the monitoring of
19 pharmacies and, you know, multiple prescribing.

20 There was also, you know, compelling,
21 I thought, literature relevant to, you know,
22 there really isn't any improvement in function

1 when you go over 90 milligrams. There was some
2 literature to support that.

3 There is two pieces of literature, one
4 that said two or more, one, four or more. So I
5 kind of wondered where we came up with going with
6 four. There wasn't a lot of literature to
7 support either of those, whether you went with
8 two, you were going to overdose, or four. So I
9 didn't think that was as strong.

10 Also there were some arguments that
11 came up from some strong organizations.
12 Cleveland Clinic commented their concern of, you
13 know, this could potentially put members at risk
14 of using illicit drugs came up, so back and
15 forth.

16 The Advance Palliative Care
17 organization had concerns about it being limited
18 to cancer and hospice. What about chronic
19 conditions? I know the HEDIS spec, we are
20 reporting this in the Medicaid space, the 90, and
21 they include sickle cell and some other chronic
22 conditions I think should be considered that are

1 already in specification.

2 And another organization, the American
3 Medical Association, had strong opinions to not
4 support any of these, some of it around, you
5 know, the same thing. Sickle cell, chronic
6 conditions not being considered, as well as
7 they've gone from being treated to treat each
8 person as an individual, and now being told do
9 limits, and some of that miscommunication that's
10 gone to them as providers.

11 I know there would be even some things
12 I had looked up in California where the medical
13 board there is going back ten years to look at
14 different opiate usage and deaths. So there's a
15 lot of fuel around opiate prescribing.

16 For some of the other comments around
17 it, that too being, you know, is this going to be
18 -- do all these things put the members at, you
19 know, the beneficiaries at harm? Because
20 providers are becoming more and more afraid to
21 prescribe. And there isn't a ton of people doing
22 pain management doctors out there.

1 So, I mean, if I was going to
2 recommend one, I probably would recommend greater
3 than 90. It's already being used in the Medicaid
4 space. We're reporting it this year in the adult
5 core set. It would be my recommendation as --

6 CO-CHAIR FIELDS: Great. So, Carol,
7 No? Okay, Helen, have you any comments at this -
8 -

9 MEMBER BURSTIN: What, do you mean all
10 of them, then?

11 CO-CHAIR FIELDS: Yes.

12 MEMBER BURSTIN: So I -- I'm very
13 familiar with these measures, I think they're
14 very useful. I think there are some potential
15 unintended consequences that, I think, a lot of
16 folks are very concerned about on the steering
17 committee for the National University and Opioid
18 Collaborative. We've spent a lot of time talking
19 about potential but unintended consequences.

20 And I think, in particular, concerns
21 about the fact that we don't have very good
22 strategies around tapering patients off high

1 doses of opioids is really quite a concern at
2 this point. Some of that's just beginning. So
3 there may really be some unintended consequences
4 of pushing on, particularly, the measures at high
5 dosage at this point.

6 I think even just the approach of
7 using the marking equivalents may be shifting in
8 terms of science as well. And I think there's
9 concern, again, about not doing harm here.

10 On the other hand, I do think the one
11 that looks specifically at multiple providers is
12 a really important opportunity, I think, for
13 preventive -- If I had to recommend one, that
14 would be the one I would do. I would not do the
15 composite, and I would not do the one based just
16 on preventive.

17 CO-CHAIR FIELDS: Thank you. Ann?

18 MEMBER GREINER: Understanding that
19 there is complexity here, and the challenges of
20 tapering, and also that providers don't have a
21 lot of other things in their arsenal, either
22 because they're not trained to have alternative

1 ways to treat pain, or they're not comfortable
2 with, you know, things like acupuncture and other
3 methodologies.

4 And that's unfortunate, so they've got
5 one thing, and unfortunately we know that there's
6 been some unfortunate consequences. Still, we've
7 got, like, a huge issue with opiates. And we're
8 not -- I mean, we're making a little bit of
9 progress. So to not move forward with some kind
10 of measure doesn't seem wise.

11 I would imagine that, given the
12 visibility of this public health issue, that
13 there would be very careful attention and
14 tracking to what the unintended consequences were
15 if this measure moved into a public program.

16 So I guess I'm inclined to want to
17 support some measure in this area and not be
18 conservative and, you know, wait. Because
19 there's such importance of trying to address this
20 issue in some way.

21 I thought it was interesting that the
22 staff felt that, you know, for Star ratings that

1 it would be relevant to patients. Because I
2 don't know, I didn't think of patients thinking
3 about this when they look at health plans.

4 I thought it'd be very relevant to
5 regulators and others who are concerned that
6 maybe plans aren't doing all they can to work
7 with providers to make sure that there's
8 appropriate prescribing. So that -- that just
9 struck me as, and maybe staff can explain that, I
10 was just kind of confused by that.

11 And I guess in terms of the measure
12 that was most attractive, it is the one about
13 multiple providers and, let me just make sure
14 I've got this, the four or more providers since,
15 like, it would be the most valuable. Because if
16 you really are doing that kind of shopping,
17 that's quite problematic.

18 In terms of the composite, I did
19 wonder why it was an and, you know, the four or
20 more providers as well as the multiple
21 pharmacies, so multiple providers prescribing and
22 multiple pharmacies. Maybe that's too overly

1 restrictive. Your sales will be very small. Can
2 it be any more to try to bring in more. So I
3 think I was attracted to both the second and the
4 third measure.

5 CO-CHAIR FIELDS: Great, thank you.
6 A brief one, and then I'll go to Kim.

7 CO-CHAIR BAGLEY: I think that you
8 mentioned the patient aspect. And if I recall
9 this conversation from last year talking about
10 these measures, that this would not only trigger
11 a plan to keep track of what their percentage
12 was, but they would almost have to create a list
13 of those people who are really, become a list of
14 people who are likely to overdose.

15 In other words, that these people that
16 are either in one of these three lists, and you
17 only need two, would be attracting extra
18 attention from the plan to either say, hey, this
19 is what this person needs. That's the way the
20 measure goes. Or this person needs some kind of
21 tapering program, we've got to get some of that.
22 So I think there is a patient-centered approach

1 to this and not just, oh, my God, you can't
2 prescribe opioids.

3 MEMBER GREINER: So it's not the Star
4 rating, per se, it's the list that we do generate
5 as a result of this measure.

6 CO-CHAIR BAGLEY: Right.

7 PARTICIPANT: Well, I mean, if I'm
8 signing up for a plan, wouldn't I want my plan to
9 be doing that with the information?

10 MEMBER GREINER: Yes, we can agree on
11 that.

12 (Laughter.)

13 MR. STOLPE: But this is what the
14 staff thought as well. And one of our
15 conversations that we've had on our opioid
16 technical expert panel was a one-on-one
17 conversation with a former Mississippi Medicaid
18 director.

19 And he pointed out that some of the
20 analytics that are going into this are quite
21 sophisticated and that the multiple provider,
22 multiple pharmacy measure was, in particular, as

1 well the larger, more of the milligram equivalent
2 measures, led them to do a lot of different
3 threshold analyses on what would be best for
4 patients, including interventions like academic
5 detailing, putting them on case management plans,
6 and the like.

7 So the fact that those sophisticated
8 methods fortified the health plans to be able to
9 attend to the details of helping the patient
10 population was something that we thought made it
11 a very patient-centered measure.

12 CO-CHAIR FIELDS: I'd like to go to
13 Kim next for the Rural Workgroup.

14 MEMBER RASK: Yes, the Rural
15 Workgroup, on these three measures, went from
16 their favorite measure to their worst measure --

17 (Laughter.)

18 MEMBER RASK: -- from the direction of
19 the logic of why they liked it. So the high
20 dosage, actually, was one of our highest, most
21 popularly rated measures by the workgroup. They
22 really thought that opioid misuse in the rural

1 community is something that impacts them, and
2 they really want to address it.

3 They were concerned about the fact
4 that, that others have already mentioned, the
5 availability of services beyond opioids for pain
6 management. In the rural community, that's
7 really a challenge. So just kind of the opioids
8 doesn't addressed that issue.

9 So overall, they felt pretty
10 positively about that. The one thing in terms of
11 a gap, they thought that there were several
12 members who thought that those measures that
13 combined opioids and benzodiazepine use would
14 actually also be really controlled in the rural
15 context.

16 The other two measures that were the
17 multiple providers, the workgroup felt this
18 wouldn't be useful for rural areas, because the
19 number of communities that have four or more
20 pharmacies or multiple providers to be
21 prescribing, it wasn't that they thought -- they
22 thought it would not be helpful to identify

1 issues in those communities.

2 So for that reason, they didn't find
3 the multiple provider one useful, and they
4 thought adding high dose with multiple providers
5 would make it even less useful in rural areas.
6 So that one they liked least of all.

7 CO-CHAIR FIELDS: Thank you. I would
8 just provide some context for those that aren't
9 on the provider side. Part of the issue of
10 putting it in the Stars plan though, is I felt
11 like if they'd be able to identify high risk
12 patients, especially in the morphine-equivalent
13 area, is a good thing to help drive a
14 conversation about how to attack it.

15 The problem is, when you put it in the
16 Stars Program, what actually happens is the plan
17 doesn't actually do it. They produce a list, and
18 then they give it to the providers or the system
19 to do something about it.

20 And there is an intent, so not a
21 pressure, especially in the last quarter of the
22 year, to kind of get things to four stars, at all

1 costs. And so just keep that in mind for
2 context, that it is no longer then a measure just
3 to have a conversation or two, evaluate how bad,
4 or big, or how developed a problem is.

5 It becomes an expectation that you
6 will get folks below 90 milligrams, you know, and
7 do it by December 31st so that we can submit or
8 Stars rating. So there are no real consequences
9 to this on the patient side that go beyond just
10 trying to do good things for people. There's
11 risk there. And it's real.

12 (Simultaneous speaking.)

13 MEMBER BLAND: The only concern of --
14 go ahead.

15 (Simultaneous speaking.)

16 MEMBER BLAND: -- like, health plans,
17 we're already kind of looking at that. Like,
18 that red flag that's with our PDF right now, you
19 know, we see that come up. That's not something
20 we allow to be happening. If they're in our case
21 management, we track, like, it's --

22 CO-CHAIR FIELDS: Right. I think it's

1 great.

2 MEMBER BLAND: -- it's not a lot the
3 provider can really do. It's really getting that
4 member, and getting him help or whatever.

5 CO-CHAIR FIELDS: Yes.

6 CO-CHAIR FIELDS: Sorry, Yan.

7 MEMBER YU: No problem. I'm just
8 trying to understand better the composite that
9 put two things together, the last measure, that
10 patient with a high dose at the same time as the
11 multiple providers.

12 Are we trying to see some cause and
13 effect with type of relationships or the high
14 dose was caused by multiple provider
15 prescription? Because sometime even to the
16 single providers could cause a high dose. So,
17 I'm just trying to wrap my mind to see what is --

18 CO-CHAIR FIELDS: Yes. I'm going to
19 think that goes back to the and/or question
20 though, and --

21 MEMBER GOZANSKY: Yes. And I think my
22 comment is related to that.

1 CO-CHAIR FIELDS: Yes, let's go to you
2 first, and then maybe we can go to --

3 MEMBER GOZANSKY: So I think part of
4 it is that the population attributable, the rest
5 that you're selecting, when you're doing the and
6 is, I mean, it's a much smaller, it is the
7 highest of the high risk, but it's much smaller.
8 And I think that you're really narrowing how much
9 of that is mutable when you don't have sort of
10 the full, all-around resources. I very much find
11 that problematic.

12 The other thing I would say, and this
13 is a measure question, because I know that Kaiser
14 Permanente has been concerned about this, and
15 part of tapering oftentimes is to have somebody
16 come in multiple times as you're watching them
17 every couple of weeks, which might not be the
18 same provider, and my understanding is it's, you
19 know, my NPI and not the fact that my group
20 practice, that they're seeing my partner as well
21 as that my pharmacy that, if I'm only giving you
22 a ten-day supply and the only pharmacy on the

1 weekend when you're open is going to be
2 different, those are still, you know, one
3 pharmacy versus the other.

4 So I have some concerns about
5 unintended consequences as we're really trying to
6 taper and follow people closely with short
7 supplies, that that multiple provider thing will
8 get us in trouble.

9 CO-CHAIR FIELDS: Thank you.

10 MS. HINES: Yes, so there's been
11 several --

12 CO-CHAIR FIELDS: Can you introduce
13 yourself --

14 MS. HINES: Yes, I'm Lisa Hines with
15 the Pharmacy Quality Alliance. And there's been
16 several question that I would like to address.
17 The first is related to the exclusions, and
18 sickle cell is a new exclusion to the measures.
19 They're not in the specifications that were
20 shared with you.

21 And we're always refining our measures
22 over time to identify valid ways you can

1 administrate claims data. To identify palliative
2 care is a little bit difficult, but we're working
3 on that. So always, I'm welcome to suggestions
4 that would mitigate any unintended consequences.

5 In terms of the four and four, why did
6 we pick that number. There's a dose response in
7 the studies that we looked at that, you know, two
8 prescribers and two pharmacies increases the risk
9 of overdose, but there's a dose response. So
10 that would just concern the highest risk.

11 And there was one study that evaluated
12 that's supposed to be the highest risk patient of
13 the thresholds that were set. So that's why it
14 was selected. You could argue for going lower
15 and increasing the actual maintenance.

16 In terms of the high dose measure, so
17 it's a great measure. It's used in the medicated
18 dose course that is widely used. It is a
19 population-level measure.

20 Retrospectively evaluating patients
21 with these MMEs, it's not intended to guide the
22 individual clinical decision. And that's where

1 there's a bit of a disconnect when there's
2 interventions that are used to drive the measure.
3 There needs to be care taken, a very careful
4 approach from the pharma perspective, and not
5 push the providers to cut off access to care.

6 So we care very much about ensuring
7 that the measures are used appropriately, and are
8 not aware of any evidence of unintended
9 consequences, but know that overall that, with
10 policy, and guidelines, and measures, that that
11 could push the needle too far, so a little bit of
12 context there.

13 And then in terms of the and, during
14 development it was just thought to be the highest
15 risk patients. There are actually independent
16 risk factors for overdose. So, looking at it or
17 is probably more meaningful. So I -- the two
18 separate measures are probably the most useful.

19 CO-CHAIR FIELDS: Thank you.

20 MS. HINES: If you had to pick one,
21 that was the thought. Even though those were
22 developed in 2015, so the rates were much higher

1 then, and there has been progress over time. But
2 that composite measure, the rates are pretty low.

3 CO-CHAIR FIELDS: Thank you.

4 MEMBER POGONES: I just have a quick
5 question. The Pro Quality Managed plan which
6 will discuss these measures, and one of the
7 reasons that they did not like this measure was
8 because it wasn't the HEDIS measure. They were
9 under the impression that the HEDIS measure is
10 different than this measure.

11 MS. HINES: When you say this
12 measure, which one are you talking about?

13 MEMBER POGONES: Two of the measures,
14 both the high dose as well as the multiple
15 providers. So is that correct, or are they
16 exactly alike?

17 MS. HINES: So NQA developed the
18 measures first. NCQA adapted them for the HEDIS
19 program. There are slight differences. We do
20 work to harmonize. They're a little bit off-
21 sync.

22 TQAs are the high dose measures used

1 in the adult core set, also used in Medicare on
2 the display page. We do harmonize to the extent
3 possible, but they are different measures, and
4 we're different stewards.

5 MEMBER POGONES: I think that was our
6 issue, is why can't they be the same?

7 MS. HINES: We would very much like
8 for them to be our measures.

9 (Laughter.)

10 MS. HINES: So thank you for that
11 question. We want to work with NCQA to harmonize
12 the value sets and everything over time. And
13 ultimately, I think that can make for a better
14 measure. I wish there was one myself.

15 And then in terms of the tax ID number
16 versus the national provider identifier, we do
17 use the national provider identifier and
18 understand the balance of the false positives and
19 false negatives in identifying multiple providers
20 and even pharmacies.

21 And, if you think about a chain
22 pharmacy, for example, when this was analyzed by

1 CMS when they evaluated this for their
2 overutilization monitoring system, the actual
3 difference when they switched to using a tax ID
4 number for multiple providers at a single
5 practice was small. So it's really not, on
6 average, a big difference.

7 I understand that, first, specific
8 health systems, there could be a disparate
9 effect. That is something that we plan to look
10 at further and, again, always open to refining
11 the measures to improve validity in that case.
12 So thank you for that feedback.

13 CO-CHAIR FIELDS: Thanks. Robert?

14 MEMBER KRUGHOFF: I'm interrupting the
15 flow here, but I don't agree with that the data
16 will run out. Just wanted to say a couple of
17 things here. One is we want to look at the
18 meaningful measure development priorities, where
19 exactly are they getting the power chords here.

20 I just wondered, do we have a, well,
21 can we and do we have a role in trying to move
22 measurement towards those priorities?

1 I think we're making a lot of good
2 decisions, and very thoughtful decisions about
3 the things that are sitting out there on the
4 table as ways of measuring. But here, the top
5 one on this list here is patient reported outcome
6 measures. We haven't rejected or endorsed such
7 measures here.

8 And one of the problems is that they
9 just are not moving very quickly out there.
10 We've been talking about it for ten years, that
11 we need to have that kind of thing. And is there
12 anything we can do to cause patient reported
13 outcome measures to be creatively developed?

14 You know, the mechanics of doing that
15 are much farther advanced than they were when we
16 were talking about it ten years ago in terms of
17 electronic records, in terms of the ability to
18 survey people over time and stuff. But I'm just
19 wondering is there a way for us to actually weigh
20 in on getting that done.

21 The next one on my list is electronic
22 clinical quality measures. If that's a priority,

1 you know, is there anything we can do to have
2 that moved forward also. I'm just sort of
3 wondering.

4 This is a lot of people who know a lot
5 about the system. And I think we're not pushing
6 things as much as we'd like. There are some
7 things more difficult than that, such as
8 measuring diagnostic skills, and diagnostic
9 accuracy, and diagnostic creativity, that's not
10 even on that list of things that need to happen.

11 But everybody I talk to says, well
12 that's, you know, believes that's really very
13 important. And so I have to get it on the list.
14 And then I'd like to help make it happen.

15 But given that those patient reported
16 outcome measures is number one on the list, I
17 guess I'd like to see that, see us playing some
18 role in pushing that going forward.

19 The other, the very next page of that
20 is considerations for future meaningful measures.
21 And the first one on that was, is developing more
22 APIs for quality measured data submission. And,

1 you know, again, this is the kind of thing that I
2 hope we can get sort of encourage that to happen
3 more and think about why we don't have measures,
4 just the way that that's happening.

5 And interoperable electronic
6 registries, we've been talking about that for oh
7 so many years, getting more useful information
8 out of the registries than different societies,
9 et cetera, and maintaining, how can we move that
10 forward?

11 So I just want to, I'm just hoping
12 that before, somehow in the course of our
13 existence here, we can push some of those things
14 forward.

15 MR. AMIN: I think those are good
16 comments. We'll make sure and reflect those in
17 the priority section of the report.

18 MEMBER KRUGHOFF: Sorry to interrupt.

19 CO-CHAIR FIELDS: No, that's all
20 right. Any further discussion on the three
21 measures? Go ahead.

22 MEMBER GREINER: From your point about

1 Star ratings and how seriously they are taken by
2 the health plans and what downstream effects they
3 may have, I mean, I think that's really something
4 that I have heard as well, you know, that so much
5 rides on those measures.

6 The other measure related to, you
7 know, number of providers and the number of
8 pharmacies, that's more structural, and that's
9 something that the health plans can work on. Not
10 that the dosage isn't important, it's really
11 important, but I do worry about that downstream
12 pressure.

13 CO-CHAIR FIELDS: All right. I'm not
14 seeing any more cards up for reports. So we'll
15 start voting, I guess. Yes?

16 MEMBER YU: Before we vote, could you
17 please give us a little bit instruction on how we
18 vote this --

19 PARTICIPANT: Individual.

20 MEMBER YU: The individual. Could you
21 remind us?

22 CO-CHAIR FIELDS: Certainly. So just

1 to be very clear, we're going to be considering
2 each one of these separately for their
3 appropriateness for inclusion inside the CMS
4 Stars. So as always, vote your conscience.

5 (Laughter.)

6 CO-CHAIR FIELDS: So just keep that in
7 mind. But CMS is going to only be implementing
8 one of these. But you're just thinking about the
9 appropriateness of each one of them individually
10 irrespective of whether or not the others are
11 adopted.

12 MEMBER YU: Thank you.

13 CO-CHAIR FIELDS: All right.

14 MR. HIRSCH: For MUC2019-57, Use of
15 Opioids at High Dosage in Persons without Cancer,
16 do you vote to support the preliminary analysis
17 as the workgroup recommendation with conditional
18 support for rulemaking with the preliminary
19 analysis recommendation? Your options are yes or
20 no.

21 MS. BUCHANAN: And we need just one
22 more.

1 CO-CHAIR FIELDS: Did we lose
2 somebody? There was 22, did we lose --

3 MS. BUCHANAN: Oh, there we are. He
4 left, oh yes, Peter left. He's still on phone,
5 but he's not voting. So we have 21.

6 MR. HIRSCH: For MUC2019-57, Use of
7 Opioids at High Dosage in Persons without Cancer,
8 do you vote to support the preliminary analysis
9 with the workgroup recommendation, 14 votes yes,
10 8 votes no. The workgroup has recommended
11 MUC2019-57 for conditional support for
12 rulemaking.

13 CO-CHAIR FIELDS: So we didn't lose
14 anyone?

15 MS. BUCHANAN: No. Apparently Peter
16 is voting on his own.

17 CO-CHAIR FIELDS: Okay, great.
18 Thanks, Peter.

19 (Laughter.)

20 CO-CHAIR FIELDS: Okay. So we're
21 moving on to the next measure.

22 MR. HIRSCH: For MUC2019-60, Use of

1 Opioids from Multiple Providers and Persons
2 Without Cancer, do you vote to support the
3 preliminary analysis as the workgroup
4 recommendation, sorry, as the workgroup
5 recommendation, the preliminary analysis with
6 support for rulemaking. Your options are yes or
7 no.

8 MR. HIRSCH: For MUC2019-60, Use of
9 Opioids from Multiple Providers and Persons
10 Without Cancer, do you vote to support the
11 preliminary analysis with the workgroup
12 recommendation, 17 votes yes, 5 votes no. The
13 workgroup supports MUC2019-60 for rulemaking.

14 MR. AMIN: Robert, before we move on
15 from this, can we just take a moment to just
16 characterize the rationale. The rationale
17 generally here was around, it's around unintended
18 consequences for high dose.

19 CO-CHAIR FIELDS: All right. In our
20 last measure, the combination that they're, I
21 think we're ready.

22 MR. HIRSCH: For MUC2019-61, Use of

1 Opioids from Multiple Providers and at a High
2 Dosage to Persons without Cancer, do you vote to
3 support the preliminary analysis as the workgroup
4 recommendation? The preliminary analysis was
5 support for rulemaking. Your options are yes or
6 no.

7 MR. HIRSCH: For MUC2019-61, Use of
8 Opioids from Multiple Providers and at a High
9 Dosage to Persons without Cancer, do you vote to
10 support the preliminary analysis as the workgroup
11 recommendation, 8 votes yes, 14 votes no. The
12 workgroup does not support for rulemaking
13 MUC2019-61.

14 CO-CHAIR FIELDS: Okay, thank you,
15 Jordan.

16 MR. STOLPE: So now we need to do some
17 algorithm work. So now, the assumption is that,
18 if there's a mitigating circumstance around how
19 this measure could potentially be incorporated,
20 and we would articulate what that is, if not then
21 we should probably move directly to a do not
22 support vote. Would we be in agreement with

1 that?

2 CO-CHAIR FIELDS: Yes, that sounds
3 right. So any suggestions on what mitigating
4 circumstances might be that would cause you to
5 affect a vote?

6 No, all right. So I guess we're going
7 straight to a --

8 PARTICIPANT: No, that's --
9 (Simultaneous speaking.)

10 MR. HIRSCH: For MUC2019-61, Use of
11 Opioids from Multiple Providers and at a High
12 Dosage in Persons without Cancer, do you vote do
13 not support? Your options are yes or no.

14 MS. BUCHANAN: And we only have 21
15 votes, we had someone leave.

16 CO-CHAIR FIELDS: If we're doing this,
17 so we vote do not support, what happens?

18 MR. STOLPE: We don't support, that's
19 what that means. We will just write in our
20 report that we did not support this measure.

21 PARTICIPANT: With all of all the
22 language.

1 CO-CHAIR FIELDS: Yes, right.

2 MR. STOLPE: So we will list the
3 reasons that were articulated, such as the
4 downward pressure on providers, the sense of
5 duplicity, as well as what the measure developer
6 pointed out, that there's low numbers inside
7 these measures and --

8 MS. BUCHANAN: So we are, okay.

9 MR. HIRSCH: We're looking for one
10 more vote. For MUC2019-61, Use of Opioids from
11 Multiple Providers and at a High Dosage in
12 Persons without Cancer, do you vote do not
13 support, 15 votes yes, 5 votes no. The workgroup
14 does not support MUC2019-61, Use of Opioids from
15 Multiple Providers and at a High Dosage in
16 Persons without Cancer.

17 MR. STOLPE: Let's move on to our next
18 measure, shall we?

19 All right, thanks to all of you for
20 making it to this point in the day. So we're now
21 at our last measure for consideration. And this
22 is MUC2019-21, Transition of Care Between the In-

1 Patient and Out-Patient Settings Including
2 Notifications of Admissions and Discharges,
3 Patient Engagement, and Medication Reconciliation
4 Post-Discharge.

5 This is implied by the, so a long
6 title, this is a composite measure that consists
7 of several components. I'll just briefly read
8 the measure description. The measure, it says,
9 is the percentage of discharges for members 18
10 years of age and older who had each of the
11 following four indicators. First, notification
12 of in-patient admission, receipt of, sorry,
13 second, receipt of discharge information, third,
14 patient engagement after in-patient discharge,
15 and lastly, medication reconciliation post-
16 discharge.

17 Plans report separate rates for
18 individuals 18 to 64 years of age and those 65
19 year and older, as well as a total rate for each
20 indicator in the measure.

21 The staff's recommendation on this was
22 a conditional support and the NQF endorsement.

1 This measure is a little bit complex. The staff
2 noted that there's one of the components, the
3 medication reconciliation portion, is currently
4 included and that, further, NCQA stated that it
5 will work with CMS so the plans will not have to
6 report both this proposed measure and the stand-
7 alone MedRec measure. And we can now move to
8 discussion.

9 CO-CHAIR FIELDS: Great. All right,
10 Kevin Bowman is our lead discussant.

11 MR. BOWMAN: Yes. So the intent of
12 the measure is to improve coordination of care
13 for any members as they transition between in-
14 patient and out-patient settings. The measure
15 set assesses the percentage of discharges
16 watching essentially four components.

17 So we're starting notification of in-
18 patient admissions, so documentation of in-
19 patients, admissions for the following day.
20 There's receipt of discharge information, and
21 there's the patient engagement after discharge
22 component, and then the MedRec component. So the

1 medication reconciliation post-discharge is
2 already a Stars measure, MRT, so that's already
3 in place with Stars. And then you have the three
4 remaining components.

5 I would add that there were two
6 comments. One was a general positive, providing
7 positive kind of global comments on the measure.
8 And then the other one was pointing out or
9 highlighting the patient engagement component,
10 how that's very critical and important.

11 The other thing that I would add is
12 that per the CMS call letter, this was earlier
13 this year, the proposal to proceed with this as a
14 display measure. So I think there's already some
15 traction on the display.

16 So as previously noted, the MRT
17 components are already part of the Stars rating,
18 Stars measures. So this essentially would be
19 kind of folding this back into this which would
20 also include these other three components.

21 CO-CHAIR FIELDS: Great, thank you.

22 MEMBER GOZANSKY: So I think certainly

1 it's a good measure. I think it's problematic
2 that it is not fully electronic. I think there
3 is the burden and how representative this really
4 is as to whether we're going to get the kind of
5 behavior change that would actually drive the
6 outcome when it's just, it's very problematic
7 that way.

8 And I think the idea that, if there
9 could be something about this that was more
10 actionable rather than just an acknowledgment,
11 and I think this does get to the issue of, you
12 know, something that was more patient-reported, I
13 think this is still a good process measure. But
14 an understanding measure from a patient would
15 obviously be much more significant.

16 CO-CHAIR FIELDS: Thank you. Susan,
17 on the phone, any comments?

18 MEMBER KNUDSON: No. I think the
19 previous two commenters said it. I would just
20 echo everything Gwendolyn just said.

21 CO-CHAIR FIELDS: Great, thank you.
22 Kim, can we go to you next on the rural workgroup

1 and then --

2 MEMBER RASK: Yes. The rural
3 workgroup had a couple of, overall, they ranked
4 this kind of intermediately, felt neutral about
5 it on the measurement side. What they liked
6 about was that they regard transitions of care
7 for rural residents are a big deal, especially if
8 they are getting care at places and then coming
9 back to their home location. So they like the
10 idea that it was trying to get some of this
11 transition information.

12 On the other hand, they didn't know
13 even if it was being done at a plan level. If it
14 was chart abstraction, would that be burdensome
15 to smaller rural providers? They liked that it
16 was at the plan level.

17 And then there was another concern
18 about whether or not, for the MedRec component,
19 did you have the level of pharmacy and pharm tech
20 staffing to be able to do those services? So
21 would rural providers be disadvantaged?

22 CO-CHAIR FIELDS: Great, thank you.

1 All right, Kevin?

2 MR. BOWMAN: Yes, so I just, I do want
3 to reiterate that there, so first the components,
4 the admission and the discharge, that
5 administrative reporting, that was not available.
6 So it does place a burden on these to have to go
7 and do the chart cases. I mean, it is
8 essentially, for MRP, as it is right now, you
9 have to do that. So it does place an additional
10 issue.

11 CO-CHAIR FIELDS: Thank you.

12 MEMBER NGUYEN HOWELL: And I had a
13 question. Is there any data on the display
14 measure?

15 MR. ROMAN: What kind of data do you
16 mean?

17 MEMBER NGUYEN HOWELL: I had it quoted
18 before.

19 MR. ROMAN: Yes. So the measures
20 dated -- the measures already in for the last two
21 years, and I can tell you what performance is at
22 the plan level. And if so, just to be clear,

1 there are four indicators. It's like four
2 measures.

3 And they're grouped together because
4 we are trying to look at the coordination of care
5 for anybody who's discharged and going from in-
6 patient to out-patient. And it felt like the
7 right thing to do to group these together so that
8 you're seeing the whole thing.

9 At the plan level, so let's see, let
10 me just pull this up, so if we talk about the,
11 let's start with the notification of in-patient
12 admission, performance the year was around 12
13 percent. And the second year, this past year, it
14 was around 16 percent. So it did go up as the
15 measure's been out there.

16 That is one of the indicators that
17 does require chart review. And just to be clear
18 about that too, the reason it requires chart
19 review is there is no administrative way to
20 capture this information yet, it's new, for plans
21 to be looking at what the communications are that
22 are occurring between in-patient/out-patient.

1 And we have prioritized this at NCQA
2 as something to try to work with the standards
3 groups that are out there to get some of that in
4 place. Because there isn't great standardization
5 for how that data goes, so notifying, like, a
6 communication from an in-patient to out-patient
7 setting, or from the plan, to say that this
8 admission occurred.

9 So it is a new thing that we are
10 working on, but it is going to take time. There
11 is no way for us to do it administratively yet.
12 So that's the first indicator.

13 For the receipt of discharge
14 information, which is looking at was there
15 information sent on the day of discharge, or the
16 day after, to the provider, and did it make it
17 into kind of the provider's record, what they're
18 able to use for care.

19 The performance on that the first year
20 was around 7 percent. And the second year it
21 went up to 11 percent. So we do see some change.
22 And that's the same thing. There is, you're

1 looking for something that is documented
2 somewhere. It's not the typical data that plans
3 are using, that anybody's using for reporting.

4 There is more standardization around
5 discharge summaries. But it's not there yet in a
6 way that we could use it to get it to an
7 administrative spec. But again, it's something
8 we are working with the standards groups on to
9 try to get there, so we can ease some of that
10 burden.

11 For the next indicator, the medication
12 reconciliation post-discharge measure, as you
13 noted, that is already in Stars. It's been in
14 HEDIS for a while. The plan is to roll that into
15 this set of measures so that there isn't dual
16 reporting, or plans don't have to report both
17 measures separately.

18 That's something we have to work with
19 CMS on, though, on the decision making of how
20 that, you know, retired one measure from the
21 program and added in the other. That's not
22 something we make on our own. So we are working

1 on that. For performance for that, the first
2 year was around 44 percent. The second year went
3 up to 53 percent.

4 And then the final piece, the patient
5 engagement piece, which is really looking at
6 follow-up of some type, so after the specs --
7 because there were three indicators that actually
8 don't require you to say anything to the patient,
9 because it's all communications and looking at
10 medications.

11 So the follow-up piece, that you're
12 actually saying are you okay, do you understand
13 what happened, when you've just been released do
14 you know what you're supposed to do next, that is
15 the highest performance. The first year it was
16 around 78 percent. And it went up to 81 percent
17 the second year.

18 CO-CHAIR FIELDS: Great, thank you.

19 MEMBER YU: Thank you. I really like
20 this piece, the patient engagement in this
21 measure, because the transition is really is part
22 of an important equation in this safe transition.

1 I'm just wondering, the data we are
2 going to use is claim data and the records
3 review. So my question is for the patient
4 engagement part, is this just going to be check
5 the box or you actually, you know, are you going
6 to do a survey, say you get to actually review
7 the records or the document that are in the
8 medical records?

9 MR. ROMAN: Yes. So the plans right
10 now can report it by looking at, they can look at
11 the claims data to see that there was a visit or
12 some sort of telephone follow-up or online
13 follow-up or they can look in the record and see
14 that there is documentation that there was a
15 visit that took place or there was some sort of
16 communication with a patient.

17 So they have two ways of reporting
18 because it is a hybrid measure currently, so we
19 allow them to use administrative claims alone or
20 they can do kind of a combination of looking at
21 claims and looking at what's in the record.

22 MEMBER YU: Great. I like that.

1 Thank you.

2 CO-CHAIR BAGLEY: I think Helen was
3 next.

4 MEMBER BURSTIN: I just have more of
5 a future tense question for you. I saw one of
6 the options when I pulled up the details of it is
7 that plants can use the ADT system to do this.

8 It would be a great standalone measure
9 to at least get a measure that got at an e-
10 measure using ADT and I would hope NCQA would
11 move in that direction if they haven't already.

12 MR. ROMAN: Yes, we're trying to make
13 sure that we include data sources like that, but
14 there are plans that are enabling the providers
15 to have that information that they get about
16 admissions and discharging transfers.

17 MEMBER BURSTIN: Right.

18 MR. ROMAN: And so we wanted to make
19 sure we -- When that's in place, when that
20 information can make it to the provider we
21 recognize it.

22 So it something that we actually

1 worked to include and then are trying to make
2 sure that the language in the spec is really
3 capturing it and making it clear that that's
4 something that we allow.

5 MEMBER BURSTIN: Well it should
6 actually be an expectation on the part of the
7 plan not just we allow it, but that information
8 flows is good evidence as far as the clinician
9 cares better, particularly primary care.

10 So I hope that would be a new e-
11 measure perhaps you guys could look at.

12 (Simultaneous speaking.)

13 MR. ROMAN: I will put it on a list.

14 MEMBER SCHREIBER: -- NCQA on this.

15 They are actually looking at many of their
16 measures for re-specifying --

17 MEMBER BURSTIN: I know.

18 (Simultaneous speaking.)

19 MEMBER SCHREIBER: -- and developing
20 electronic measures. So they are really being
21 very supportive in this area.

22 CO-CHAIR BAGLEY: Will, you're next.

1 MEMBER FLEISCHMAN: Given that this is
2 already a HEDIS measure do you expect any
3 additional burden to, I guess, trickle down to
4 clinicians or groups by making it part of Part C
5 and D?

6 MR. ROMAN: So additional -- I think
7 the plan is going to put more focus on trying to
8 improve their rates and trying to make sure that
9 this communication where -- because the two
10 hardest indicators are the pieces that are about
11 communication and information sharing and it
12 doesn't happen well and that is part of what we
13 are seeing I think with the low rates.

14 The burden is actually is absolutely
15 an aspect of the low rates as well without a
16 doubt, but I mean I think you will see that
17 providers are going to hear from plans more that,
18 you know, why isn't there communication happening
19 or that the plan is providing that information to
20 them, because that's really what we hear quite
21 often from the plans that are really engaged is
22 that they take the step and they provide

1 information.

2 They have the discharge information
3 and the admission information and say this
4 admission has happened, this discharge has
5 happened.

6 So we hope that it's not necessarily
7 adding burden but that it's improving the
8 communication and the information sharing that
9 the plans do have, which is why we have it at the
10 plan level.

11 MEMBER FLEISCHMAN: Are they going to
12 be I guess hurting the providers by -- I don't
13 know how they get their information now in terms
14 of let's say knowing whether the provider
15 received a discharge summary from the discharging
16 institution.

17 So having this, you know, more
18 prominent, it's obviously on their end, on the
19 plan's end, is that going to trickle back to the
20 provider to somehow have to, I don't know, give,
21 survey a sample a random number of charts to see
22 what percentage they have?

1 MR. ROMAN: So I mean right now the
2 plans themselves identify patients when the do
3 the report of this measure.

4 So Medicare plans are already
5 reporting this measure, it's just whether or not
6 it's in their discharge program, right?

7 MEMBER FLEISCHMAN: Right.

8 MR. ROMAN: So they are already asking
9 the plans -- we are have the plans reporting the
10 measure and because there is a component that
11 requires medical record review they do, they
12 select a sample and they reach out to their
13 providers, or if they have access to the records
14 already they look at those records and get a
15 sampling from the provider.

16 So there is that level but that's with
17 any chart view measure that we have is that there
18 is some outreach to providers to get that
19 information so that they can look at the charts
20 and see if the patient they have identified does
21 actually qualify for the measure or not.

22 MEMBER FLEISCHMAN: Yes, back to what

1 Helen said I think this could be eventually
2 converted to a completely electronic measure.
3 ADT could also report whether the discharge
4 summary was faxed or somehow submitted to the
5 provider.

6 MR. ROMAN: Yes, absolutely. We have
7 had a lot of discussions with some of these
8 groups about this and we were hoping that we
9 would be further along but found that especially
10 with the notification of admission piece the
11 communication piece which you are trying to
12 capture to have that be an electronic measure,
13 we're just not there yet, what is available that
14 we could code into an e-measure, but it is, like
15 I said, it is something we are working on.

16 CO-CHAIR BAGLEY: Joy, you are next.

17 MEMBER BLAND: Yes, I mean I think the
18 intent of the measuring period I think it, again,
19 comes to the medical records retrieval burden and
20 the inconsistency of how health plans identify
21 some of those.

22 I mean some you're sitting there, you

1 know, abstracting, circling, oh, he said "hi"
2 instead of patient is at considered engagement.

3 There is a lot of room here and I
4 think with probably some of the goals we've
5 talked about is when do we kind of put the stop
6 on, if we're going to go towards e-measures do we
7 not implement anymore hybrid and start going that
8 direction or do we continue on the path?

9 CO-CHAIR BAGLEY: Trudy?

10 MEMBER MALLINSON: No.

11 CO-CHAIR BAGLEY: Okay. Wendy?

12 MEMBER GOZANSKY: I guess the only
13 other question I would ask is that these changes
14 that you've seen year over year are they actually
15 associated with decreases in the PCR at the plan
16 level?

17 MR. ROMAN: We have --

18 MEMBER GOZANSKY: Because I think
19 that's the question is that what we are talking
20 about is that just hypothetically the plans that
21 are improving are simply going and capturing the
22 existing data.

1 It doesn't necessarily mean -- because
2 I think that's the problem with this as a process
3 measure that just gets me a little concerned.

4 PARTICIPANT: What is PCR?

5 MEMBER GOZANSKY: That's the
6 readmission measure.

7 PARTICIPANT: Oh, thank you.

8 MEMBER GOZANSKY: Which is what we are
9 trying to drive.

10 PARTICIPANT: Right.

11 MR. ROMAN: And that is something we
12 want to explore, but the measure, so, you know,
13 with HEDIS measures the first year is really put
14 it out there and see how performance works.

15 It's almost like the final last test
16 of the measure before we start reporting on
17 public rates and start holding anybody
18 accountable for it.

19 So this is just in its second year and
20 based off the first year we did make some changes
21 to the language that is being implemented in this
22 next version of the measure because we want to

1 make sure that we are recognizing all the good
2 care that is being provided.

3 So I think that that is something that
4 the analysis of two measures together and looking
5 at the outcomes or, you know, how this might
6 relate to the re-admissions is something that is
7 definitely what we are planning to do, we just
8 have not gotten to it yet.

9 CO-CHAIR BAGLEY: Okay. Before we go
10 to a vote, I just wanted to explain why Rob left.
11 Rob got to the counter at the airport this
12 morning to find out that his reservation had been
13 cancelled, not the flight, his whole reservation.

14 So the only way he could get back on
15 a same-day kind of trip was to go on a 5 o'clock
16 flight. So he didn't do that intentionally, it
17 was kind of done to him by the system, I guess.
18 So, anyway, let's go on to the vote.

19 PARTICIPANT: Okay.

20 MR. STOLPE: While we are pulling that
21 up, we did want to add that we would especially
22 recognize Rob for his efforts in getting here.

1 So we did award him the first annual PQA
2 diligence and valor award.

3 (Laughter.)

4 CO-CHAIR BAGLEY: His first email was
5 I can't make it, I'll be on the phone, so he did
6 well.

7 (Off mic comments.)

8 MR. HIRSCH: For MUC 2019-21
9 transitions of care between the inpatient and
10 outpatient settings including notifications of
11 admissions and discharges, patient engagement,
12 and medication reconciliation post discharge do
13 you vote to support the preliminary analysis as
14 the workgroup recommendation, conditional support
15 for rulemaking as the preliminary analysis
16 option? Your options are yes or no.

17 CO-CHAIR BAGLEY: We have 19 total.

18 MS. BUCHANAN: Yes. And that is if
19 Peter is still here tomorrow.

20 (Off mic comments.)

21 MS. BUCHANAN: It looks like we are
22 looking for one or two more votes. So, Chad and

1 Susan, were you able to vote?

2 MEMBER TEETERS: Yes, I was.

3 MS. BUCHANAN: Great. Sue, were you
4 able to vote?

5 MEMBER KNUDSON: Yes, I did.

6 MS. BUCHANAN: Okay. So it looks like

7 --

8 (Off mic comments.)

9 MS. BUCHANAN: Is it not coming
10 through?

11 (Off mic comments.)

12 MS. BUCHANAN: You said yes, okay,
13 great.

14 MR. HIRSCH: Okay. For MUC 2019-21
15 transitions of care between the inpatient and
16 outpatient settings, including notifications of
17 admissions and discharges, patient engagement,
18 and medication reconciliation post-discharge, do
19 you vote to support the preliminary analysis of
20 the workgroup recommendation?

21 Fourteen votes yes, four votes no.

22 For MUC 2019-21 the workgroup recommends

1 conditional support for rulemaking.

2 CO-CHAIR BAGLEY: Okay. We have to
3 have a quick chat, thank you, about gaps and some
4 other things. We are almost at the end.

5 I have taken a count and I have
6 noticed that almost everybody has taken their own
7 individual break as needed, so instead of
8 breaking and coming back I think we'll press on
9 and get out of here, how about that.

10 Okay. So this is a wide open
11 question, how about gaps in the Star Program,
12 what should we be putting in there?

13 (Off mic comments.)

14 CO-CHAIR BAGLEY: Any thought about
15 that?

16 MR. STOLPE: Yes, we're going to put
17 up a list of the current measures for you to
18 consider as we discuss gaps.

19 PARTICIPANT: Yes.

20 CO-CHAIR BAGLEY: Any of you have a
21 lot of experience with the Star Program? Amy,
22 you're kind of an expert, right? What does it

1 need?

2 DR. ANDERSON: What does it mean or do

3 I --

4 (Laughter.)

5 DR. ANDERSON: I think what I would
6 like to see and I think it's not exclusive to
7 Stars, but really more patient-reported outcome
8 measures and experience measures, so PROMs and
9 PREMs.

10 And also within PROMs the patient-
11 reported, I think it's called patient measurement
12 measure, so they are evaluating their actual
13 perception and their change in status and
14 function.

15 So I think that's one thing that is
16 pretty demonstrably noticeable second to care
17 coordination, transitions of care, it's really
18 the patient's voice and the consumer's
19 perspective in this.

20 CO-CHAIR BAGLEY: Wendy?

21 MEMBER GOZANSKY: Yes. So I would
22 just second that and I think that the measures

1 that we have in the health outcomes survey I
2 think are around sort of physical and mental
3 health.

4 I don't think that we note that they
5 are sensitive to change or that they necessarily
6 have the reliability, so I think new measures
7 something along the lines of, you know, self-
8 rated health, the Cantril Ladder, that type of
9 thing, or it would be just so much more
10 meaningful and would actually drive people to be
11 trying to do things to impact outcomes.

12 I would also say that if we get to the
13 place where, you know, reducing risk of falling,
14 those sorts of things, that are truly going to
15 increase or improve the health of folks, I think
16 actually getting whether people are diagnosing
17 falls or urine incontinence or those types of
18 things and getting to an administrative measure
19 for addressing things rather than just a report I
20 also think would be really beneficial.

21 And I think the other thing I would
22 say is just simply on the medication adherence

1 measures we are getting to a place where I am not
2 clear that, you know, randomized clinical trials
3 with highly, you know, compliant folks, we are at
4 levels of adherence that make me think that
5 people are not taking those medicines.

6 I am a geriatrician, I go do home
7 visits. The medicines are sitting there, they
8 are just not taking them, and so I think we need
9 to really think about what we are driving
10 currently with where we are with those measures
11 and being three-fold weighted, you know, really
12 important.

13 But I guess this also gets to the
14 issue around how, you know, if you have a shared
15 decision making discussion with somebody and they
16 don't want to take a medication or they don't
17 want to have their breast cancer screening, you
18 know, how do we capture that, that we sat with
19 them, they made an informed decision, and not
20 penalized because that actually takes me way more
21 time to sit and have the discussion with a
22 patient, as you all well know, than that.

1 I know it's very hard to capture. How
2 do you capture it that I didn't just check the
3 box, but I think that's where is it a patient-
4 reported outcome measure.

5 CO-CHAIR BAGLEY: Kim?

6 MEMBER RASK: And I think one of the
7 things that comes through from the rural
8 workgroup a lot, which echoes some of what Sandy
9 has already said, is that appropriately managing
10 someone's care when they are challenged by
11 geographic isolation, it's not clear whether it's
12 better to always transfer for a higher rated
13 setting or have more timely accessible care with
14 what is available in the area and answering those
15 kinds of questions are impossible to do, very
16 difficult to do at the individual provider level
17 or individual clinician, but at the plan level we
18 have the opportunity to think about
19 appropriateness of care measures and what are
20 those outcomes.

21 Are there times when surgery is better
22 done by a low volume provider that is nearby that

1 has good -- that you could have timely follow-up
2 care, or is it better to fly 300 miles to the
3 expert center and do it.

4 And so they really struggled that a
5 lot of the measurement doesn't feel like it -- a
6 lot of the measures that are out there don't feel
7 like they address the needs of the rural
8 communities that really want to know what is
9 appropriate care, what is best care, not in an
10 ideal setting, but given the setting that we live
11 in.

12 And as we bring in telehealth, can you
13 replace some of that travel with telehealth, but
14 we need to have measurement and quality
15 monitoring at a level where we can see as these
16 things come in what are the best practices and
17 what seems to have the best outcomes so that
18 people kind of know what that path should be and
19 how do some of those measures at the plan level
20 seems to come up to people as like that's the
21 right level where you might get enough experience
22 and enough observations to be able to figure out

1 kind of what is good and what is better.

2 CO-CHAIR BAGLEY: Helen, you were next.

3 MEMBER BURSTIN: I am just very much
4 echoing what has been said. If you just look at
5 the list there are just a lot of older process
6 measures that have been there forever split out
7 into the separate screening measures of diabetes
8 and I don't think that's how people pick their MA
9 plans and I think it would be great to begin
10 thinking about it.

11 I know NCQA has been thinking about is
12 as have others, but what are the kind of measures
13 that a consumer who actually does pick among a
14 set of MA plans could find useful and given this
15 day in age first dollar coverage, out-of-pocket
16 costs, the kinds of issues that are really often
17 pocketbook issues and combining that with some real
18 quality outcome measures would be better.

19 So I'd go for a much smaller set of
20 measures that get at how people actually select
21 plans.

22 CO-CHAIR BAGLEY: Louise?

1 MEMBER PROBST: Along the same lines
2 and to underscore what Kimberly said, I think we
3 really need complication rates by surgeons by
4 types of procedures.

5 I think you said that the people
6 aren't just looking at their geography. I live
7 in St. Louis, there is all kinds of specialists,
8 but I can chose to go to Cleveland or Washington
9 D.C. or somewhere else, and so I like the fact
10 that your Star ratings so far compare people
11 across markets and I hope you will continue to do
12 that.

13 CO-CHAIR BAGLEY: Amy, you have your
14 card up again?

15 DR. ANDERSON: Yes. I just wanted to
16 add maybe with the kidney care choices model
17 perhaps looking at the measurement and
18 performance there and seeing if there is any
19 relevance to the Stars Program as you look at
20 alignment and the need with our patient
21 population changing with kidney care.

22 MEMBER GOZANSKY: And then in a

1 perfect world something that is about over
2 diagnosis or over treatment for frail elders
3 because they get excluded on the upper level but
4 that 85-plus as we started is the growing group,
5 so, you know, it might be interesting to say
6 something in that realm.

7 CO-CHAIR BAGLEY: Girma?

8 MEMBER ALEMU: Yes. I just want the
9 opportunity to say yesterday we learned about the
10 importance of telehealth, including telehealth
11 into existing measures or developing, you know,
12 separate data health measures, that's very
13 important, especially for the rural health
14 population and also to find, you know, looking
15 forward to develop measures that can be used at
16 multiple levels of analysis in multiple settings.

17 You have a large number of quality
18 measures out there and we have to focus on those
19 high volume measures and that can be used really
20 in, you know, instead of developing separate
21 measures for all, you know, settings that we
22 have. So just to pay attention to those areas.

1 CO-CHAIR BAGLEY: Yanling?

2 MEMBER YU: Thank you. I really like
3 that CMS is putting patient-reported outcomes as
4 one of your top priorities and I think it's very
5 important.

6 I just wonder if the agency has
7 thought about, you know, the AHRQ who is pushing,
8 you know, the CAHPS surveys on patients, you
9 know.

10 I'm just wondering if there is any
11 correlate efforts between AHRQ and CMS and then
12 to expand on this effort, CAHPS, and then add
13 more attributes of, you know, the survey to
14 including different aspects of when you come to a
15 procedure measures or outcome measures.

16 MEMBER SCHREIBER: Can I answer that.

17 CO-CHAIR BAGLEY: Go for it.

18 MEMBER SCHREIBER: So the answer is
19 yes, we are having conversations with the people
20 who are in charge of both CAHPS and HCAHPS.

21 MEMBER YU: Yes.

22 MEMBER SCHREIBER: Because that's --

1 And I'm not saying that's the direction we'll
2 take, but it is kind of a natural way of doing
3 it.

4 We are already surveying patients.
5 You could in theory then add other questions
6 related to outcomes, functional status, or any
7 other uses for it.

8 MEMBER YU: Yes, I am glad to hear
9 that. Another thing is I have been attending
10 this overall webinar by AHRQ about AHRQ's CAHPS
11 survey and, you know, like any survey it's not a
12 100 percent return rate and lots of times
13 consumers are --

14 MEMBER SCHREIBER: No, that's true.
15 (Simultaneous speaking.)

16 MEMBER YU: -- you know, you are
17 surveying them. They are not -- They don't say
18 the need or incentive or whatever it is to
19 participate, so you may have to pay some
20 attention to how to really get people
21 participating in this type of a survey to provide
22 a useful information.

1 MEMBER SCHREIBER: I agree. I would
2 hate though for us to all look like car sales
3 people though.

4 (Laughter.)

5 MEMBER SCHREIBER: But you're point is
6 well taken, the response rates are very low in
7 some cases.

8 MEMBER YU: Right, yes.

9 CO-CHAIR BAGLEY: And if I might add
10 on the same topic, you know, as somebody who is
11 trying to drive quality improvement at the
12 practice, you know, microsystem level, if you
13 will, things like suggestion boxes and patient
14 advisory boards are far more useful in terms of
15 driving improvement and change than CAHPS will
16 ever be for the actionable stuff you get back.

17 Now once in a while you identify an
18 outlier provider, but you knew about that person
19 before because he's a jerk.

20 (Laughter.)

21 CO-CHAIR BAGLEY: So any others that
22 --

1 (Simultaneous speaking.)

2 CO-CHAIR BAGLEY: The margin and
3 utility of all that effort that we are putting
4 into CAHPS I would call into question.
5 Stephanie, you were next.

6 MEMBER FRY: Following on to some of
7 the recent comments I think, you know, with
8 response rates declining there are different
9 strategies for different purposes, so for your
10 own quality improvement purposes, you know,
11 absolutely, your suggestion box, but I still
12 think that, you know, you're not going to get
13 where we've talked about like what is the
14 reliability and validity of measures, that won't
15 be the threshold for that and to kind of relegate
16 the patient voice to quality improvement and just
17 hope that it comes through I don't think is quite
18 the way to go.

19 But I really like CMS's idea in terms
20 of moving toward how can you reduce burden in the
21 collection of that information by combining
22 patient-reported outcomes with experience.

1 You know, if you are going to get
2 people to respond to a slimmest number of items
3 and minimize their burden, you know, can you put
4 that in one place.

5 And I think there is also, you know,
6 as we look at coordination there has been a
7 number of measures trying to get at what's the
8 coordination so it's not just siloed healthcare
9 being delivered.

10 I think it's the patient experience
11 across the various settings of care also that we
12 need to start figuring out how to do a better
13 measurement job of, so not just what was your
14 experience in a hospital, what was your
15 experience with your, you know, primary care doc,
16 but, you know, how do we try to have a better
17 understanding of how to improve that overall
18 experience for patients because that's where I
19 think we'll be able to see improvements in their
20 outcomes.

21 CO-CHAIR BAGLEY: Other comments? If
22 not we have an opportunity for public comment.

1 I'm not exactly sure what they are supposed to
2 comment on, but we'll let them say whatever they
3 want.

4 (Laughter.)

5 CO-CHAIR BAGLEY: And if anybody on
6 the phone still wants to have something to say
7 it's time to do it right now.

8 MS. BUCHANAN: To unmute your line is
9 *7.

10 CO-CHAIR BAGLEY: Maybe I could say a
11 few comments while you are waiting. The next
12 thing on the agenda is for me to summarize the
13 day and I don't think that I would be willing to
14 do that in terms of trying to summarize the
15 discussion.

16 But let me say this, that if our
17 purpose today was to inform CMS about how we
18 think the measures should be used and implemented
19 and modified and whatever then I think we have
20 accomplished our purpose, in a sense that they
21 have been attainable thereon and kudos to you
22 guys for the third day you are looking pretty

1 good.

2 (Laughter.)

3 CO-CHAIR BAGLEY: And still paying
4 attention. And to the staff who has been here
5 all day kind of taking notes and probably on the
6 phone as well, so thanks to all of you guys for -
7 - it makes us feel like our time was well spent
8 because you are paying attention.

9 So the next group I would like to
10 thank is you, each one of you who took a whole
11 day out of your life to come here and I hope that
12 you enjoyed the conversation as much as I did.

13 I always learn something. I always
14 see things in a different way and in a different
15 perspective and I appreciate the growth it allows
16 for each of us kind of professionally to know a
17 little bit more about how this all fits together.

18 I especially want to thank those lead
19 discussants who put, you know, extra effort into
20 making sure they are ready to talk about the
21 measures. And, Kim, you had to actually do that
22 for all the measures, thank you for that.

1 And I think finally a real lot of
2 thanks to the NQF staff and, you know, if it's
3 okay with you I'll talk to your boss after the
4 meeting and let him know what a good job you did

5 In case you want to know they are the
6 ones that do the heavy lifting and you guys make
7 my job easy, but, anyway, from Rob and me thank
8 you for spending your day with us.

9 Anybody have any other -- Did you guys
10 have any comments or --

11 MEMBER SCHREIBER: I mean our only
12 comment is really to echo what you said, your
13 input to CMS is extraordinarily valuable. We
14 took some extensive notes.

15 You're right, we have lots of people
16 on the phone also taking notes. But even as I
17 sit here and reflect on the last three days it is
18 clear that the feedback that we got is going to
19 change some of the measures, I can tell you that
20 already because of some of these sidebar
21 conversations we've been having is going to
22 impact the measures, impact them as to how we use

1 them in the programs, and we have particularly
2 really appreciated first of all the opportunity
3 to discuss some strategic direction and then to
4 really have some significant input on it, so
5 thanks you.

6 And, of course, as always, thank you
7 to NQF, but, Bruce, to you and Rob we would
8 really like to say thank you for co-chairing.

9 CO-CHAIR BAGLEY: You're welcome. I
10 always like to do at least a brief meeting
11 assessment. So if you have a comment about
12 something you liked about the meeting or if you
13 have a comment about what could have been done a
14 little better that is fine.

15 And it goes everything from the food
16 to the temperature to the speaker system, or lack
17 thereof, anyway, whatever you would like to say
18 to help us do better next time. Louise?

19 MEMBER PROBST: This is my first MAP
20 in many years, a big difference. I really
21 appreciated the user guide, so thank you.

22 CO-CHAIR BAGLEY: Yes?

1 MEMBER BOWMAN: I thought the IHI
2 presentation was very good, very informative.

3 CO-CHAIR BAGLEY: Other comments?

4 MEMBER GOZANSKY: My first time here,
5 I appreciated the level of dialogue. I thought
6 it was very collegial, appropriate, and very
7 informal and comfortable, although still heard to
8 hear.

9 (Laughter.)

10 PARTICIPANT: We'll fix it.

11 MEMBER BURSTIN: I was just going to
12 say our CMS colleagues were remarkably open and
13 really listening.

14 CO-CHAIR BAGLEY: Okay. If that is
15 all -- Mr. Hirsch, do you have any comments?

16 MR. HIRSCH: Yes. Thanks for very
17 much. I guess we're heading down the final
18 stretch then so on behalf of NQF leadership and
19 staff I just wanted to say a very big thank you
20 to each one of you for all of the hard work
21 necessary to come prepped.

22 It was clear that you did a lot, so --

1 and in a very short turnaround. Just the way
2 that the MAP is structured requires us to act
3 quickly and you all just did an absolutely
4 wonderful thing, so thank you all for everything
5 that you do, especially to our Co-Chairs, we
6 recognize that Rob Fields isn't here to accept
7 our thanks, but, Bruce, thank you so much.

8 (Applause.)

9 MR. HIRSCH: One more thing that we
10 would like to add is to our CMS colleagues,
11 thanks for staying with us these three days.

12 The sincerity that you bring to your
13 jobs is really clear that you take this very
14 seriously and the earnestness by which you engage
15 with us it truly means a lot, so thanks very much
16 for your engagement for the two days and with
17 that I think that we can adjourn. Thanks very
18 much.

19 CO-CHAIR BAGLEY: Safe travels,
20 everybody.

21 (Whereupon, the above-entitled matter
22 went off the record at 3:59 p.m.)

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In the matter of: MAP Clinician Workgroup

Before: NQF

Date: 12-05-19

Place: Washington, DC

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